Syracuse University

SURFACE

July 2016

AN ANALYSIS OF TALK AND INTERACTIONS IN INITIAL SESSIONS IN THE CONTEXT OF COUNSELING AND FAMILY MEDICINE

Yihhsing Liu
Syracuse University

Follow this and additional works at: https://surface.syr.edu/etd

Part of the Student Counseling and Personnel Services Commons

Abstract

This study used conversation analysis, a method that directly investigates language use and interactions at both the thematic level and microanalytic level, to explore the processes of talk and interactions of initial sessions between trainees and their clients/patients in two professions, counselor education and family medicine. The naturally occurring, audio and/or video-recorded data regarding initial sessions conducted by trainees in both professions were used to explore three overarching questions: (1) How are the conversations between trainees and clients developed and maintained in their initial encounters? (2) How are therapeutic relationships and therapeutic discourses developed in initial sessions? (3) How do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability? The results indicated that while professional practice was contextual and circumstantial, both professions in this study share a number of strategies and talk features with regard to the development of therapeutic relationships, the process of disclosures, and the presentation of unique interactions as a result of co-constructed therapeutic discourses. The study of talk and interaction provides authentic materials of clinical practices and a comprehensive analytic framework for supervision. Future studies regarding clinical encounters, working alliances, and therapeutic discourses that include analyses of talk and interactions will provide additional insight and enrich the methodological repertoires for current studies related to the best practices, effective therapeutic alliances, and communications.

AN ANALYSIS OF TALK AND INTERACTIONS IN INITIAL SESSIONS

IN THE CONTEXT OF COUNSELING AND FAMILY MEDICINE

By

Yihhsing Liu

B.A in Psychology, Duquesne University, 2008

M.S.Ed. in Community Counseling, Duquesne University, 2011

Submitted In Partial Fulfillment of the Requirement for the Degree of

Doctor of Philosophy (PhD) In

Counseling and Counselor Education

Syracuse University

July 2016

Acknowledgement

So a ground is both the soil and the farewell to any kind of stability. It is in that sense that the PhD was a ground, to the extent that it gave me confidence in the absence of ground, if I may say so. Which is a ground which helped me to bear the absence of ground. A time for farewell.

— Catherine Malabou

I identify myself in language, but only by losing myself in it like an object.

— Jacques Lacan

I would like to begin by expressing my sincere gratitude to the three counselors-in-training and five doctors-in-training who participated in this study and allowed me to tape and analyze the initial clinical encounters with their clients/patients under a variety of unexpected circumstances. This dissertation would not have been possible without their unusual openness and embrace towards this research idea. I sincerely thank them for their great contributions.

I also want to acknowledge the following leaders who have assisted me with my study, as they made my data collection possible. Drs. Sue Snyder, Paul Pickett, Andy Lobl, James Tucker, Ford Brooks, David Delmonico, Bill Casile, Jocelyn Gregoire, Lisa Lopez Levers, Jerry Kolbert, and Linda Goodfellow generously offered their time, support, and connections during my data collection. I also want to thank Drs. Sean Finnerty, Jim Bellini, Nicole Hill, and Ms. Sindy Pitts, who offered their support during my doctoral endeavors as well as throughout the dissertation process.

This dissertation as well as my doctoral study at Syracuse University was formed, inspired, challenged, shaped, reshaped, and eventually developed through my interactions with my advisor, mentor, and dissertation chair, Dr. Melissa Luke, and my two committees, Drs. Melissa Arthur and Jeff Good. First, I would like to express my deep appreciation to my academic and dissertation advisor, Dr. Melissa Luke. Dr. Luke was the very first person who encouraged me to explore the idea of discourse analysis in the area of counselor education. During my entire journey at Syracuse University, Dr. Luke provided me with both professional and personal mentorship and never stopped demanding the best of my potential. Despite having many other ongoing duties and responsibilities, Dr. Luke dedicated a great deal of her time and

energy to reviewing my work and providing me with valuable feedback. Her impact on my growth is unforgettable.

Dr. Jeff Good was one of the first people who inspired me to undertake this study as I had never imagined it would be possible. His encouragement and guidance during my very first research project on the study of clinical interaction evoked my passion for language and eventually inspired me to develop this dissertation topic.

I cannot be thankful enough to my clinical supervisor, mentor, guidance, and committee member, Dr. Melissa Arthur, whose clinical wisdom and multidisciplinary professional endeavors added incredible assets to this study. Dr. Arthur always helped me to see the light at the end of the tunnel during my doctoral study as well as my dissertation process, especially when frustrations arose and the path forward was uncertain. She has provided me with tremendous emotional and intellectual support throughout my professional development. In addition, she always installed hope and possibility whenever I encountered challenges. I can never forget that during my data collection in the coldest, harshest winter, Dr. Arthur reminded me not to give up and provided me with hope to continue this difficult task. It brings me to tears when I look back at the process and the completion of this study is at hand.

I want to give my special thanks to my former mentors and now colleagues at Duquesne University, Drs. Lisa Lopez Levers, David Delmonico, and Bill Casile who were very influential in my decision to pursue my doctorate. Their encouragement and support established the foundation for my success. During the writing process, Ms. Beverly Sughrue, Ms. Lisa Chir, Drs. Lisa Lopez Levers, Debra Hyatt-Burkhart, and David Delmonico constantly encouraged me and patiently offered me their wisdom and warmth on various occasions. I was very fortunate to have had such gracious support during this critical stage of the process.

Despite having had several unexpected challenges during the final stage of my doctoral study, I have never forgotten the encouragement, love, and support that I received from many great friends and family members. Ms. Christie Hudson, a remarkable human being and soul, has given me enormous support during this very challenging time of my life. Drs. Abeer Rasheed, Kanat Bolazar, and Wayne Chou, as well as Mr. Sukru Colak and Ms. Mona Ramadan, have offered me their unconditional friendship. I am also very grateful to know Dr. Michael Calloway, a very admirable person who always inspires me intellectually. My sister, Enhsing Liu, my brother Shih-Diing Liu, as well as Drs. Lisa Brush, Walter Boykowycz, John Spurlock, and

Zhiping Mi always asked me how I am doing and how my dissertation was progressing. Dr. Olga Kuksenok, Mr. Sasha Kuksenok, and Dr. Katerena Kuksenok constantly surprised me with warmth and love, and made sure that I obtained peace and nurture. All my dearest and fun-loving friends from the tango and ballet community in Pittsburgh, Meghan Tighe, Rafael Herrera, Erin Dornenburg, Kausik Chakrabarti, and Igor Kurnikov, as well as my endearing family members, Sue Corrado, Anthony Corrado, Barb Mangieri, Andy Harkness, and Elaine Miller, have given me countless laughs, happiness, and warmest regards. All of them have provided a testimony that family is defined by the love of heart.

This dissertation is dedicated to my love and my best friend, George, who has given me the most unconditional generosity, patience, affection, and nurture during my dissertation process. Thank you for the powerful listening, comfort, and for teaching me your unique perspectives and philosophy on life, challenging me when I need it, and always embracing who I am and my vulnerability. My appreciation, gratitude, and love toward you goes beyond my linguistic capacity and this chapter can never be completed.

TABLE OF CONTENTS

CHAPTER I

Introduction

Health care service delivery involves information inquiry, assessment, and
implementation of procedures that relieve physical and emotional suffering. In an initial session,
health care service providers regularly encounter a variety of physical and psychological issues
(Budman, Hoyt, & Friedman, 1992; DeGood, 1983; Easter & Beach, 2004; Esogbue & Elder,
1979; Odell & Quinn, 1998; Saltzman, Luctgert, Roth, Creaser, & Howard, 1976; Whitlock,
Polen, Green, Orleans, & Klein, 2004; Zisook, Hammond, Jaffe, & Gammon, 1978). In order to
effectively respond to the presenting issues, clinicians engage in various decision making
processes as part of assessment and intervention implementation. For example, to conduct an
accurate diagnosis, health care providers need to have a comprehensive knowledge of patients'
health concerns and accurate conceptualizations, including past history, present functioning and
current symptoms, a physical examination, and the results of clinical and diagnostic tests. One of
the most important procedures for getting sufficient information about the patients'/clients'
conditions is from a clinical interview (Esogbue & Elder, 1979). In addition to an examination
and a clinical observation, intervention and treatment may be required in the first appointment
(Budman et al., 1992; Easter & Beach, 2004; Odell & Quinn, 1998; Rahman, 2000). In some
cases, use of an effective screening method and brief intervention in responding to presenting
health issues, even in an initial encounter, may produce immediate therapeutic effects (Whitlock
et al., 2004).

While an initial session often involves technical tasks and the sequencing of scientific
operations including assessment, diagnosis, and treatment (Deuster, Christopher, Donovan, &
Farrell, 2008; Easter & Beach, 2004; Esogbue & Elder, 1979; Rahman, 2000; Street, Makoul,

Arora, & Epstein, 2009), the first clinical encounter can reveal additional layers of concerns and vulnerabilities that differentiate itself from subsequent, routine visits. Most often, an initial encounter involves a variety of relational dynamics such as uncertainty of mutual trust between a clinician and a client (Easter & Beach, 2004; Odell & Quinn, 1998), uncertainty of personal agendas related to a clients' complaints and requests, or uncertainty of a clinician's responses (Esogbue & Elder, 1979; Katon & Kleinman, 1981). In some cases, relational dynamics can manifest through a process of decision making of interventions or potential dropouts (Budman et al., 1992; Zisook et al., 1978). As such, initial clinician-client encounters are not simply task oriented interactions; they involve a sequence of clinical tasks that include multiple interactional and relational dynamics within the interaction. Thus, the characteristics of initial interactions have a tremendous bearing on future encounters and may shape subsequent therapeutic process (Budman et al., 1992; Odell & Quinn, 1998; Rahman, 2000).

Since an initial encounter is highly relational, how an interaction starts, and how a relationship is formed is part of the practice within an initial session (Rosen et al., 2012). Interactions, which include the verbal and nonverbal communication between speakers, mirror social relations, context, and discourses (Wetherell, Taylor, & Yates, 2001). Interactions in institutions reveal relational dynamics between speakers as well as institutional practices (Heritage & Clayman, 2010). As suggested, a quality therapeutic interaction sets the tone of the therapeutic direction and structure (Budman et al., 1992). In addition, rapport building and the establishment of a working alliance is embedded in each sequence of the interaction (Arbuthnott & Sharpe, 2009; Horvath & Symonds, 1991; Mead, Bower, & Hann, 2002; Ruusuvuori, 2001). For example, in the process of information gathering, a well formed relationship may open up the possibility for further self-disclosure and emotional vulnerability (Tay, 2011; Tryon, 1990).

Discords and difficult conversations frequently occur in health communications (Agnew, Harper, Shapiro, & Barkham, 1994; Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Candlin & Candlin, 2002; Horowitz et al., 1993; Retzinger, 1998). Thus, both the clinician and client are in constant negotiation of their expectations toward the visit and their relationship in the moment during communication (Angus & Korman, 2002; Brink-Muinen & Caris-Verhallen, 2003; Katon & Kleinman, 1981; Like & Zyzanski, 1986; Maynard, 1991; Street et al., 2009; Strong, Zeman, & Foskett, 2006; Sutcliffe, Lewton, & Rosen et al., 2004). Individual and institutional factors, as well as interactions created moment by moment, inevitably shape how one speaks, acts, and reacts (Jones & Beach, 1995). For example, analysis of talk and conduct of health communications indicates that assessment and interventions can be co-constructed through interactions despite clinicians' prior knowledge and skills (Ainsworth-Vaughn, 1992; Beach, Easter, Good, & Pigeron, 2005; Buttny, 1996; Katon & Kleinman, 1981; Maynard, 1991). In some cases, clinicians may provide interventions that are against the original therapeutic intentions and clinical judgments (Sanders, 2012).

The foundation of this study is primarily formed through the given phenomena of initial sessions, as well as the author's positionality towards training and practices of psychiatric care, behavioral science in family medicine, and mental health counseling. Specifically, this study will explore how talk and interactions manifest within initial sessions taking place in both family medicine and counseling settings. The author's interdisciplinary background, which includes both medicine and counseling, has provided a cross-institutional lens to study the phenomena of initial clinical sessions. Through the analysis of how conversations are initiated and how talk and interactions are produced and co-constructed, the primarily goal of this study is to descriptively

assess characteristics of talk and interactions of health communications in initial sessions conducted by novice practitioners.

Counselor Education and Family Medicine

As this study focuses on institutional talk and the interactions of trainees who conduct their clinical practice as novice practitioners, it is important to understand the broader picture of both medical and mental health professional training and their common features of practices. This overview is intended to provide a general understanding of the two professional communities. The following paragraphs will first summarize training and practice regarding behavioral health in counselor education and family medicine. Then I will provide a discussion of how the two professions' emphases overlap and how this existing structure helps form the inquiry and development of research questions in this study.

Conventional beliefs in counselor education and family medicine indicate that there are distinctive features of practice in each field, that is, counselor education primarily focuses on mental health/ behavioral issues, and family medicine primarily focuses on bio-physiological causes of pathology (Barrett et al., 2003; Doherty, Baird, & Becker, 1987; Engel, 1977; Myers & Sweeney, 2008). That said, a common feature of emphasis across both mental and behavioral health service fields' are accreditation standards and training programs (www.acgme.org; www.cacrep.org). In counselor education, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) requires master's level trainees to complete a total 100 hours of practicum and 600 hours of internship after the required course credits in their degree programs have been fulfilled. A total estimated 300 direct service hours are required for a master's degree. Direct service hours include psycho-social assessment, mental health diagnosis, guidance and career services, individual counseling, group counseling, and couple-family

counseling. Similarly, doctoral training is required to complete a minimum of 100 hours of counseling practicum and a minimum of 600 hours in a counseling internship that includes supervised counseling practices (www.cacrep.org).

Behavioral health training is a unique curriculum to primary care residency training. Although the accreditation body, Accreditation Council for Graduate Medical Education (ACGME), does not stipulate the hours of training, they do indicate that family medicine physicians get training in and attend to both diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, sensitivity to gender, race, age, and cultural differences in patients, family violence, abuse, and factors influencing patient compliance (www.acgme.org). In addition to routine skill and knowledge-based trainings related to diagnosis and treatment of medical issues, behavioral health components including skills in building doctor-patient relationships, mental health assessments, and psycho-social evaluation related to health and wellness are required as part of the residents' routine training. The physician-patient relationship and treatment compliance are recognized as key components in ensuring effective diagnosis and treatment (Lutfey, 2005; McDonald, Garg, & Haynes, 2002; Noble, 1998; Quill & Brody, 1996; Zola, 1981).

Based on the different pedagogical missions and training philosophies in each profession, anecdotal beliefs indicate general patterns and characteristics of professional practices for each profession. Accordingly, a rapport focused, relational, and accommodating style of practice has been emphasized in the field of counseling (Goodman et al., 2004; Reis & Brown, 1999; Rosen et al., 2012), whereas in the medical field, a relatively report focused, formal, and dominant style of practice abounds (Mathews, 1983; Pace, Chaney, Mullins, & Olson, 1995; Roter, 2000).

While such general phenomena may differentiate each discipline's institutional talk and practice,

they do not reveal how they are different through actual interactions such as characteristics of

speech styles and nuance of speech patterns nor do they reveal divergence and convergence of

practices at the micro level. The current study will begin to address this gap.

As suggested, the two professional practices may aim at different agendas due to unique

professional contexts. In addition, the amount of time allocated to training of behavioral science,

skills, and clinical interventions are not equivalent. Nevertheless, both professions share similar

professional experiences and aims. For example, both professions experience intensive and

frequent encounters with psychosocial issues related to wellness, mental health, re-adjustment,

and emotional regulations (Arthur, Kowel, & Liu, 2012; Myers & Sweeney, 2008). One of the

main therapeutic goals is to provide treatment and help clients manage their health issues

(Brown, 2004; Howgego et al., 2003; Mann, Gaylord, & Norton, 2004; Mead & Bower, 2002,

Street et al., 2009; www.aafp.org; www.counseling.org). Moreover, both professions involve

frequent social interactions and communications in their work routines. Since therapeutic

processes involve careful assessment and understanding of clients' psycho-social environment

(Barrett et al., 2003; Borrell-Carrió, Suchman, & Epstein, 2004; Doherty et al., 1987; Engel,

1977; Mann et al., 2004), a strong working alliance is required to achieve a desired treatment

outcome and compliance for both professions (Buttny, 1996; Fuertes et al., 2007; Horvath &

Symonds, 1991; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Kim, Kim, & Boren,

2008; Lelorain, Brédart, Dolbeault, & Sultan, 2012; Mead & Bower, 2002; Mead et al., 2002;

Sexton & Whiston, 1994; Tryon, 1990). Last but not least, because both involve frequent

encounters with mental health issues and treatment (www.acgme.org; www.cacrep.org), ongoing

supervision of therapeutic skills and practices are necessary for training and professional development (Arthur & Bernard, 2012; Bernard & Goodyear, 2009).

This study does not intend to privilege either profession in terms of the evaluation of the use of counseling or medical skills, but rather, it intends to understand how novice practitioners' talk is organized, structured, and co-constructed in each professional practice. For example, this study explores questions such as, how does communication between clinicians and their patients/clients' manifest in clinical interactions; and, how do trainees in both professions communicate in their initial sessions to accomplish their tasks and agendas? Since relational aspects of interactions is one of the common features across the two fields, this study also intends to explore how language is used by novice practitioners to create therapeutic relationships in the context of initial encounters and how the subsequent actions and interactions occur as a result of the co-construction of interactions between trainees and their patients/clients.

Function of Language

From a conversation analysis perspective (henceforth CA), as well as a sociolinguistic one, communication is relational, and action and interaction all involve the role of language and talk (Buttny, 2004; Heritage & Clayman, 2010; Heritage & Maynard, 2006; Van Herk, 2012). Thus, language is a key tool both for transmitting information, content, and maintaining social relations (Van Herk, 2012). For example, language in health care institutions is used for discussing health issues, delivering diagnoses and health information, communicating therapeutic directions, building therapeutic relationships, and documentation (Easter & Beach, 2004; Heritage & Clayman, 2010; Heritage & Maynard, 2006; Kokotovic & Tracey, 1990; Wetherell et al., 2001). Various studies show that in health care settings, language is one of the main tools of clinical interventions (Heritage & Clayman, 2010) and communicating health

knowledge (Blake, McMorris, Jacobson, Gazmararian, & Kripalani, 2010; Kripalani et al., 2010; Wynia & Osborn, 2010). The importance of language has been supported in explaining health conditions (Deuster et al., 2008; Kinderman & Lobban, 2000; McCarthy, Waite, Curtis, Engel, Baker, & Wolf, 2012; Reisfield & Wilson, 2004) and treatment modalities (Beach et al., 2005; Shaw, Ibrahim, Reid, Ussher, & Rowlands, 2009; Wagner, Steptoe, Wolf, & Wardle, 2009). Studies of the relationship between language, health, and clinical interactions in health care settings come from multiple disciplines, primary in the domains of social science, medicine, and mental health related scholarly community (Anderson & Sharpe, 1991; Beach et al., 2005; Buttny, 2004; Kripalani et al., 2010; Heritage & Maynard, 2006; Reis & Brown, 1999; Sanders, 2012; Strong, et al., 2006; Tryon, 1990). For example, a number of studies focus on the relationship between language use and state of mood and emotion (Şimşek & Kuzucu, 2012), personality traits (Chung & Pennebaker, 2007), or mental health condition (Anderson & Goolishian, 1988; Şimşek, 2013; Şimşek & Çerçi, 2013). Some studies focus on how talk and practices are produced in health communication (Ainsworth-Vaughn, 1992; Beach et al., 2005; Buttny, 2004; Heritage & Clayman, 2010; Katon & Kleinman, 1981; Marnard, 1991; Street 1992; ten Have, 1991; Tikkanen, Stiles, & Leiman, 2013; Treichler, Frankel, Kramarae, Zoppi, & Beckman, 1987; Voutilainen, Peräkylä, & Ruusuvuori, 2010).

Analysis of talk-in-interaction is a key component in most CA studies (Heritage & Clayman, 2010; Maynard, 1991; Wetherell et al., 2001). Accordingly, talk-in-interaction is a fundamental source of human sociality and a social function that helps individuals manage, structure, and develop various social relations (Heritage, 2001). Individual, ordinary interactions are not merely reflecting discourses between speakers and audiences, but rather they are reflecting larger, systematic yet often unspoken social rules and practices (Garfinkel, 1967;

Heritage & Clayman, 2010; Wetherell et al., 2001). Addressing language use and relations in a particular talk context are necessary when studying talk-in-interaction. For example, CA studies have suggested that an asymmetrical relationship can be found in doctor-patient interactions, co-created and co-constructed through the structure of question and answer, turn-taking, and topic shifting (Ainsworth-Vaughn, 1992; Maynard, 1991; ten Have, 1991).

In mental health care and behavioral science settings, language is a primary tool of information gathering (ten Have, 1991). Language also serves as a means for identification of requests and complaints (Voutilainen et al., 2010), recognition of emotion (Anderson & Goolishian, 1988), and to convey therapeutic interventions (Buttny, 1996). In addition to the performance of assessment and intervention (if required), language is crucial in the process of forming a relationship, which is recognized as a crucial predictor of therapeutic outcomes in mental health care (Kress et al., 2005; Erikson & Kress, 2006).

To date, little is known about how the therapist and client engage in conversation and use talk to develop, maintain, or repair the therapeutic relationship as well as what linguistic features display empathy. Despite the essential function and role of language in clinical settings, studies that aim at examining language use in mental health practices are limited. Moreover, these studies tend to appear more in medical, sociological, and linguistics fields rather than in counseling and psychology literatures. Thus the current study will use conversation analysis to look at talk-in-interaction in initial sessions conducted by novice practitioners. This study expects the results will provide additional insights regarding talk and interactions as well as language use and therapeutic relationship in both medical and counseling fields.

Research Questions

The current study intends to collect data on health communication from trainees-patients/clients dyads of practical trainings in the fields of counselor education and family medicine. Thus, this study expects to identify features of talk and how these features function in the healthcare communication and vice versa. In addition, microanalytic analysis of communications and model of practice will be one of the focuses. The premise of CA is to look at how a conversation is organized and ordered in a given social encounter. Using CA methods allows an "open form" of revelation on contextual and institutional knowledge in analytical processes, that is, allowing data to reveal the themes beyond the thresholds of contextual information and relevant knowledge of professional structures (Schegloff, 1993). Also, CA allows researchers to examine professional practices through talk-in-interaction at a micro level where specific characteristics of coding schemes are revealed (Schegloff, 1991, 1993). The inductive approach poses the three overarching questions, which will be presented in numerical order.

Temporal organization of talk and sequential interactions provides a global sense of talk phenomena which produce subsequent discursive relationships and co-construction of specific contexts (Atkinson & Heritage, 1984; Boden & Zimmerman, 1991; Buttny, 1996; Heritage & Clayman, 2010; Heritage & Maynard, 2006; Maynard, 1991; Sacks, Schegloff, & Jefferson, 1974; Sanders, 2012; ten Have, 1991; Treichler et al., 1987). Thus, the three overarching research questions guide the inquiry, each question having subcomponents within. Convergence demonstrates shared themes of talk, interactions, and linguistic strategies found in initial sessions conducted by trainees in both professions. Divergence indicates distinctive features of practice in

counseling and family medicine as result of the unique context of the session and professional norms:

Question one: How are the conversations between trainees and clients developed and maintained in their initial encounters?

A. How are the interactions presented and constructed in the process of communication? What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

B. How do individual trainees negotiate between professional norms and interactions present at the moment in order to achieve therapeutic tasks and goals in initial sessions?

Question two: How are therapeutic relationships and therapeutic discourses developed in initial sessions?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Question three: How do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Additional linguistic analysis using theoretical constructs from sociolinguistics will allow a more detailed revelation on speech patterns in two professional speech communities. The theoretical constructs in sociolinguistics and conversation analysis can be combined to analyze variations of linguistic strategies in developing professional practices. For example, some proposed analytical structures related to CA and sociolinguistics focus on topic introduction

(Van Herk, 2012), transition of topics (Buttny, 2004; Ainsworth-Vaughn, 1992; Jefferson, 1993), unidirectional and bidirectional conversation (Besnier, 1990; Guilfoyle, 2003; Howgego et al., 2003), and style shifting such as formal speech and ordinary interactions (Drew & Heritage, 1992; Heritage & Clayman, 2010; Leahy, 2004; Treichler et al., 1987; Walsh, 2007), as well as community of practice, speech community, and community of choice (Parboosingh, 2002; Van Herk, 2012). The details of these theoretical constructs concerning this study and how they are manifested in communication will be presented in chapter two.

Potential Implication

Findings from this study have several potential implications for professional practice and talk-in-interaction within health communication. First, this study analyzes talk and interaction within initial sessions in health care systems. Past research suggests that the interactions, interventions, and relationships that have occurred in initial sessions have an impact or connection to the following therapeutic alliance and subsequent treatment (Buttny & Jensen, 1995; DeGood, 1983; Greenberg & Stone, 1992; Kokotovic & Tracey, 1990; Odell & Quinn, 1998; Saltzman et al., 1976; Whitlock et al., 2004; Zisook et al., 1978). Yet, initial sessions, as phenomena, have been understudied and overlooked by researchers in related fields. The current study seeks to fill this gap by exploring processes of talks and interactions in initial encounters in health communication.

In addition, while previous studies have investigated the effect of relationship building and skill performances in regular institutional interactions (Anderson & Sharpe, 1991; Beck, Daughtridge, & Sloane, 2002; Elder, Ayala, & Harris, 1999; Fielding, 1995; Negri, Brown, Hernández, Rosenbaum, & Roter, 1995; Roter et al., 1995; Satterfield & Hughes, 2007), very few focus on the crucial training period of trainees who are in the field practicing as novice

practitioners. The current exploratory, descriptive study expects to provide additional insights and relevant theoretical premises related to the current client-centered model of practice, which has been emphasized in both disciplines (Angus & McLeod, 2004; Guilfoyle, 2003; Like & Zyzanski, 1986; Maizes, Rakel, & Niemiec, 2009; Mead & Bower, 2000; Mead et al., 2002; Sexton & Whiston, 1994; Quill & Brody, 1996). The emerging themes identified from linguistic data and process of interactions will help medical and counselor education to improve current training and pedagogy regarding assessment, diagnosis, and skills that focus on forming therapeutic alliances. Further, the focus on details of talk and conduct informs clinical supervisors to effectively assist trainees to achieve the client-centered model of practice. It also assists to establish supervisory protocols to clinical supervisors who can effectively assist trainees in their practices. In addition, conversation analysis will be integrated to future research regarding the promotion of patient-centered care programs, treatment effectiveness, and outcome research.

Unlike previous studies on interactions between clinicians and clients, which involved indirect data such as interviews (Ajjawi & Higgs, 2007; Farber, Berano, & Capobianco, 2004; Pillai, 2010; Rosen, Miller, Nakash, Halperin, & Alegría, 2012; Wynn, 2005), surveys (Alegría et al., 2008; Barkham & Shapiro, 1996; Quirk et al., 2008; Schwartzberg, Cowett, VanGeest, & Wolf, 2007; Shaw, Ibrahim, Reid, Ussher, & Rowlands, 2009; Wynia & Osborn, 2010;), and scale measurement and rating (Bensing, Schreurs, & Rijk, 1996; Brink-Muinen & Caris-Verhallen, 2003; Castro, Wilson, Wang, & Schillinger, 2007; Deuster et al., 2008; Horowitz, et al., 1993; Koch-Weser, Rudd, & DeJong, 2010; Owen, 2008; Sleath, Svarstad, & Roter, 1997; Street, 1992) to assess therapeutic processes, the current study will utilize direct observation of naturalistic, mundane, and ordinary interactions between clinicians and patients/clients in health-

related communications. The primary methodology, the CA, along with proposed theoretical constructs from previous studies related to community of practice, will directly investigate speech and acts which occur in routine visits between trainees and their patients/clients. This will also give direct logical inferences and scientific procedures to assess speech and interactions in communicating health-related concerns.

A key addition of using CA as both the methodological and analytical tool in this study is that CA examines talk phenomena on both a process level (or so called "thematic level") (Heritage & Maynard, 2006) and a microanalytic level. While a process level of analysis explores a broader, overall theme of interaction, microanalysis of talk focuses on forms and function of specific language use, co-construction, and co-creation of therapeutic discourses. With the combination of two levels of analysis, CA provides a systematic and comprehensive analytic frame in studying interactions. Few studies on language have focused on both. This study expects that this multilevel analysis on talk and interaction will provide a wealth of information with regard to health practices and potentially contribute to training, education, and supervision related to human services fields. This innovative method will also enrich methodological repertoires on future studies related to health communication.

Conclusion

The initial sessions in both the physical and mental health care settings establish the foundations for subsequent visits and are paramount for establishing a treatment alliance (Budman et al., 1992). Language and interactions between clinicians and patients/clients in initial sessions can provide direct data and observations regarding how interactions are co-created and co-constructed, how relationships are formed, and how subsequent actions and interactions are produced. The fields of family medicine and counselor education have unique

emphases for professionalism (Barrett et al., 2003; Doherty, Baird, & Becker, 1987; Engel, 1977; Myers & Sweeney, 2008); at the same time, they share common features of practices, particularly in relation to person-centered practice and a focus of behavioral and mental health (Fuertes et al., 2007; Horvath & Symonds, 1991; Howgego et al., 2003; Lelorain et al., 2012; Mead & Bower, 2002; Mead et al., 2002; Sexton & Whiston, 1994; Tryon, 1990). Because both fields require trainees to engage in ongoing practical training and supervision, novice practitioners in both fields frequently encounter patients/clients visits and often directly interact and communicate with them in routine practices.

This study explores processes of talk and interactions of initial sessions between trainees and their patients/clients in the two professions, family medicine and counselor education. The naturally-occurring recorded data allow researchers to examine the following three overarching questions: How are the conversations between trainees and clients developed and maintained in their initial encounters? How are therapeutic relationships and therapeutic discourses developed in initial sessions? And, how do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability?

Since talk-in-interaction functions as human sociality and maintains social relationships, it is assumed that talk is achieved through sequential and co-constructed interactions. Discursive relationships and subsequent actions and interactions such as disclosures, challenging communications, and vulnerability could occur as a result of the formed initial relationship. Using CA allows researchers to directly investigate both the thematic level and microanalytic level of talk and interactions. This study expects that the two levels of analysis of talk and interactions from novice practitioners will provide additional insights and enrich methodological

repertoires in current studies related to the best practice, effective therapeutic alliance, and

effective health communication in initial sessions.

CHAPTER II

Review of Literature

Studies of doctor-patient and therapist-client interactions have gradually received increased attention in medical and social science research (Bensing, Schreurs, & Rijk, 1996; Brink-Muinen & Caris-Verhallen, 2003; Castro, Wilson, Wang, & Schillinger, 2007; Deuster et al., 2008; Dulmen, 2002; Greenfield, Kaplan, Ware, Yano, & Frank, 1988; Hepburn, 2004; Heritage & Maynard, 2006; Horowitz et al., 1993; Koch-Weser, Rudd, & DeJong, 2010; Langer, 1999; Owen, 2008; Peyrot, 1987; Ruusuvuori, 2001; Sleath, Svarstad, & Roter, 1997; Street, 1992; Wynn, 2005). In addition, studies that attend to the micro-linguistic features of talk tend to exist in disciplines outside of medicine and counseling, such as sociology (Boden & Zimmerman, 1991; Heritage & Clayman, 2010; Maynard, 1991; Ruusuvuori, 2001; ten Have 1991), communications (Buttny, 1996; Dulmen, 2002; Hepburn, 2004; Heritage & Maynard, 2006; Sanders, 2012; Treichler et al., 1987), and linguistics (Atkinson & Heritage, 1984; Peyrot, 1987; Sacks et al., 1974; Wynn, 2005). Thus, the literature review for the current study will come from multidisciplinary scholarly works in order to provide an overall understanding of the phenomenon of initial sessions, professional practices, therapeutic relationships, person-centered care, as well as language and communication between clinicians and patients/clients.

The following literature review will be organized based on each aspect of the research questions in this study: initial sessions, behavioral health which overlaps in two professions, language and professional practice, relational aspects of communication, and jointly constructed interactions. The review is structured using a funneling approach: first, although characteristics, functions, and issues of initial sessions in health care settings have been discussed in the broader literature, they remain under-studied. This chapter will provide reviews of previous research that

focused on initial encounters in clinical settings. Secondly, although unique professional and institutional practices are found in both fields, common features of practice, such as frequent encounters of mental and behavioral health issues, person-centered care of practices, intense interpersonal interactions, and building working alliances, are shared between the two. The review will begin with a discussion of these overlapping elements of practices and how they connect to the focuses of this study.

Thirdly, as mentioned earlier, language plays a key role in clinician-patient/client interactions and professional practices in both fields. The following review will then discuss conceptual works of community of practice (CoP) (Wenger, 1998, 1998, 2000, 2004, & 2009), speech community (Tagliaventi & Mattarelli, 2006; Li et al., 2009; Van Herk, 2012), and conceptual works that integrate the two. Conversation Analysis (CA), the central methodology of this study, has several key theoretical assumptions in talk and interactions. This chapter will summarize the key elements that are relevant to this study, which will provide a foundation for the subsequent review of empirical studies related to relational aspects of health talk.

Following the discussion of the function of language, the review will focus on literature related to working alliances and empathy in medicine and counseling. The selected CA studies focusing on both doctor-patient interactions and therapist-client interactions will be combined for review. Since a formed relationship may potentially open up further disclosures and emotional vulnerability, studies related to these unique features of interactions will be discussed.

Initial Sessions

Overview of the Review

Training protocols in both medicine and counseling focus on how to conduct an initial session (Alegría et al., 2008; Budman et al., 1992; DeGood, 1983; Deuster et al., 2008; Easter &

Beach, 2004; Owen, 2008; Rahman, 2000; Rosen et al., 2012; Whitlock et al., 2004). For example, in addition to routine skill and knowledge-based training related to the diagnosis and treatment of medical issues (www.acgme.org), skills in building doctor-patient relationships, mental health assessments, and psycho-social evaluation related to health and wellness are required as part of family medicine residents' routine trainings; also, they are recognized as key components in ensuring effective diagnosis and treatment (Lutfey, 2005; McDonald, Garg, & Haynes, 2002; Noble, 1998; Quill & Brody, 1996; Zola, 1981). In counseling, using basic counseling skills in the first encounter, assessment, expression of ethical responsibility, attentiveness to culture, identity, and social justice issues is emphasized in course training in counseling theory and practices (Corey, 2012; Gladding, 2005; Hackney & Cormier, 1996; Young, 2001). In addition, studies have supported that, by and large, a therapeutic relationship plays an essential role in predicting treatment outcome (Castonguay, Constantino, & Holtforth, 2006; Horvath & Symonds, 1991; Saltzman et al., 1976).

Despite the important role of initial sessions in therapeutic relationship and treatment outcomes, literature on initial sessions has received relatively little attention in counseling or family medicine (Odell & Quinn, 1998). The current study has used databases related to medicine, medical education, psychology, counseling, sociology, and communication to locate the relevant literature. Major databases include JSTOR, ERIC, PsycNet, PsycInfo, PubMed, Wiley Online, SAGA, and Google Scholar. The keywords used for searching include "initial," "first," "early," "beginning," "counseling," "medical," "doctor visit," "therapy," "clinical interview," "appointment," and "session." In addition, "diagnosis" and "diagnostic interview" were included in the search because a diagnostic process tends to occur at an early stage of treatment. The researcher also alternated combinations of keywords in the search process to

ensure the optimal breadth of the search results. Based on the search method, this review identified 15 articles that included initial sessions as the topic of focus, and only six of those articles were empirical studies.

For the most part, previous studies related to initial sessions tended to focus on the function and impact of the session on treatment effectiveness and outcome, such as brief interventions in assessment periods (Whitlock et al., 2004), prediction of treatment durations and outcomes (Odell & Quinn, 1998; Saltzman et al., 1976; Zisook et al., 1978), and patients' satisfaction (Tryon, 1990). Two studies looked at the process of interactions in initial encounters (Easter & Beach, 2004; Rahman, 2000). However, none of these studies looked at the use of language and the detail of communication such as verbal and nonverbal features expressed by both clinicians and clients/patients. Furthermore, the majority of these studies used indirect data such as surveys or patients' ratings. Studies that used coding and observation methods focused on a thematic level of analysis, and none of these examined the microanalytic features of talk and interactions in an initial encounter.

The review of the empirical articles will be organized based on topic of focus and the impact of initial sessions (Odell & Quinn, 1998; Tryon, 1990; Zisook et al., 1978), and followed by interactive elements in initial sessions (Easter & Beach, 2004; Rahman, 2000; Reis & Brown, 1999). While not directly addressing initial sessions, Alegria et al.'s (2008) study touched upon interactions and processes of diagnostic interview in mental health treatment facilities. Thus, it is selected for review. A total of seven articles are included in this section.

Initial Session Studies

Previous studies on the impact of the initial session on treatment compliance and subsequent outcomes have had mixed results. For example, Zisook, Hammond, Jaffe, and

Gammon (1978) conducted a correlational study in relation to psychiatric patients' reactions toward the effect of initial sessions and attrition. Patients in this study were recruited in a university outpatient psychiatric clinic. Of a total 82 participants, 62 were women and 20 were men, with an age range between 18 to 76 years old (M=30). All participants completed demographic forms and twelve items of the post-interview questionnaires (PIQ) after their first encounters. Accordingly, PIQ aims at measuring patients' perceptions regarding the degree of their request being understood by the residents and patients' perception of session outcome. The attrition rate was measured after the first session. The study defines continuers as patients who came back for their subsequent appointment after the first encounter; non-continuers were those who did not come back for their appointment after the initial session. The attrition rate was found to be a total of 35%. In their subsequent analysis of correlation between attrition and patients' perceptions of their first interview, Zisook et al. (1978) found that attrition was not significantly associated with patients' perception that their problems were understood, receipt of desired interventions from their doctors, or a sense of improvement of symptoms. Patients' feeling satisfied and planning to return for the following appointments were significantly associated with continuation of treatment.

Zisook et al.'s work has linked an initial session's impact on treatment continuance. In addition, the study included patients' perspectives as a main variable. This is a unique approach that is different from traditional medical research where most attention has been paid on clinicians' behaviors. Thirdly, participants were recruited in a naturally occurring treatment setting where patients intended to seek treatment in the clinic prior to the study that was conducted. This approach has allied to CA's approach to data collection where the study of

interactions should focus on a naturally formed and ordinary context (Heritage & Clayman, 2010).

Several limitations were found in this study. First, the survey data of patients' perception regarding their experiences of initial encounters provided limited knowledge of what was actually happening in the first encounter. According to CA's perceptive, interaction is jointly achieved between or among speakers (Buttny, 2004). Thus, numerical measures of degrees of being understood does not capture the sequence of interactions that may result in one's perception toward a session. In addition, a correlation found between a survey measure and an attrition rate provides very limited information regarding the process of how and why attrition may occur. For example, what are the features of talk that represent the sense of being understood and satisfied or vice versa? Furthermore, what elements of talk and interactions may form a patient's sense of being understood, satisfaction, and decision to continue treatment?

Tryon (1990) also conducted a correlational study focusing on the initial session's depth and smoothness in predicting the subsequent treatment continuance in a university counseling center. Therapists in this study included five doctoral level staff therapists and five practicum trainees of counseling psychology. Clients included a total of 290 college students who came to the counseling center for personal, vocational, and educational concerns. Measures included a pre-counseling assessment of clients obtained from staff therapists and trainees (n=288). Client satisfaction questionnaires (CSQ) were obtained from clients (n=263). Session evaluation questionnaires (SEQ) that measured the session depth and smoothness of initial sessions were obtained from staff therapists (n=185), trainees (n=85), and clients (n=263). Continuance of counseling was measured and a 58% return rate was found in this sample. Correlational analyses indicated that clients who returned after initial interviews had longer sessions than those who did

not return. In addition, clients' continuance of therapy after an initial encounter was significantly associated with the depth of the conversational processes, clients' greater satisfaction, disturbance of their issues, and motivation toward counseling.

Tryon's (1990) study has provided a new insight regarding session factors associated with attrition; variables associated with session depth and smoothness capture more details of the process of interaction than variables that represent satisfaction and perception of outcome (Zisook et al., 1978). Session depth and smoothness connect to one of the current study's focuses, the unique features of talk in relation to clients' self-disclosure of challenging and vulnerable topics. Similar to the limitation found in Zisook et al.'s (1978) study, session depth and smoothness measured in Tryon's (1990) study remained perceptions rather than data from actual interactions. The current study expects to fill such gaps by using the transcribed direct interactions of initial sessions as data for analysis.

Odell and Quinn (1998) conducted an observational, correlational study using an observation method to code therapists' and patients' behaviors in 38 counseling sessions. The research focused on the impact of first sessions and therapists' global types of behaviors on treatment duration. In addition to including survey data from patients, Odell and Quinn added an observation method that coded therapists' and patients' behaviors. The coding system regarding global types of behaviors was developed for guiding the process of observation. The observation and coding of both therapists' and clients' behaviors showed that global types of behaviors in the first session defined as demonstration of caring and ways of structuring sessions had little relation to affect treatment duration. Instead, patients' symptom severity was found to be positively related to compliance and treatment duration, but negatively related to session smoothness and sense of emotional relief.

The coding system used in Odell and Quinn's study attended to the process/thematic level of analysis, specifically, a broader, overall categorization of presenting phenomena (Heritage & Maynard, 2006). However, the microanalytic features of talk such as contextual, detail, sequential, and unremarkable interactions often reveal ample information about behaviors and practices; yet, this was not included in the research process. Another limitation found in Odell and Quinn's study is that while intending to build a model of global behaviors that predict the desirable treatment outcome and patients' compliance, the sessions that were included in the study were from one-on-one individual counseling to couples or family counseling, with two or more clients involved in a single session. These diverse types of sessions signify different characteristics of interactions; therefore, it is difficult to generalize global behaviors because interactions are created and constructed by actors in a particular context. While the current study does not intend to build a model of effective behaviors in clinical practices, the focus on the co-constructed, co-created process of interactions will add additional insights and perspectives on understanding helpful institutional interactions in health care settings.

As mentioned in chapter one, both verbal and nonverbal communicative elements convey the various discursive practices of individuals and reveal the relational dynamics of interactions. In a literature review of variables including client, therapist, and administrative factors related to premature termination, Reis and Brown (1999) found that overall, interactive factors such as working alliance, satisfaction, and expectation were more salient indicators than client, therapist, and administrative factors. Consistent with Ainsworth-Vaughn's (1992) discussions of clinicians' linking skills and acknowledgement during topic transition, Reis and Brown (1999) concluded that when different perspectives between therapists and clients were acknowledged

and recognized during interactions, premature termination could be minimized and subsequent interventions may be implemented.

Though not directly capturing all the details and processes of interactions between clinicians and patients/clients, some research on initial sessions touched upon the role of communication in health care institutions. For example, in a focus on empathic language provided by clinicians during stressful initial interviews with oncology patients, Easter and Beach (2004) conducted a content analysis of video-taped sessions. The study used two major coding structures, patient-initiated actions (PIAs) and doctor-responsive actions (DRAs) to code a total of 16 video-taped initial sessions conducted by surgical residents and attending physicians. All of the DRAs were identified as either matching with or missing from PIAs in order to record the occurrences of empathy provided by clinicians. A major finding from the study is that in a total of 160 occurrences of clearly identified empathic opportunities from patient-initiated actions (PIAs), residents missed 70% of the empathic responses in doctor-responsive actions (DRAs).

Easter and Beach's (2004) study is one of the few that looked into the initial interactions between doctors and patients. In addition, using video-recorded data allows researchers to attend to detailed interactions and engage in the back-and-forth analytic process. The focus of empathic opportunity (PIAs) and responses (DRAs) indicates a process/thematic level of coding structure and provides an overall picture of the frequency of empathy. This structure of coding and analysis indicates a linear and uni-directional type of interaction. Furthermore, it does not present a sequence of interactions and relational dynamics between clinicians and patients. This current study intends to fill this gap by examining the micro process of interactions.

Another study which was focused on communication in initial sessions was conducted in a medical training center in Bangladesh (Rahman, 2000) using independent raters and scales of patients' satisfactions toward their initial sessions (N=25). Results indicated that a majority of doctors-in-training asked patients' names in the beginning stage (96%), but only 20% provided a greeting, and only one did a self-introduction to the patient. In addition, none of the doctors-in-training provided an explanation of the purpose of the consultation. Ninety percent had successfully picked up most verbal and nonverbal cues from patients. Sixty-eight percent used facilitative skills during history taking, and more than 75% avoided using medical terminology. Psycho-social evaluation and empathic utterances during initial sessions were not found in this sample. In terms of nonverbal behaviors and listening skills, more than 50% of the doctors-in-training never interrupted their patients or they interrupted at the appropriate time.

Overall, patients' satisfaction were consistent with the rating of the process of intake. For example, the majority of patients reported that their doctors listened carefully (84%), maintained eye contact (88%), and did not interrupt, or provided enough time for patients to tell their stories (72%). Eighty-one percent reported that they had wished that their doctors explained the purposes of the session; 88% did not feel that their doctors were empathic, and 84% reported not being asked about any psychological aspects of their lives connecting to their presenting physical issues. Based on the finding, Rahman concluded that patients' dissatisfaction toward health services may not be due to lack of clinical competencies, but may due to problems of communication.

Rahman's (2000) study shed some light on interactions in initial encounters. For example, allied with the assumption that interaction contains both verbal and nonverbal behaviors, Rahman's study included measures of both verbal and nonverbal communication in

the coding procedure and analysis. The survey questions regarding doctors-in-training attended to psycho-social, relational aspects of care, which is consistent with the current trend of a holistic approach in medicine (Bradley, 1992; Brown, 2004; Hemminki, 1975; McCabe, Cranford, & West, 2008; Pace et al., 1995; Zuvekas, 2005). The survey result of patients' satisfactions was consistent with the video-taped analysis where clinicians' communication skills play a key role in shaping patients' perception and experiences (Rahman, 2000). This conclusion is necessary but not sufficient because it only captures a stimulus-response (S-R) mechanism of the therapeutic relationship. However, a therapeutic relationship is often jointly achieved (Buttny, 2004), even in an asymmetrical interaction between a doctor and a patient (ten Have, 1991).

Alegria et al. (2008) published a report in the National Institute of Health (NIH) regarding methods of obtaining and using information provided by clients during diagnostic interviews. Content analysis of 129 video tapes conducted by experienced practitioners indicated that clinicians tended to rely on general information to assess and evaluate clients' symptoms, as opposed to evaluate specific chief complaints. Furthermore, the analysis of decisions of diagnoses indicated that there was a high level of agreement about diagnoses among practitioners in substance abuse, a low agreement in mood disorder and anxiety disorder, and a very low agreement in specific diagnoses. Qualitative analyses of perceptions from both clinicians and clients indicated expectation of a less time-constraining, narrative approach for diagnostic interviews. Furthermore, clients in this study reported a preference for an open form, narrative process in a diagnostic interview as opposed to questions and answers with clinicians who often used documents and interview protocols provided by institutions. Clinicians in this study rarely reported completed comprehensive assessments for clients and frequently experiencing tension in fulfilling multiple roles during intake processes due to a limited amount of time.

Though not directly including the initial interview as a criterion of the study, Alegria et al.'s (2008) research helps inform the dimension of analysis that will be used in the current study, particularly the interactions that occurred during the diagnostic process, which may likely appear in initial encounters. Moreover, the qualitative analysis regarding perceptions and expectations of interviews connects to one of this study's main lines of inquiry: how language is used to initiate an initial interview, how talk and sequential interactions are presented in such a process, and how the constraint of time for diagnostic interview reflects institutional practices?

In summary, the reviewed literature provides insight into the impact of initial sessions on continuance of treatment and effective communications perceived by patients/clients. That said, research on the process and detail of such interactions in initial sessions is limited. In addition, no research on talk and interactions in initial sessions connects both a thematic and micro-analytic level of analysis. The current study aims to fill the gaps by focusing on linguistic data from both clinicians and patients/clients; analytic procedures will connect both the thematic level and details of interactions.

This section has summarized and reviewed studies related to initial sessions. Since a focus on behavioral health and integrative approach serves as a key professional component in both counselor education and family medicine, the following section will discuss this practice and how it connects to the relational aspects of therapeutic interactions, which is one of the main analytic focuses in the current study.

Behavioral Health Issues and Integration of Holistic Approach in Health Care Practice

Psychological and behavioral issues, unlike physiological mechanisms of pathology, have rather complex and multifaceted factors of consideration (www.apa.org). The focus of behavioral science in the field of medicine has gradually received attention, particularly on the discussions

of best practices, integrative care, and the person-centered approach (Bensing et al., 1996; Borrell-Carrió et al., 2004; Brown, 2004; Doherty et al., 1987; Engel, 1977; McCabe, Cranford, & West, 2008; Pace et al., 1995; Verhaak, 1986, 1988; Zuvekas, 2005). While behavioral and mental health issues are the primary focus in mental health professions, attention to psycho-social health are growing in primary health care settings as well (Brown, 2004; Pace et al., 1995; Verhaak, 1986, 1988). For example, in an extensive review of previous studies (n=12, from 1994–2003) with regard to the effectiveness of using brief counseling interventions to reduce risky alcohol consumption in primary care settings, Whitlock, Polen, Green, Orleans, and Klein (2004) reported that on average, participants who received brief counseling interventions during initial contacts reduced alcohol consumption (per week) by up to 34% compared to control groups. Moreover, participants who received brief intervention in the initial stages of clinical visits had a greater safe level of proportion of consumption, as well as improved drinking habits compared to control groups. An assessment of alcohol consumption is one aspect of a psycho-social approach to medical issues. There are more aspects of the holistic approach to health issues, and its role in medical practices needs more empirical attention. Nevertheless, Whitlock et al.'s (2004) review indicates an essential function of counseling in achieving a desirable health outcome in medical practice.

As there is a link between diagnosis and treatment in both counseling and medical contexts, both family medicine and counselor education use integrative and holistic approaches that acknowledge the mind-body connection (Barrett et al., 2003; Borrell-Carrió et al., 2004; Doherty et al., 1987; Mann et al., 2004; McKinlay et al., 1996; Stange et al., 2001). The concept of an integrative approach to health and wellness is not new. Over three decades ago, an article published in *Science* suggested that while the biomedical model is a dominant model of inquiry

for explaining and understanding pathology, the psycho-social dimension of individuals and their environments must be included to understand and explain health and illness (Engel, 1977).

A bio-psycho-social model (BPS) approach to physical and psychological health is adopted as a model framework by both mental health disciplines and medicine and, in particular, family medicine (Barrett et al., 2003; Bell et al., 2002; Borrell-Carrió et al., 2004; Doherty et al., 1987; Stange et al., 2001). Philosophically, BPS uses systematic approaches to explore a person's symptoms and illness while at the same time valuing subjective experiences and explanations of disease and health conditions. There are three principles of care: first, mind-body integration to explain heath issues; second, consideration of all aspects of individual conditions of treatment and interventions; third, because this model requires practitioners' effort to understand their patients in a holistic and systematic way as opposed to segments of symptoms and diseases, relationship is a key factor in implementing such integrative care. Thus, self-awareness, trust, empathy, ongoing education and supervision, and the flexibility to include different aspects of treatment and care are valued in such an approach (Borrell-Carrió et al., 2004).

The notion of person-centered practice, originally proposed by Carl Rogers (1902–1987), is a dominant discourse in the field of counseling in the U.S (www.counseling.org). Along with inclusion of the psycho-social dimensions of care, a patient-centered approach has increasingly received attention in medicine (Like & Zyzanski, 1986; Maizes et al., 2009; Mead & Bower, 2000; Mead et al., 2002; Quill & Brody, 1996). Mead et al., (2002) proposed that patient-centered care contains three dimensions of practice: the bio-psycho-social perspective, sharing power and responsibility (between both practitioners and clients), and therapeutic alliance. Sharing power and responsibility, in particular, refers to an inclusion of patients' perspectives in

the treatment process (Shaw et al., 2009). Maizes et al. (2009) argue that integrative care is a potential solution of health care crises including cost of medical expenses, unnecessary prescriptions, poor treatment outcomes, and health care disparities. In addition, the emphasis of person-centered care and the relational approach is attention to various psycho-social factors such as health practices, beliefs, cultures, and contexts. Accordingly, attending to relationships and the client-centered approach are identified as common features of practice in the two professions (Cheston, 2000; Corey, 2012; Katon & Kleinman, 1981; Kokotovic & Tracey, 1990; Maizes et al., 2009; McKinlay et al., 1996; Stange et al., 2001).

Currently, very few empirical studies in medical journals address the relational aspects of interactions in an initial encounter. Through an extensive search with keywords including "client-centered," "person-centered," "beginning stage," "initial," and "therapy" in databases of counseling and psychology journals, this review found one study that addressed such a concept. Kokotovic and Tracey (1990) conducted a correlational analysis looking at the relation between working alliances with client characteristics and premature termination after the first counseling session. This study recruited a total of 144 clients in a university counseling center. The 144 sessions were conducted by 15 counselors. The Working Alliance Inventory (WAI) was completed by both counselors and clients to measure working alliance; the interpersonal relationship scale (IRS) was completed by counselors to measure client characteristics, including hostility, quality of past and current relationships, level of adjustment, and type of presenting concern. Correlational analysis indicated that the relation between WA and clients characteristics was only partially supported, including the item of quality of current relationships and past family relationships. The relation between WA and clients' presenting concerns, as well as premature termination, were found to be not significant.

Kokotovic's and Tracey's (1990) study connected the role of WA and the relational aspect of interaction in initial encounters, which has been under-studied in both medicine and counseling fields. In addition, the measures of WA include both clinicians' and clients' ratings, suggesting that WA reflected experiences from both ends. This is consistent with the current study's assumption that interaction is jointly achieved. Measures and data in Kokotovic and Tracey's study mostly relied on rating and numerical measures, which lack information regarding how WA is presented and what part of interactions signifies WA. In addition, while client characteristics contributed to the outcome of interactions, they do not reveal the process of co-constructed interactions between speakers. If individual characteristics may have influences on interaction, clinicians' characteristics should also be included in the measure. This current study expects to fill such a gap by looking into the details of how trainees and clients jointly formed their interaction in an initial encounter.

More empirical support regarding this approach is needed to validate the model of practice. In addition, based on an extensive review of the literature regarding BPS and the integrative approach, this study finds no empirical work that focuses on how this approach is conducted in a clinical session. To fill the gap, this study will explore how this integrative approach is manifested in a trainee-client interaction during health visits. Note that although the discussion of BPS primarily appears in the field of family medicine, the holistic approach and integrative care are also emphasized in the counseling field. Thus, the inquiry includes both trainees in counselor education and, in particular, family medicine. The current study expects the results will provide additional perspectives about this holistic model of practice.

As suggested by earlier studies regarding initial sessions and discussions of integrative model of practices, language and communication play a key role in both the process and

outcomes of therapeutic interactions (Heritage & Clayman, 2010; Wetherell et al., 2001). In order to explore how talk is conducted in initial sessions and how language helps achieve therapeutic goals among trainees in family medicine and counselor education, it is necessary to explore how institutional talk and acts are formed, shaped, and reshaped through professional practices and interactions. Although there is a dearth of empirical studies related to the community of practice and speech community in health care settings, conceptual works and theoretical discussions have been used to apply (to apply what?) in studies related to language and communication (Gordon & Luke, 2012; Luke & Gordon, 2012).

In addition, the main guiding theory and methodology, conversation analysis, has a theoretical foundation regarding intalk and interaction. Because the review of relational aspects of talk and interactions as well as challenging conversations will include CA's studies, it is essential to understand how CA views social interactions and how talk and interactions are studied. Following the discussion of conceptual works from sociolinguistics, the review will then provide an overview of CA's theoretical premises.

Language and Professional Practices

There is a growing body of research that stresses the impact of communication on the therapeutic relationship and subsequent interactions (Arbuthnott & Sharpe, 2009; Horvath & Symonds, 1991; Mead, Bower, & Hann, 2002; Ruusuvuori, 2001). Some studies have recognized the role of communication in understanding the community of practice in health care settings (Barkham & Shapiro, 1986; Easter & Beach, 2004; Kivlighan & Shaughnessy, 1995; Matarazzo & Wiens, 1977; Ruusuvuori, 2001, 2007; Tay, 2011; Voutilainen et al., 2010). Parboosingh (2002) indicated that learning and doing are closely connected. Specifically, one learns professional norms, skills, and language through interactions with clients, peers, and mentorships

in ordinary contexts. Counselor education and family medicine, for example, may each form its own communities, unique professional identities, and practices based on its respective training mission and types of clients it serves. Thus, it is fair to say that acquiring professional identity is a process of linguistic construction where an individual learns, negotiates, and develops particular practices, language use, and worldview from a profession that one is situated within (Gordon & Luke, 2012; Luke & Gordon, 2012).

This section will review one of the main elements within professional practices in family medicine and counselor education: communication and professional practice. The focus here will include community of practice, speech community, and integration of the two.

Community of Practice (CoP)

The concept of community of practice (CoP) is proposed by Etienne Wenger (2000), who discussed the role of social learning systems. Accordingly, the establishment of a social learning system and participation in broader social systems are key factors for the formation of professional communities and establishment of a professional community's identity and social recognition. CoP is a component of social learning theory which is different from traditional notions of learning; that is, rather than learning through artificial materials or materials selected by institutions, individuals learn through joining community in daily life, a so-called "informal learning." Participation in professional groups and day-to-day interaction all involve processes of learning. Individual members gain recognition, social capital, and the acquisition of discourses by becoming part of the core members in a specific community. In addition, CoP focuses on doing activities that indicate group identity. Global and local behaviors that exercise specific discourses, linguistic styles, and characteristics of interactions are elements of CoP.

Current works related to CoP in health care practices remained theoretical discussions with very few empirical studies (Parboosingh, 2002). In counseling, some have incorporated the CoP into studies of counseling supervisory contexts (Gordon & Luke, 2012; Luke & Gordon, 2012), but very few CoP theoretical frameworks, as well as empirical studies, focus on actual, day-to-day counseling sessions. To fill the gap, this study expects to identify distinctive talk phenomena between trainees and their clients in both family medicine and counseling settings. Furthermore, since the current study examine how language is used to achieve specific goals in initial sessions in each setting, theoretical and empirical studies related to speech communities will provide valuable perspectives for analysis.

Speech Community and Community of Choice

Speech community is a concept primarily from sociolinguistics (Van Herk, 2012). Current research and theoretical discussions of speech communities primarily focus on variations of speech among different groups. For example, Van Herk (2012) indicated that speech community is "a language variation among different gender, racial, and national groups" (p. 21). In other words, speech variations occur due to social identity related to race, gender, ethnicity, and other distinctive features of identity.

While speech communities characterize patterns and norms of particular groups, variations and divergence within a group exist. Community of choice is a notion that members in the speech community diverge from marked features of speech norms (Van Herk, 2012, p. 23). In other words, members of a group may cross a boundary of membership and shift away from group norms and practices. As a result, tensions may occur. Community of choice provides opportunities to look at the process of negotiations between individual talk-in-interaction and communal aspects of discourses. As supported in CA literature, ordinary talk and professional

practice are not distinctive, or separate, social activities. In other words, ordinary talk and interaction is influenced by and embodies institutional characteristics, often in a predictable way (Heritage & Clayman, 2010; Heritage & Maynard, 2006). Going back to the notion of community of choice, it is assumed that divergence and convergence between members within systems, as well as between different communities, exist. Community of choice in this theoretical assumption can be further explored by examining how language use reflects formation and transformation of professional identity. For example, what are features of interactions that signify professionalism and institutional practices among trainees in both counselor education and family medicine? Furthermore, how do individual trainees negotiate between professional norms and interactions present at the moment in order to achieve therapeutic goals and maintain relationships?

CoP provides a framework to understand speech communities because the doing and practicing in daily interactions is an embodiment of how a member becomes part of a community and maintains its status quo, and how members gain recognition and control by adopting dominant discourses. In such a process, individuals exercise their learning system; at the same time, participation may reinforce such identity (Li et al., 2009; Tagliaventi & Mattarelli, 2006; Wenger, 2009). In a theoretical discussion regarding CoP in language research, Holmes and Meyerhoff (1999) indicated that a critical distinction between CoP and speech community is that CoP emphasizes the notion of practice overall, whereas speech community focuses on variations of speech styles and patterns. Studying talk and interactions is compatible with a combined framework of speech community (talk) and community of practice (act), that is, how talk-in-interaction in health institutions is a manifestation of professional membership and formation of

clinical practice. While institutional norms are global aspects of professional practices, ordinary talk and acts provide rich and authentic reflections of CoP.

Connection of CoP and Speech Community

Some research, though not directly addressing CoP and speech community, has engaged dialogues related the two concepts. This review has identified two conceptual works that represent such connections. For example, Street et al. (2009) identified indirect elements of doctor-patient interactions that serve as a mediator of positive health outcomes. Based on this, seven principles of professional practice in medicine were proposed: increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment, and better management of emotions. Grounded in these principles, Street et al. also suggested that communication (speech community) should then achieve the seven principles of practice (CoP) to maximize patients' health outcomes. Street et al.'s analysis provides a preliminary linking of talk and practice, and shows how such connection can help achieve therapeutic goals. However, there are questions that remain unexamined and need further investigation. For example, what is the role of language and communication in achieving best practices? What elements, features, and characteristics of a speech community can be further developed to achieve therapeutic communications?

In their review of literature published from 1975–2000 regarding the practice of health communication (n=22), Beck et al. (2002) identified 14 articles that addressed verbal communication and eight articles that addressed nonverbal behaviors that characterize effective communications. Similar to Street et al.'s (2009) discussion, Beck et al.'s review links the role of communication to effective physician practices. For example, empathic language, reassurance

and support, techniques that characterize patient-centered principles, explanations (during interventions and assessments), humor, language that involved psychological aspects of the person, education, summarization and clarifications are verbal behaviors that led to better working alliances and health outcomes. Nonverbal behaviors such as nodding, leaning posture, forward lean, and fewer mutual gazes are also identified as effective communicative tools. Beck et al. concluded that more studies need to be done regarding elements of facilitative communication in relation to desired therapeutic outcome. In addition, there is a lack of empirical support regarding nonverbal behaviors. Thus, future studies should attend to the nonverbal aspects of health communications.

A limitation found in Beck et al.'s (2002) review is that there is a wide range of measurement and variation of findings regarding effective verbal and nonverbal therapeutic communications. Thus, it is difficult to generalize communications that signify person-centered principles of practices. In addition, the current study believes that interaction is highly contextual because speakers constantly construct, revise, and redefine their discourses (Wetherell et al., 2001). In addition, limited empirical studies also contribute to the lack of generalizability. The current study will include analyses of both the verbal and nonverbal elements of practices in both family medicine and counseling without an intention to find a consensus to determine what effective communicative behaviors are. The purpose is to look into how trainees produce, negotiate, and reproduce professional communication in their ordinary practices.

As mentioned above, the study of communication needs to attend to interactions and what is actually happening at the moment. The proposed current study assumes that language and communication plays an important role in professional practices. However, this study does not intend to explore a linear relation between communication and therapeutic outcome. Rather, the

analysis intends to explore how trainees and their patients/clients jointly achieve the process of communication and create subsequent behaviors. Studying interaction, which includes both verbal and nonverbal behaviors, helps answer this question. This open-ended paradigm of research inquiry could provide ample information regarding professional practices and associated responses. CA will guide the current research to address this gap.

Since language, speech, interactions, and negotiation of social relations are highly involved in both counselor education and family medicine, CA is the most appropriate method to study clinician-client/patient interactions. Methodological considerations and subsequent designs such as data collection, contextual information, and analytic process are guided by CA's epistemological assumptions and principles. The next section will focus on a discussion of CA, in particular, theoretical assumptions about talk and interactions. The theoretical discussions will provide a foundation of review of CA empirical studies related to empathic language and challenging conversations discussed in the subsequent sections.

Conversation Analysis

Conversation Analysis (CA) has gradually received attention as one of the most theoretically sound and rigorous methodological frameworks for studying social interaction (Heritage & Maynard, 2006). As a "grass-roots" methodology, CA emphasizes a bottom-up, inductive, and naturalistic approach to data collection and analysis (ten Have, 1990). In addition, the presentation of analysis is highly empirical. Different from traditional institutional ethnography in social science where researchers focus on key actors, institutional actions, and written documents, CA sees mundane, routine, and daily interactions occurring in institutions as representing a larger institutional structure and organization of work knowledge and actions (Buttny, 2004). In order to understand how CA works in studying communications and

interactions, it is necessary to understand the major theoretical assumptions about talk and interactions. The following paragraphs will provide a detailed discussion of these key components.

Co-Created Interactions

Co-created interactions in CA literature refer to a discourse that is relational and contextual; the meanings of co-created communications are jointly produced through complex and dynamic social interactions (Wetherell et al., 2001). Note that co-construction may involve cooperation, but it does not necessary signify equal power between speakers. According to CA, co-construction and co-occurring sequences often appear in communications; meaning and understanding are produced and created rather than simple information transmissions (ten Have, 1990). Erving Goffman indicated that a discourse is not fixed, stable, and constant, but a fluid phenomenon. For example, speakers constantly negotiate intentional or unintentional speeches that may potentially represent or misrepresent the self or others. Thus, studying a talk situation does not simply assume that speakers are speaking "their own words" because speakers constantly change their positions in interactions in order to jointly achieve goals through communications (as cited in Yates, 2001, p. 83).

The concept of co-created interactions or "co-construction" has both theoretical and methodological implications for this study. First, because interactions are often mutually achieved (Maynard, 1991), an interaction is the unit of analysis in CA studies. Secondly, microanalysis aims at detailed interactions such as turn taking, sequential interaction, and what is actually happening at the moment. Coding process, then, should not simply use pre-developed, thematic categories but focus on immediate preceding talk and its subtlety (Heritage, & Maynard, 2006). Examples of how interactions are jointly achieved and the microanalytic

focuses will be illustrated in the sections "Working Alliances and Utterances of Empathy" and "Challenging Situations in Clinical Encounters."

Talk-in-Interactions in Institutions

According to Goodwin (1994), a representation of professional practice includes three dimensions: coding schemes, highlighting, and articulation of graphic representations by given materials or phenomena. A coding scheme is a process of organization of human cognitions through classifications and categorizations. This cognitive function helps dissect a larger, complex, dynamic theme into sub-categories and objects of knowledge. For instance, in order to understand specific social relations and factors, individuals may use coding schemes to categorize groups of people into identity categories such as gender, sex, or ethnicity (Goodwin, 1994, p. 5).

The concept of coding schemes is relevant in studying multi-faceted and multi-dimensional phenomena such as talk and interactions in everyday contexts. For example, in health communication, coding schemes helps clinicians categorize given phenomena such as patients' chief complaints and presenting symptoms. Coding schemes provide the principles and processes of scientific operations. For example, patients' chief complaints and presenting symptoms are often understood and analyzed though scientific principles such as diagnoses. There are two directions using the concept of coding schemes in studying talk and interactions in a health care setting, firstly, how a communication is organized through processes of information giving and receiving regarding health concerns, and secondly, how health practices, knowledge, skills, and expertise are articulated and presented through interactions.

A coding scheme and highlighting of specific issues may be packaged in initial inquiries of patients'/clients' concerns. For example, the comprehension of health knowledge, meaning

associated with specific health issues and diagnoses, and judgment of presenting health issues are not coming from linear, one-dimensional, uni-directional linguistic constructions, as suggested by structuralists (Chomsky, 1959). Rather, such processes are inter-subjectively related and co-constructed (Anderson & Goolishian, 1988; Buttny, 2004; Heritage & Clayman, 2010; Heritage & Maynard, 2006; Van Herk, 2012). In other words, both clients/patients and health care professionals contribute to the processes and outcomes of communications. Thus, an observation is no longer an objective phenomenon, but a meaning attached through both experts' and laymen's perspectives.

Going back to the function of language where both information giving and the relationship are co-occurring in the process of interactions, a key insight gained from Goodwin's (1994) work is that while scientific languages and the exchange of information are highly valued in a professional situation (i.e., in legal proceedings or a health care setting), relational aspects of talk and speakers' joint constructions of knowledge are playing important roles in social interactions. They are embedded or disguised in the process of information giving and information receiving. For example, a study of professional communication between counseling supervisors and supervisees found that co-authorships of narrations through reinforcement of particular speeches and actions, as well as reframing a reported event and associated meaning, helped accomplish supervisory goals (Luke & Gordon, 2012).

Goodwin's (1994) analytical structure of professional vision and practices provides a framework of study for talk-in-interaction in institutions. For example, how do experts and laymen navigate between jargons and common languages in talking about health issues (coding schemes)? How is the information emphasized through utterances (highlighting)? How is an interaction represented through both verbal and non-verbal behaviors (articulation of graphic

representations)? The insights gained from Goodwin's analytic structures open up several inquiries for this study. For example, the three dimensions of institutional practices may be expanded to questions and answers related to complaints about health issues and diagnostic procedures (Heritage & Clayman, 2010), styles of history taking and the asymmetry of doctor-patient relationships (ten Have, 1991), misrepresentation of self and repair (Sanders, 2012), difficult and challenging topics (Beach et al., 2005), and the exploration of emotions (Voutilainen et al., 2010).

Identity, Power, and Social Interactions

CA studies contain extensive discussions regarding the role of preexisting identity and contextual information in data collections and analytic processes (Boden & Zimmerman, 1991; Schegloff, 1991; ten Have, 1990, 1991). In an essay on talk and social structure, Schegloff (1991) discussed the notion of the problem of relevance and procedural consequentiality. In social science research, various social identity categories are often the subject matter of the study. For example, a particular identify variable is often compared, described, and itemized in statistical calculations. In some discourse analyses and critical discourse analyses, power dynamics and pre-supposed power positions are often used as a guiding theoretical framework in studying social relationships (Wetherell et al., 2001). Schegloff (1991) indicated that studying social interactions should not separate social identities into separate constructs of study, unless they are empirically revealed in the process. The problem of relevance indicates that identity categories should be treated as embedded in conversations and interactions in a single occurrence. For example, a sentence or a speech occurrence produced by a person should be seen as a collection of the person's whole identity including race, gender, class, etc, as opposed to singling out an identity as a study of focus. Moreover, some identities may not be activated, and

some may be pronounced during interactions depending on contexts or talk events. Presumably, salient themes of contexts and identities should be revealed through the data of interactions, not interpretation (ten Have, 1990). In other words, an analytical process should not presume the impact of a specific identity with no justification from the given data.

CA's epistemological stance on pre-existing identity categories presents a different argument from typical social studies where identity variables are often selected as independent variables. Contextual information such as positions of power and social identities in analytic processes should be originated by participants and organically revealed through the empirical data of talk and interaction, rather than researchers' evocations (Buttny, 2004; Schegloff, 1991; ten Have, 1990). Such a stance is consistent to an inductive, descriptive, and empirical approach to qualitative research (Heritage & Maynard, 2006; Schegloff, 1991). Selecting a preexisting category for a focus of study may be contradictory to the epistemology of qualitative research where researchers are using a "presumption-less" and inductive approach (Schegloff, 1991, 1993). Schegloff indicated that this methodological premise does not mean the considerations of social identities, power, and contexts are not important; rather, they matter in occasional instances of interactions

Ordinary Interactions

Talk, accordingly, plays a key role in understanding the fluidity and dynamics of human relations and discourse of issues discussed in a context. Buttny (2004) argued that talk serves as a formative function in co-creating social realities, that is, conversation is a main agent that presents sociability and interpersonal relations (Wetherell et al., 2001). In addition to the social and relational aspects of talk and interaction, the study of discourses focusing on ordinary interactions has a theoretical base. Accordingly, discourse occurring in interactions is a product

of the intersectionality of multiple identities. Each identity has its own internal logic and orderliness. Since everyday conversation presents the basic form of speech exchange systems that exists in diverse conversational settings, studies of discursive relationships should be based on understanding the process of ordinary interactions (Maynard, 1991). Anecdotal beliefs about ordinary talk tend to see everyday interactions as mundane, messy, trivial, inconsequential, and not generalizable. CA views ordinary conversations as validly representing the circumstantial and discursive occurrences of individuals and institutions (Buttny, 2004; Heritage & Clayman, 2010; Heritage & Maynard, 2006; Maynard, 1991; Schegloff, 1991, 1993; ten Have, 1990). Thus, the study of institutional talk should focus on conversations occurring in everyday interactions in institutions (Maynard, 1991).

Natural Occurrences and Recorded Data

An important component of CA research is the use of video or audio recordings of naturally occurring interactions for analysis. CA researchers argued that interviews, observational study, intuition, and experimental methods contain researchers' or informants' manipulation selection, and retrospective biases contain preconceived notions of what should be provided during encounters (ten Have, 1990). Studying language, interactions, and conversations should then focus on how one uses language in an unobtrusive, naturally occurring encounter. Recording natural occurrences allows viewers to be exposed to a wide range of data sources and multiple angles of observation, sequence of events, actions, and reactions at a temporary context. In addition, such data allow repeated and detailed investigations of particular moments of interactions, which enhance the trustworthiness and credibility of analytic conclusions (Heritage & Maynard, 2006; ten Have, 1991).

Fine-grained Analysis

Unlike most research wherein attention is often given to larger, overarching themes, CA research pays a great amount of attention to themes that emerged through interactions. These themes are often revealed through in-depth, extensive, and detailed analysis. Some have connected microanalytic features of talk with analysis of institutional practices in order to formulate theoretical components of talk and interactions in health communication. This provides a more comprehensive picture of the phenomena of a single interaction.

<div align="center">

CA in Medicine and Mental Health

</div>

This study reviewed CA studies that focus on communications occurring in medical and mental health care settings by using the key phrase "conversation analysis" combining with the following key words in the search process: "doctor-patient interaction," "medical visit," "medical," "counselor-client interaction," "therapist," "counseling," "therapy," and "psychotherapy." Keywords related to initial sessions such as "initial," "first," "early," and "beginning" were also used for searching. In addition, keywords related to trainees such as "trainee," "intern," and "resident" were included. However, the current study found no CA study focusing on the first-time clinical interaction or sessions conducted specifically by trainees. Based on extensive searches and reviews of literature across disciplines such as medicine, counseling, communication, linguistics, and sociology, the current study identified a total of eight CA studies that addresses communications and interactions between therapists and clients as well as doctors and patients. Readers will expect a detailed review of these CA studies in the following two sections, "Working Alliances and Utterances of Empathy" and "Challenging Situations in Clinical Encounters."

In reviewing all CA studies related to talk and interactions in clinical settings, a couple of CA theoretical and methodological characteristics have surfaced. These features are very different from the typical representation of social science research. First, unlike typical medical and counseling studies where methodology, sampling process, sample characteristics, and analytical tools are listed with detailed descriptions, methodological procedures and sampling processes are relatively loose and discrete in CA studies. Secondly, unlike traditional social science research where a large sample size is encouraged in order to optimize generalizability, most CA studies involved case studies and use a single portion of excerpts of conversations to illustrate analytical themes. Thirdly, while CA studies may have different focuses depending on research questions, all CA studies in this review tend to report results that show both clinicians' and patients'/clients' interactive processes. Patients' narrations are included in the report of results and analysis in order to demonstrate what is actually happening between speakers. Finally, CA studies tend to mingle results and analysis with extensive descriptions in order to mirror such analysis with a direct portrait of narrative data. Authors often went back and forth between data and analysis to present research results and discussions.

The current study expects to fill the gap in the current trend of CA in medicine and mental health by including data from naturally occurring sessions conducted by trainees in both family medicine and counselor education. Allied with CA's key theoretical premises in studying interactions, the current study will focus on detailed and sequential features of interactions while attending to a macro, thematic level of talk phenomena.

As suggested by several studies, communication and relationship plays a crucial role in an initial session (Easter & Beach, 2004; Odell & Quinn, 1998; Rahman, 2000; Tryon, 1990). Communications that involve health concerns, emotional and relational issues often elicit both

intra and interpersonal reactions, and such reactions can be socially and psychologically intense in an initial encounter. As therapeutic interactions progress in the first clinical appointment, unique features of talk and interactions such as working alliance, difficult conversations, and vulnerability may be manifested through relationships. The following sections will review studies related to these dynamic talk phenomena. CA studies that touched upon these features of talk will also be included in the following review.

Working Alliances and Utterances of Empathy

Working alliance (WA) and therapeutic relationships have received a great amount of theoretical and empirical attention (Bordin, 1994; Castonguay et al., 2006; Eriksen & Kress, 2006; Fuertes et al., 2007; Graugaard, Holgersen, & Finset, 2004; Griffith, 1990; Horvath & Symonds, 1991; Howgego et al., 2003; Kress et al., 2005; Kivlighan & Shaughnessy, 1995; Lutfey, 2005; Matarazzo & Wiens, 1977; Noble, 1998; Saltzman et al., 1976; Sexton & Whiston, 1994; Trostle, 1988). A positive link between effective working alliance and therapeutic outcome has been found consistently in studies across the field of medicine and counseling. For example, in a survey of medical patients' perceptions of both cognitive and emotional dimensions of working alliance (n= 118), Fuertes et al. (2007) found a significant relationship between a strong physician-patient working alliance and patients' perception of treatment effectiveness, beliefs of usefulness of treatment, and self-efficacy behaviors that promote the action of health practices. In addition, patients' perceptions of working alliance and self-efficacy behaviors predicted both adherence to treatment and satisfaction of outcomes. In addition, some studies suggested that the quality of a counseling relationship predicts effective counseling outcomes (Horvath & Symonds, 1991; Howgego et al., 2003; Sexton & Whiston, 1994). For example, in Horvath and

Symonds' (1991) meta-analysis (n=24), positive WA has moderate reliable association with positive outcomes.

Although the link between WA and therapeutic outcomes has been overwhelmingly discussed and examined, of the studies that have focused on WA and effective skills, a majority have used experiments, retrospective surveys, interviews, and observations (Fuertes et al., 2007; Graugaard, Holgersen, & Finset, 2004; Horvath & Symonds, 1991; Howgego et al., 2003; Kivlighan & Shaughnessy, 1995; Saltzman et al., 1976; Sexton & Whiston, 1994; Tryon, 1990). Very few studies have directly focused on direct, naturally occurred clinical interactions.

Despite the prevalence of research related to WA in family medicine and counseling, studies that explore interactions and language use related to empathy and therapeutic interactions are limited. Major databases include JSTOR, ERIC, PsycNet, PsycInfo, PubMed, Wiley Online, SAGA, and Google Scholar. With an extensive search with combinations of key phrases such as "communication," "interaction," "therapeutic relationship," and "working alliance," this review identified a total of 12 articles focused on talk and interaction, as well as working alliance in relation to language and interactions that signify empathy or forming therapeutic alliance. The following section will review these studies. To do so, the review is divided in three sections, beginning with four articles that explore interaction in relation to the therapeutic relationship (Barkham & Shapiro, 1986; Heritage & Clayman, 2010; Street et al., 1992; Strong et al., 2006). Next, some researchers have studied asymmetry in conjunction with different phases of the clinical session, from a beginning structure of question and answer to discussions related to treatment and intervention (Heritage & Clayman, 2010; Heritage & Maynard, 2006; Maynard, 1991; ten Have, 1991). A total three CA articles related to asymmetry were selected for review (Bergmann, 1992; Buttny, 1996; Maynard, 1991). Finally, five research studies that focus on

empathic language and utterance are selected for review. The studies utilize a variety of analytic methods, including one multivariate analysis (Bensing et al., 1996), one qualitative, content analysis (Walsh, 2007), one case study (Guilfoyle, 2003), and two CA studies that present microanalytic features of empathic utterances (Tikkanen et al., 2013; Voutilainen et al., 2010).

Interactions in Therapeutic Relationship

Despite the overwhelmingly consistent finding regarding the positive influence of a good WA, Lutfey (2005) argued that there was much less attention paid to how interactions may produce or impede alliance. Interactions, according to CA, signify co-construction of discourse and reveal microanalytic features of a relationship. The fluid, dynamic nature of interactions reflects why the study of relationships should look into the details and processes of interactions. The current study will add to this.

Street et al. (1992) conducted a content analysis focusing on variations in patterns of medical communication in pediatricians and communicative styles and adaptation in doctor-patient consultations. The study used independent, trained coders to code physicians' and patients' utterances in a total of 115 audio-recorded sessions. Multivariate analyses focused on communicative behaviors including level of information giving, directives, and positive socio-emotional utterances. The results indicated a variable, fluid style of utterance and interactions among physicians when encountering patients who had a specific level of education and question styles. Circumstantial factors such as personal and interactive factors alter clinical interactions. For example, clinicians tended to respond more when clients displayed more concerns. Moreover, clients who displayed a more overt emotional expression received more active and supportive responses from clinicians.

Accordingly, physicians' responses toward clients in Street et al.'s (1992) study demonstrates a co-constructed, jointly achieved interaction. Specifically, the therapeutic relationship is dynamic, contextual, and circumstantial rather than a linear, static, cause-effect relationship. Street et al. indicated that the circumstantial factors influence the interactions between physicians and clients. The current study assumes that interactions are jointly achieved with complex personal, institutional, and circumstantial factors. It is difficult to conclude whether an interaction results from a specific circumstance, unless it is clearly presented from the data (Maynard, 1991; Schegloff, 1991). In the current study, the microanalysis of interaction in CA will add an additional contribution regarding such a dynamic relationship through demonstration of transcription and excerpts of conversations.

As mentioned above, studies that include only clinicians' or only patients'/clients' utterances are necessary and can be informative, but it can be argued they are not sufficient for investigating how empathy is produced, given, and perceived because reaction to empathy can be quite contextualized. Illustrating this, in examining both counselors' and clinicians' perceptions of empathy in 24 client-counselor dyads, Barkham and Shapiro (1986) conducted a content analysis of transcriptions of 12 initial sessions, 12 ongoing sessions, as well as the same number of clients' and counselors' recall sessions. The study used independent coders and raters for both clinicians' and clients' behaviors and responses toward empathy. The multivariate analysis indicated that clients perceived empathy occurred more during ongoing sessions than initial sessions. However, counselors perceived more empathy occurred in initial sessions than working stages. From clients' perspectives, less advise giving, using more exploration, and less assurance was perceived as empathy. Exploration as perceived by both counselors and clients was strongly associated with experiences of empathic communications across sessions.

A limitation found in Barkham and Shapiro's (1986) study is that survey research looking at perception and satisfaction is inadequate to study therapeutic relationships and dynamics. Sexton and Whiston (1994) suggested that both facilitative conditions and interactive processes are essential in studying the role of relationships in counseling and psychotherapy. Specifically, empathy is a complex construct because in therapeutic processes, empathy is often interactively achieved. Perceptions of empathy as perceived by patients/clients provide limited reflection with regard to what is actually going on in interactions. Moreover, perception and actual behaviors are not always consistent. As in the proposed current study, data that presents utterances as they occur in interactions can provide this insight.

Both Street et al.'s (1992) and Barkham and Shapiro's (1986) studies illustrate that a therapeutic interaction is complex, relational, and circumstantial. The findings from both studies capture the significance of a question asked by the current study: How are therapeutic relationships and therapeutic discourses produced in initial sessions? and how does the content and process of the talk reflect the therapeutic relationship or empathy? Studying language and interaction in naturally occurring clinical sessions and the demonstration of actual conversation are parts of the design of this study. This helps provide unanswered information in the current literature. The following two CA studies have demonstrated a microanalytic feature of interactions between clinicians and their patients/clients, such as patient's problem presentation and how therapists introduce new therapeutic discourses.

In a focus of patients' utterance of problem presentation, Heritage and Clayman (2010) found that clients respond differently toward known and unknown problems while presenting health issues and receiving diagnoses. Several excerpts of communication illustrate that while known issues are often verbalized through terminologies and brief descriptions of symptoms,

unknown problems often contained rich narratives along with emotional descriptions (or lack

thereof). These extensive narrations allow patients to articulate the nature of presenting problems

and experiences of them. Two excerpts illustrate the differences in terms of degree and intensity

of narrations between known and unknown problems. A known problem presentation may

appear to be brief and succinct (Heritage & Clayman, 2010, p. 122). Note that markers such as

columns, brackets, parentheses, numbers, space between lines, spaces between words, and spilt

lines between sentences provide orthographic review of the textual verbatim and noted elements

of utterance in order to record the sequential feature of talk and microanalytic interactions

(Atkinson & Heritage, 1984; Buttny, 2004; Sacks, Schegloff, & Jefferson, 1974). In addition,

this study used the typical CA format of the transcription text, which is displayed in Courier

New, font size 12:

```
(2.1)
1 Doc:    what's been goin' o:n.
2 Pt:     Ba:d sinuses (.4) achey. (0.2) cold an' ho't.
3         (0.6) ((physician gazes at pt and nods twice))
4 Doc:    ° ok °
5 Pat:    headaches.
6         (1.0) ((physician gazes at pt and nods twice))
7         °You know . ° (.) your usual. =
8 Doc:    = when did they start . do you think
```

A richer description of symptoms and expression of uncertainty can be found in an excerpt in

which a patient tried to describe her symptoms, which turned out to be Costochondritis (Heritage

& Clayman, 2010, p. 127). Note that in order to be consistent with the line number from the

original text, the excerpt displayed here may not seem in alignment with the numbering system:

```
(2.2)
1 Doc:    what can I do for you today.
2         (0.5)
3 Pat:    we:ll – (0.4) I fee:l like (.) there's something
4         wro:og do:wn underneath  here in my rib area.
5 Doc:    mka:[y
6 Pat:        [I don't tuh:m (0.4) I thought I might'a cracked
```

```
7              'em somehow but I have no clue ho:w,
8              (0.4)
9              And I don't even know what cracked ribs £f(h)eel like.
10             £ I jus' know that there's a pa:in there that
11             shouldn't be. .hh an' as I'm sitting' here its not (.)
12             not as ba:d but when I'm up an' active an' (.) movin'
13             around an' breathin' an' (.) doin' all that (.)you
14             =know (.) extra (.) [heavy breathin' it (w's)
15 Doc:                           [mh hm:,
16 Pat:   really bo:therin' me.
```

Another study using CA focused on how a new therapeutic discourse is introduced in the process of counseling in two dyads of therapists-in-training, using a constructionist theoretical approach and undergraduate volunteer clients (Strong et al., 2006). Several linguistic strategies used by trainees were found in segments that presented mutual understanding. First, the therapist used clients' language before interjecting new words and meanings. Strong et al. (2006) argued that this is a "pragmatic choice" that indicates a therapeutic attempt at building rapport. Secondly, discourse markers such as "ok," "uh-hm," and lengthy pauses were packaged in the conversations indicating future occurrences of new therapeutic perspectives. Thirdly, the merging of discussions was presented by the coordination of words used by both clients and trainees. This indicated shared knowledge created by both parties.

There are several methodological questions regarding Strong et al.'s (2006) study. First, the analysis included participants' retrospective accounts and interview data, which is different from typical CA approaches where analysis should separate interview or perception data in order to validly examine what is actually happening in interactions. In addition, data were not taken from actual, naturally occurring counseling sessions. Clients in this study were informed that they were in a study and not engaging in therapeutic conversations. Thirdly, counseling trainees in this study self-identified as using constructivist approaches to counseling. Note that introducing a new discourse can be for the purpose of changes (Ainsworth-Vaughn, 1992; Luke

& Gordon, 2012), for acknowledgement (Buttny, 1996), and for new experiences of emotion

(Voutilainen et al., 2010); thus, this phenomenon is not limited to specific theoretical orientation.

Asymmetry

Asymmetry is a construct that is widely discussed in current CA research on doctor-

patient interaction. Asymmetry is perhaps one of the few overarching themes that has emerged

across sociological studies in health communications (Ainsworth-Vaughn, 1992; Beck et al.,

2002; Boden & Zimmerman, 1991; Leahy, 2004; Maynard, 1991; ten Have, 1991). Accordingly,

asymmetry may be an inevitable social relation between ordinary people and institutional actors

(Ainsworth-Vaughn, 1992). However, conversation analysis of doctor-patient interactions sees

that asymmetry is produced in the process of interaction, and such processes should be revealed

through close analysis of participants' actions in the data (Heritage & Clayman, 2010; Maynard,

1991; ten Have, 1991). Asymmetry may exist according to the speaker's status at the moment of

the talk, and sequences of talk should reveal the process of how asymmetry is interactively

achieved (Katon & Kleinman, 1981; Maynard, 1991). Despite asymmetry, the clinician-patient

relationship is not stable and fixed. They constantly negotiate emotions internally and externally

while fulfilling a given role or responsibility. For example, clinicians and clients/patients may

jointly experience particular emotions, jointly fulfill tasks required by institutions, and jointly

attend to solutions (Beach et al., 2005). With said or unsaid emotions or motivations, a

relationship is constantly built, experienced, and shaped, rather than being an independent,

linear, uni-directional set of interactions.

Studies on asymmetry. Three studies were selected to represent features of asymmetry

include monopolizing initiatives, withholding information, and selecting agendas from the

doctor's position during question-answer processes.

Maynard (1991) examined over 50 clinical interviews between pediatricians and parents who presented their concerns regarding the developmental disabilities of their children in a pediatric clinic. There are several analytic findings in relation to asymmetrical interactions between a pediatrician and parents. First, an invitational speech and inquiry initiated by a clinician may communicate expertise and professionalism. Specifically, questions initiated by a clinician may be designed for obtaining answers that are limited to relevant information perceived by the clinician. An example is illustrated in this interaction, with the doctor referred to as "D", the parent referred to as "P", and the child or juvenile being discussed referred to as "J" (p. 452). Note that there is no line number indicated in the text:

(2.3)
```
D:   now that you've-we've been through all this I'd just like to
     know from YOU how you see J at this time
P:   the same, she can't talk, she can't speak…clearly, she can't
     pronounce words
```

Moreover, in examining the sequence of questions and answers, marked and unmarked questions were analyzed. A clinician-patient interaction often contains both marked and unmarked questions. Marked questions connote and expect complimentary assessment. For instances, speakers ask closed-ended questions; or a tag question is asked after the speaker's comment. These strategies have assumed a discourse and invited expected answers. The doctor's questions that intended to solicit answers of confirmation of the doctor's diagnostic proposition from the parent can be found in a continuing dialogue regarding a concern of J's developmental issue. Note that the word "retardation" within a bracket was not spoken but implied within the utterance (p. 453). In addition, there is no line number indicated in the text:

(2.4)
```
D:   is this something that you were worried about, that she
     might be retarded, and that might be the reason for the
     language problem?
```

```
P:    I can't worry about it, I have to live with that, I can't
      worry
…
D:    is this [retardation] something in the back of your mind,
      that maybe that was the reason why she isn't talking?
P:    I don't think so, I think she just slow in learning
```

Different from marked inquiry, unmarked inquiry is not presumptuous. The unmarked

inquiry, known as neutral inquiry, allies with counseling skills related to opened-questions,

which reveal rich narration and presumption-less positions. While presumably unmarked

questions encourage narrations from clients and potentially invite mutual understandings, they

can be used to present clinicians' authority and expertise. An example can be found in a

conversation between another doctor-parent dyad, Dr. E, who inquired about the situation of

"B," a child of Mrs. M. In this excerpt, Dr. E first conducted a general greeting, followed by a

paraphrasing of Mrs. M's words and an inquiry of Mrs. M's perspectives. Then, the two speakers

jointly formulated an answer with regard to B's issue (p. 469). In order to be consistent with the

line number from the original text, the excerpt displayed here may not seem in alignment with

the transcription lines:

```
(2.5)
9  Dr. E: He doesn't think that he's gonna need to be sent
10 Mrs. M:Yeah that he was catching on a little bit uh more you
11        know like I said I- I- I KNOW that he needs a- you
          know I was 'splaining to
12        her that I'm you know that I know for sure that he
          needs some
13        special class or something
14 Dr. E: Wu' whatta you think his PROblem is
15 Mrs. M:Speech
16 Dr. E: Yeah. yeah his main problem is a- you know a LANguage
          problem
17 Mrs. M:Yeah language
```

Maynard (1991) argued that while both ordinary conversations and professional talk in clinical

settings include both marked and unmarked inquires, clinical conversations often reveal

professional opinions from clinicians, which constitutes the expertise and authority of knowledge despite using unmarked questions. Unmarked questions can indirectly invite expected results and represent authority.

In another analysis of psychiatric intakes from various mental hospitals in Germany, asymmetrical interactions between psychiatrists and patients were found to be implicit under formative question and answer processes (Bergmann, 1992). First, questions asked functioned as confirmation of previous history taking or symptom checklists, as opposed to an open-ended inquiry. Secondly, questions represented by psychiatrists in this data were indirect and formative rather than interrogative. However, they often contain information that presents psychiatrists' pre-existing knowledge about their clients. In other words, questions were designed not for asking but telling clients about themselves. An example of such indirect, circuitous, and yet presumptuous dialogues can be found between a psychiatrist, Dr. F, and a patient, Mrs. B. In the first excerpt, Mrs. B's husband, Mr. B, was silent in the process of inquiry (p. 138):

```
(2.6)
1 Dr. F:   (I just) got the information, (0.8)
2          (that you're) not doing so well.
3 Mrs. B: Yea::h well that is[the opinion
4 Dr. F:                      [Is that correct?
5 Mrs. B: of Doctor Hollmann
6 Dr. F:   I [see
7 Mrs. B:     [but it isn't mine
8 Dr. F:   It isn't your[s
9 Mrs. B:               [No::
10 Mr. B: (              )
11 Mrs. B:[I'm doing very well.]
```

The second excerpt demonstrates a progression of the intake process between Dr. F and Mrs. B where history taking was conducted. Here Dr. F again used pre-existing knowledge of Mrs. B and a doctor's name as a frame of reference to confirm Dr. F's perceptions of Mrs. B's issues (P. 149):

```
(2.7)
11 Dr. F: Doctor Hollmann told me something
12         like you were running across the street not so
13         completely dressed or something like that.
14 Mrs. B:(h) yes: that's:-I am a child of God:=
15         =I am his child
```

Thirdly, while asymmetry manifests itself through clinicians' speech and initiatives, interactions are shaped and reshaped by further interactions. Clinicians experienced relational dilemmas despite the presence of doctors' monopolizing position. For example, with the absence of mutual agreement under asymmetrical interactions, patients refused to answer questions while a doctor used indirect probing in history taking (Bergmann, 1992). This interaction can be found in another doctor-patient dyad, Dr. B and Mrs. K (p. 152). In order to be consistent with the line number from the original text, the excerpt displayed here may not seem in alignment with the numbering system:

```
(2.8)
1 Dr. B:  Obviously you withdrew very much
2          (.)
3          recently
4          (.)
5          in your flat.
6          (0.7)
7 Mrs. K: Hu! That's private business. There is nothing
8          to talk about!.=
9          =Withdrew.=I can do what I want.
10         (0.8)
11 Dr. B: Well here [it says you had yourself -
12 Mrs. K:          [Saying such things.=
13 Dr. B: =Here it says you had yourself barricaded
14         and (-) you we [re-
15 Mrs. K:               [Pardon?
```

Some CA studies illustrate that the therapeutic relationship is a co-construction of the therapeutic process, and a relationship, whether it is symmetrical or not, is produced through exchanges of discourses, and is not a fixed state of phenomena. This research tends to exist in studies of communications between therapists and clients. For example, in two therapeutic

communications using perspective display series (PDS) where therapists' utterances indicate

understanding and acknowledgement of clients' discourses, Buttny (1996) found that therapists'

initiatives of inquiry with the subsequent acknowledgement of clients' perspective brought up

clients' further self-reflection and adjoining therapists' perspectives. An example can be found in

a couple's therapy. Accordingly, the therapist first recognized a position of conflict between the

couple, Lanny and Jenny, who shared different points of view regarding therapy. The PDS

demonstrated that the therapist acknowledged this phenomenon by elaborating the risk of

engaging in therapy and potential problems created as a result of Jenny's individual therapy (p.

130). After this acknowledgment and elaboration was interjected in the process of therapeutic

dialogues, the couple presented a moment of dispute about the problem elaborated by the

therapist and a shared point of view between the two, indicating that the problem was not created

through therapy, but simply being presented through therapy (p. 131). This segment included

three phases of talking about problems as Buttny indicated: problem presentation, negotiation,

and dispute.

      The following excerpt shows a discussion of Jenny's self-ascription of engaging in

couple's therapy and the possible risk of exploring problems though therapy. "T" represents the

therapist, and "J" represents the client, Jenny (p. 132–133). In order to be consistent with the line

number from the original text, the excerpt displayed here may not seem in alignment with the

numbering system:

```
(2.9)
1 J: …and uhm (.) I don't feel comfortable about it >at all<
2     (0.9)
3 J: I just think it's something ne:[w
4 T:                                [yeah in addition to
5        that [I
6 J:         [>it's something new <
7 T: I concur very much with you in the fact that precisely
```

```
8     because you have been exposed to several things in recent
      week[s     .h=
9 J:     [Uh  huh
10 T:=ah you should be:: skeptical to start with and >you know<
11   to move slowly
12 J:uh huh
13 T:very important to go very slowly
…
1 J: Yeah I think- I mean in the past I 've I 've ah (0.9) been
2    a lot (0.5) less open with my feelings and I 've repressed
3    a lot of my own feelings but I've been in therapy now for
4    awhile and a[h::
```

While telling clients about themselves from therapists' points of view connotes asymmetrical, expertise positions, as illustrated in Bergmann's (1992) data, counseling sessions presented in Buttny's (1996) data indicated that such interaction is a rhetorical, back and forth dialogue between clients and therapists rather than an asymmetry between experts and laymen.

Empathic Utterances

Utterance contains both a cognitive level and an affective level (Besnier, 1990; Graugaard et al., 2004; Ruusuvuori, 2007). In addition to conveying knowledge and using purposeful language to meet therapeutic goals, utterance also presents affect and a particular state of emotions. Kuno and Kaburaki (1977) pointed out that utterance functions as a "camera angle" of information, that is, utterance alters how information is perceived and expressed and how a discourse is established, reestablished, and transformed. A speaker can describe an event depending on where the angles are and how much focus is put on specific information. Empathy and the relational aspects of health communications are encapsulated in the process of expression (p. 628). Giving information and achieving therapeutic goals are an ultimate part of discursive agendas; how an agenda is perceived depends on how it is presented and conveyed. Kuno's and Kaburaki's (1977) work provides insights regarding doctor-patient and therapist-client relationships because empathic utterance reveals relational discourses from two parties; it is also

a micro presentation of interactions between institutions and individuals in ordinary conversations.

In a correlational study using an observational coding method measuring general practitioners' affective behaviors, instrumental behaviors, space for patients, and outcomes in a sample of 1524 consultations among 30 GPs, Bensing, Schreurs, and Rijk (1996) reported that affective behaviors were negatively correlated with some aspects of instrumental behaviors among physicians, in particular with technical-medical interventions and prescriptions. Affective behavior also indicated the significance of interactions; that is, physicians' affective behaviors were positively related to indicators of session structure such as consultation length, proportion of talk, patients' influence on diagnoses, and discussion of psycho-social topics. In addition, affective behaviors appeared to be the strongest factor that explains patients' satisfaction and perception of quality of care. Bensing et al.'s (1996) focused measures regarding affective and instrumental behaviors can be used as background information regarding report and rapport style discussed earlier in this chapter. One of the important questions posed by the current study is in what context and circumstances do speakers shift their style during conversations? Correlational studies provide limited knowledge of such dynamic shifting. The proposed current study expects that CA's demonstration of detailed, sequential interaction will capture such a process.

A few studies focus on discourses and utterance that mark alliance and empathic stances. For example, in a discourse analysis of two speech language pathologists' interactions with patients using a total of 16 sessions of audio-recorded data for over five months, Walsh (2007) studied the role of small talk in relationship building in a therapeutic interaction. Analytic focuses include frame and framing, the role of power, and the use of politeness. Analysis of transcriptions indicated that small talk and day-to-day language in clinical interviews produced a

more collegial conversation, which subsequently facilitated a more informative discussion. Despite managed care's expectation of outcome-based measures and cost-effective conversational practices, small talk that contributes to relationship building has powerful effects in facilitating health communications. Walsh's (2007) finding is consistent with CA's assumption that ordinary interactions and institutional talk often overlap (Hertiage & Claymen, 2010). A question posted (do you mean "posited"?) by the current study regarding small talk in clinical settings is in what ways small talk links to building a therapeutic relationship. It is not clearly explained and analyzed in Walsh's (2007) study. The current study will fill such a gap by examining the sequence of talk and how small talk occurs in the sequence of interaction, if such incidents appear in the data.

Other studies focus on utterances that signify therapeutic relationships. For example, Guilfoyle (2003) conducted a textual analysis of a previous psychotherapeutic case study to illustrate power and relationship in the practice of dialogued-oriented, "not-knowing" forms of therapy. In dialectical types of practice, overt expression of power threatens the co-construction of dialectical process and interactions; on the other hand, a "not knowing" practice defers power. When a therapist assumes a "not-knowing" stance, he/she withholds an aspect of personal voice, which sets as a foundation for further dialogues. In other words, a "not knowing" stance helps constitute dialectical processes. This is not to deny the presence of interpersonal or institutional power. However, the "not knowing" position conceals such power in individual interactions. Note that the case that Guilfoyle (2003) used to illustrate was in a psychotherapeutic context, where a client presented relational issues in the session. Guilfoyle's (2003) analysis suggests a clinician's "not-knowing" stance may produce a different power dynamic, if the circumstance is different. For example, a "not knowing" position may produce an anxiety-provoking scenario if a

patient/client is in need of immediate interventions due to a critical condition. On the other hand, a dialogued-oriented, "not-knowing" stance may likely occur in an initial encounter where speakers have no prior social interaction. How power and therapeutic relationship is negotiated and established in such a context will be part of the inquiry.

CA research focused on conversations that display empathy or working alliances tend to appear in studies of psychotherapeutic interactions. Studies of health conversations related to mental health, relational issues, and wellness, similar to doctor-patient interactions, focuses on detail and mundane interactions. This review selected two articles that represent empathic utterance, both coming from psychotherapeutic settings.

Tikkanen, Stiles, and Leiman (2013) used dialogical sequence analysis, a microanalytic method studying utterances, to examine how changes occurred through reflective and empathic dialogues between a mother and a child who exhibited oppositional behaviors. Accordingly, parallel development of interpersonal and intrapersonal empathy was established through two ways of recognition, a recurring inter and intra dialectical position. An analysis of 18 sessions between the parent and child indicated that recognition requires two ways of transaction: a speaker's recognition of personal discourses and the listener's discourse. An example between the therapist and the mother is used to illustrate such a dynamic. Here the therapist, "N," intended to help the mother, "M," reflect her own position of attempting to control her child's, Satu's, behavioral issues (p. 182). The line numbering system is consistent with the original text:

(2.10)

```
445 N: Yes. So, that sounds like that this [blackmailing] is not
       quite the means you would want to use, or somehow, [is it?
446 M: No,] of course I would not want to use that kind of means,
       of course not! Satu, at  times she just doesn't leave any
       choice here. Occasionally you just have to take the toys
       away and; she has like learned it fairly well that there
       are also other things, which you must do. And about that
```

eating, she had at one time a bad habit to carry a huge
pile of toys on the table and we just right there started
to do so that no toys were from then on allowed on the
table. If she tried to sneak them we took them back. That
they are waiting there in the other room until we have
eaten. These kinds of things. Of course I would not want
to use them. No, no way. I guess it is common, he-hee
(*laughing*), to every parent. Sometimes you have these
moments.

447 N: Yes. Yes.] So that, on one hand, you should be sort of
tough and then, like in some situations, like decide that
now, in this eating situation, you cannot take them.

After helping the mother recognize her own intention and position of being controlling toward

Satu, the therapist introduced a new perspective toward Satu's behaviors by linking the mother's

perspectives which had been mentionedpreviously (p. 183):

(2.11)

457 N: Well, like, own will is; she does seem to have a strong
will.?

458 M: Hm. Hm." Yes, yes, yes." (*fast*)

459 N: On the other hand, it is kind of a good thing [too

460 M: "Yes, yes, yes, yes], I did not say that, but *it* should
understand that, if there is something else that has to be
done; so it is then that; *it* should also give in,
shouldn't it, but *it* doesn't understand this yet;
because *it* is searching for its boundaries now!

The presentation of two people's perspectives (both the mother and Satu) in the process of

dialogues between N and M create a mother's realization of a similarity between herself and

Satu. Then, the mother indicated another similarity that may be a potential element that can

strengthen her parenting strategy and her relationship with Satu (p. 183–184):

(2.12)

464 M: Yes, we have [a battle], but we have both been flexible
too. At home you can clearly see that*Satu* is flexible and
gives in, and at times I just don't have the energy to
start fighting. So that also happens sometimes. (*chuckles*)

465 N: Yes, yes. How do you yourself notice it; how do you act
when you are more flexible?

```
466 M: I give it a little bit more time to play; or something
       similar and then, well, well and; then occasionally; if I
       have had a bad day anyway and I feel that it might "click"
       in my head and that I would get really angry, then at that
       stage I prefer to make a retreat so that I don't blow up
       totally. At that stage I rather give in. Of course there
       are moments when you just blow up, but now that I have
       learned it, hah (laughs), to step back; it has been better
       that way. You feel better when you have not yelled and
       been offensive (laughs)
```

Tikkanen et al.'s (2013) case study provides new perspectives on the study of empathy and

empathic utterance. Speakers' recognition of intrapersonal discourse has not been mentioned by

previous studies regarding working alliance and empathy, which were primarily focusing on how

empathy is delivered and perceived. The recognition of interpersonal dialectical positions adds a

third level, that is, "a third person's perspective" (p. 184). A speaker's participation in others'

discourses while maintaining the speaker's current stance allows the development of these three

ways of transactions. Changes occur as a result of such shifting dialectical positions.

A study of counseling conversation indicates that recognition and interpretation of

emotions, along with exploring personal experiences, are part of therapeutic interventions and

assessment of working alliance (Voutilainen et al., 2010). Voutilainen, Perakyla, and Ruusuvuori

(2010) analyzed how a therapist negotiated a present asymmetrical relationship while helping a

client process emotions in a total of 26 counseling sessions conducted in a two-year treatment

period. An extensive presentation of therapeutic dialogues indicated that when the expression of

emotions or potential opportunities of empathic discourses are present, validation and expansion

of narration occur. Also, acknowledgement of emotions was an a priori condition for subsequent

interpretations of emotions. While recognition and interpretation can happen in different

sequences, the two strategies often overlap. For example, when the client disclosed emotional

disturbance, the therapist provided a question that elaborates the phenomenon of a particular

emotion. This type of acknowledgement and encouragement is similar to "homeopathy" (Voutilainen et al., 2010), a term that describes medical doctors' responses to trouble-telling. Accordingly, talk and acts that involve responding to and recognizing patients' experiences of suffering seem to be a common empathic utterance that can be shared in both medical practices and psychotherapy (p. 103).

This section summarized current literature regarding working alliance and empathy, and how they are presented and operate in health communications. In general, studies that examined empathy through interactions provide insight into and references to analytic tools for this study, for example, how asymmetry is presented, how emotions are acknowledged, and how relationships are formed. Disclosures, presentation of challenging communications, and vulnerability frequently occur in the communication of health concerns. The following sections will review studies that focus on these unique interactive phenomena.

Challenging Situations in Clinical Encounters

Conversations that involve stressful subjects and emotionally charged topics are inevitable in health care settings, and this is particularly true in both family medicine and counseling (Beach et al., 2005; Deuster et al., 2008; Easter & Beach, 2004; Lelorain et al., 2012; Quirk et al., 2008; Wynn & Wynn, 2006). Stressful subjects and emotionally charged topics often elicit a variety of reactions and social interactions. The current study focuses on two common scenarios: difficult conversations such as discord and rupture, as well as emotionally charged topics that contain vulnerability, trauma, or adverse events disclosed by patients/clients during their first visit.

In general, medical studies that focus on challenging clinical situations tend to focus on decisions regarding medical interventions. Few connections have been identified between

therapeutic interactions within emerging challenging situations in a medical context. The current study found very few psychotherapeutic studies that focus on interactions that illustrate discord and rupture between psychotherapists and clients. CA's focus on microanaytic features of talk and analysis of the sequence of interaction illustrates how discord occurs, how it is portrayed, and how clinicians use language to respond in such situations. To date, few studies using CA examine the process of challenging conversations that emerged in clinical encounters and utterances that signify such situations.

In reviewing this unique feature of talk and interactions, the current study used keywords such as "discord," "rupture," "difficult subject," "challenging conversation," and "emotion" in the search. Major databases such as JSTOR, ERIC, PsycNet, PsycInfo, PubMed, Wiley Online, SAGA, and Google Scholar were used. This review has selected a total of five studies for review. These include three qualitative designs in medical contexts (Bradley, 1992; Quirk et al., 2008; Sutcliffe et al., 2004), one correlational study in a psychotherapeutic context (Sommerfeld et al., 2008), and one CA study that illustrates jointly constructed emotions in challenging conversations (Sanders, 2012).

Difficult Conversation, Discord, and Rupture

Quirk et al. (2008) conducted a qualitative study that included coding of caring behaviors in a total of 60 challenging encounters and a focus group that explored patients' perspectives of those encounters. In their analysis of a video tape that presented caring behaviors in challenging encounters, such as delivering bad news, discussing medical errors, and discussing the transition of medical treatments (from cure to palliative care, for example), Quirk et al. (2008) found that in a total of 600 caring behaviors, person-centered discourse and conveyance of caring were subject to interpretation; as such, they were also highly individually specific. However, taking

patients' perspectives and reflecting on patients' responses facilitated further communications in discussing stressful topics. In other words, changes can occur as a result of one's own discourse being perceived and recognized (Tikkanen et al., 2013; Voutilainen et al., 2010). Including the others' perspectives in difficult conversations can alleviate tensions, avoidance, and unexpressed grievances.

Sutcliffe, Lewton, and Rosenthal (2004) conducted a qualitative study focusing on the relationship between communication failure and medical mishaps. Semi-structured interviews regarding discussions of recent medial mishaps and related factors associated with the incidents were conducted with a sample of 85 residents, stratified from 26 specialties. Analysis of interview data indicated that the two most common contributing factors were communication and patient management, specifically, poor communication related to hierarchical differences, concerns with upward influence, role conflicts, role confusion, as well as problematic interpersonal power and conflict.

A major limitation found in both Quirk et al.'s (2008) and Sutcliffe et al.'s (2004) studies are that data were gathered from one-sided perspectives. In Quirk et al.'s (2008) study, emerging themes and categories of caring behaviors were developed though focus groups where the majority of perspectives were patients'. Interview data from Sutcliffe et al.'s (2004) study were gathered through clinicians' perspectives. In addition, as Sexton and Whiston (1994) discussed earlier, practitioners' perception of care or empathy provides only one-sided, limited insights, and the actual process of challenging interactions should be included in the analysis. CA's emphasis on using naturally occurring data and presentation of actual interactions will fill such a gap.

Another NIH study explored factors associated with physicians' uncomfortable decisions regarding administering prescriptions (Bradley, 1992). In-depth qualitative interviews were conducted with practitioners in a GP facility (N= 74), using an emerging coding method to code interview transcriptions. The emerging theme showed that the most uncomfortable prescription decision-making related to medical conditions were respiratory disease, followed by psychiatric conditions, and skin problems. Patients' factors that were associated with clinicians' discomfort in administering prescriptions included their age, ethnicity, socioeconomic status (SES), education, unknown knowledge of patients, feelings toward patients, communications, and desire to preserve relationships with patients. The practitioners' factors associated with uncomfortable decisions about prescriptions included their concerns about the effects and side effects of medications, perceptions of roles and expectations, professional culture, and experiences of medical misadventures. Bradley (1992) argued that psycho-social and relational factors need to be included to understand the process and phenomenon of excessive pharmaceutical interventions in medicine.

Bradley's (1992) conclusion illuminates a complex process of assessment, diagnoses, and interventions from initial sessions to subsequent health visits, particularly an experience of clinicians' uncomfortable decision-making related to intervention. Analytic results show that these challenging and uncomfortable situations can be related to both practitioners' and clients' factors. Since the therapeutic relationship is embedded in each stage of performance and interactions in health communications (Arbuthnott & Sharpe, 2009; Horvath & Symonds, 1991; Mead et al., 2002; Ruusuvuori, 2001), interaction and relationships should be incorporated into analysis of uncomfortable decisions regarding diagnoses and interventions. Bradley's (1992)

study has not demonstrated such. The current study intends to provide additional insights by looking at details of this unique feature of interactions, if it emerges in the data.

Similar to the themes that emerged in Bradley's (1992) study, a CA study conducted by Sanders (2012) analyzed a physician's discomfort when making prescription decisions. The discord was illustrated through a sequence of interactions between the physician and the patient. Sanders (2012) connected ordinary conversations and institutional talk by analyzing representation of the self in a position of conflict in two talk transactions: two children's negotiation of getting a marker and a conversation between a physician and a patient who demanded the inappropriate usage of medication. The segments of doctor-patient communications regarding prescriptions showed that a position of conflict occurred in an expert-layman relationship, that is, a doctor's difficulty in presenting professional judgment and medical agendas in front of a patient, despite the presence of medical expertise and authority. The following excerpts indicated the development of the doctor's dilemma and an uncomfortable medical decision. The doctor ("D") intended to prescribe Dolobid instead of Tylenol three to the patient ("P"), but failed to convince the patient of such a decision (p. 36). In order to be consistent with the line number from the original text, the excerpt displayed here may not seem in alignment with the numbering system:

```
(2.13)
16 D: =It's not aspirin. [It won't irritate your stomach.
17 P:                     [I have to buy it off the street. I
       have to buy
18    it from somebody on the street somewhere. Oh, shit.
19 D: Why don't you try it first.
20    (3.0)
21 P: I- I know it's gon' irritate my damn stomach=
22 D: =Ok, jus try it. Just try it. Take my word for it if it
23    irritates your stomach you can come back and we'll change
24    it. Is that sound good?
25    (2.0)
```

```
26 P: By then by the time I get an appointment it's two months
      away man=
27 D: =No, you just call them and tell them you want to see me
28    today. That is Thursday. Any Thursday. You can do that.
29    (3.0)
30 P: I know I'm not gon' take it. I'm gon' have to buy Tylenol
31    threes off the street from somebody.
```

It appears that on the one hand, the doctor tried to assert authority by insisting on the prescription

of Dolobid. On the other hand, the doctor failed to maintain such position after the patient

threatened to get Tylenol three somewhere else. As a result, the doctor ended up prescribing both

(p. 38):

```
(2.14)
53 P: I get ANGRY ( ) pain and I can't take that other shit
54    you're talkin' bout's [gon' burn my ass up ( )
55 D:                       [OK, why don't I give you that AND
56    some Tylenol three. Does that sound good?
57 P: Yeah, ok? Then I'll try it them! (.) and um (.) see how it
58    works (.) ok then. If it don't- then I can throw back on
      the threes (.)    [ok- and=
59 D: [just try it
60 P: = see but then (.) if I DO like it, ((laughs)) yeah,
61    there's a possibility ok? I think you know what I'm
      talking about. But um (1.0)ok, I got
62    to have something to fall back on ok? [instead of me ( )
63 D:                                       [Ok, I'm gonna give
64    you some threes under the- under the the promise that
65    you're gonna try the other ones as well=
66 P: =Yeah, OK, I swear to God I'll do it that way.=
67 D: =OK, you can get some Tylenol threes. (1.0) But next time
68    we're gonna have a talk about=
69 P: =yeah my stomach is hurtin' I need some Mylanta, too
```

In a psychotherapeutic context, Sommerfeld, Orbach, Zim, and Mikulincer (2008)

conducted a multivariate analysis focusing on ruptures in the counseling relationship and their

associations with clients' core conflictual themes outside the therapeutic setting. The study used

independent raters in comparing clients' self-report questionnaires after the session. In a coding

analysis of 151 counseling sessions conducted by five therapists in a university counseling

center, Sommerfeld et al. (2008) found that ruptures positively related to clients' core conflictual relationship themes (CCRT) when the therapist was the subject of such themes. Moreover, while confrontational ruptures occurred, therapists' attempts to focus on working alliance and therapeutic agenda increased. Contrary to the conventional and somewhat negative view toward ruptures, Sommerfeld et al.'s (2008) analysis indicates that while rupture can be highly stressful in therapeutic interactions, it is a critical therapeutic opportunity. Specifically, the emerging CCRT that can be dealt with during therapeutic interactions may open possibilities to explore clients' intra-psychic domains and potentially disrupts the equilibrium of clients' interpersonal patterns. On the other hand, the withdrawal nature of rupture (i.e., avoidance) during sessions was associated with less emotional comfort in the post-session period.

Sommerfeld et al.'s (2008) study added to the understanding of the role of clinician-client interaction in clinical encounters, such as conversations regarding clients' disclosures of difficult subjects, or exploration of challenging life history. Similar to the phenomenon of empathy, a therapeutic relationship in conjunction with discussing challenging topics or difficult subjects is rather complex and cannot be understood simply through survey research or inquiry of perceptions because such data provide limited insights. Therefore, the current study will fill the gap by analyzing detailed, sequential interactions between trainees and their patients/clients.

Vulnerability, Adversity, and Trauma

Difficult conversations can include revelations of vulnerability, adversity, and narrations related to difficult life histories. Bochner (2009) suggested that vulnerability is one of the most unique qualities of narrative medicine, where relational aspects of medicine see doctor-patient relationships tightly connecting to illness and narration. Accordingly, language and communication of illness requires understanding the language of pain. Bochner (2009) further

argued that health practice often places such narration as a secondary, less trustworthy source of information and primarily relies on standardized tests, examinations, and diagnostic protocols. As a result, vulnerability contains both layers: the primary layer is from the illness or symptoms themselves, and the secondary layer is where a patient's narration is not seen as a valuable source of standardized protocols and diagnostic processes. If effective communication and a strong working alliance predict clinician-patient relationship and subsequent health outcomes, as shown by previous research (Buttny, 1996; Fuertes et al., 2007; Horvath & Symonds, 1991; Howgego et al., 2003; Kim et al., 2008; Lelorain et al., 2012; Mead & Bower, 2002; Mead et al., 2002; Sexton & Whiston, 1994; Tryon, 1990), vulnerability may be buffered by these factors, or at least, relieved.

Like challenging conversations in clinical settings, disclosure of adverse life events is a complex psychological, emotional, and relational process rather than simply a stress reduction (Farber et al., 2004). In some cases, disclosures may elicit a sense of distress, shame, and concerns related to the listener (Bruce et al., 2001). Some studies have touched upon the detailed process of disclosure of vulnerable topics and its interactions with the therapeutic relationship in clinical settings. This section will include a total of three studies that focus on interactions that contain emotionally charged topics in clinical encounters. This includes one CA study examining fear of cancer-related topics in medical settings (Beach et al., 2005) and two psychotherapeutic studies regarding clients' disclosure of vulnerable topics (Farber et al., 2004; Horowitz et al., 1993).

Delivering bad news often shows discord and disconnected dialogues such as minimum responses and avoidances between doctors and patients. Beach et al. (2005) analyzed how doctors, family members, and patients responded to conversations related to cancer screening,

treatment, and diagnoses. Several features of interactions reflecting ongoing fear and avoidance were found in analyses of six video recorded sessions; these include first-time and returning visits. Emotions associated with avoidance (fear, anxiety, etc.) were present in the process of conversation and experienced by doctors and patients, despite attempts at minimizing related discussions from both parties. For example, doctors presented selective responses and glossing over difficult topics; joint fear responses can be found in patients' repeating indirect references to raised cancer-like symptoms, doctors' avoidance of referencing cancer diagnoses, doctors' language that presents less negative events as "good news," doctors' focus on tasks and instrumental conversations, and withholding reassurance. In an excerpt of cancer history taking by a doctor (DOC), the direct diagnostic language was avoided, replaced with terms and phrases of cancer-related treatments to inquire whether the patient (PAT) has been diagnosed with melanoma (p. 896). Note that there is no line number indicated in the text:

```
(2.15)
DOC: Okay. (0.2) .hh U:m (0.3) pt The:: other thing is u::m
     (0.5) you were never((shakes head)) (U) a:h (0.2) started
     on any chemo:: or immunothe[rapy: or anything like that.]
PAT:                            [(( shakes head ))            ]=
DOC: Okay.
PAT: Cause they got it (0.2) early enough.
DOC: Okay, good.
     (1.0)
```

The words "cancer" or "melanoma" did not appear in the conversation, but were implied through other words such as "chemo," "immunotherapy," and the patient's usage of the pronoun "it."

Emotionally charged topics often occur in the counseling process as well. Horowitz et al. (1993) conducted a single case study regarding the topics of ongoing relational issues in conjunction with unresolved grief from the past. The study examined the client's patterns of speech and style of communications in linking current events with past occurrences in the process of psychotherapy. Out of 28 weeks of 50 minutes of psychotherapy sessions, three

sessions that respectively represented the beginning, middle, and ending phases of therapy were

chosen for further analysis. Quantitative measures of the rating of audio taped sessions from the

early phase to later stage of therapy showed that talking about a deceased one is characterized by

fewer verbal statements, lower level of disclosure, lower frequency of result reasoning, lower

disclosure of major information, and lower participation of processing emotion compared to

other topics such as work and intimacy. In addition, a higher level of nonverbal negative

emotional signs and arousal occurred when the topic of bereavement was present. Horowitz et al.

(1993) argued that processing emotionally charged topics may elicit short term memory and

reminders of personal implication in the present reality. Emotionality and defensive control are

signs of unresolved emotional states because processing significant life events simultaneously

activates memories and associated affects. The defensiveness and over control of emotions

function as a counter-action in order to control present vulnerability.

Though there were only three sessions presented in the study, Horowitz et al. (1993)

provided an in-depth analysis of clients' utterances regarding self-disclosure. This gave valuable

information regarding how emotionally charged topics may be manifested and controlled in the

process of interaction. However, this is necessary but not sufficient in studying interactions

because the clinician's utterance and reaction should also be included in the analysis so that it

shows a more comprehensive picture of sequential interactions. The current study will add this

insight by including utterances from both trainees and their patients/clients.

Another mixed method study relates to the effect of disclosures in psychotherapy and

clients' perceptions of such disclosure. In an analysis of 21 semi-structured interviews and

clients' ratings regarding disclosures, Farber, Berano, and Capobianco (2004) found that

disclosures connected to clients' perception of relationships. Similar to the immediate effects of

disclosure of grief and bereavement where individuals presented a more heightened physical arousal and anxiety (Horowitz et al., 1993), participants in Farber et al.'s (2004) study reported feelings of shame and anxiety. Fear of therapists' reactions and a sense of shame, embarrassment, and feeling vulnerable were key factors that hindered further disclosures. Perceived quality of relationship was a mediator of the decision to engage in this complex psychological and emotional process, as well as in facilitating subsequent disclosures. Farber et al. (2004) argued that the impact of the interpersonal process served as a foundation and protection for the psychological effects of disclosures. Again, Farber et al.'s (2004) study would give a more comprehensive picture regarding interpersonal processes in a context of a client's disclosures by including the in-depth, detailed, and microanalytic features of talk and interaction in a psychotherapeutic setting. This study will focus on such details if such topics occur in both counseling's and family medicine's initial encounters.

To date, no study focuses on disclosures or challenging situations in initial sessions. How the interaction occurs and how the language is used are part of the inquiry in this study. In addition, what the role of a therapeutic relationship is in this process, how clinicians and clients manage associated meanings and negotiate the subsequent interaction are important questions. Both the thematic level and the microanalytic level of analysis will provide additional insights into this unique encounter.

Conclusion

This chapter reviews both theoretical and empirical literature regarding the focus of this study: exploring processes of communication in initial sessions conducted by trainees in both family medicine and counseling. Because there is no previous study that has combined the phenomena of initial sessions, conversation analysis, and trainees in family medicine and

counseling, this review collected studies across disciplines in order to get the overall insights of conceptual works as well as the empirical support of related topics. The literature review included the following sections: initial session, behavioral health which overlaps in two professions, language and professional practice, relational aspects of communication, and jointly constructed interactions.

There are several observations of overarching themes based on the review. First, the phenomenon of initial sessions is under-explored; both CA studies as well as other studies that focus on best practices, person-centered care, and working alliance show rather limited information about initial sessions. This study will enhance knowledge regarding this area. Secondly, except CA's studies that include both clinicians' and patients' interactions, the majority of previous studies focused on clinicians' practices (Anderson & Sharpe, 1991; Bensing et al., 1996; Castro et al., 2007; Deuster et al., 2008; Rahman, 2000; Schroeder et al., 1998; Treichler et al., 1987; Walsh, 2007; Zisook, 1978) or patients' satisfaction regarding clinicians' behaviors (Beck et al., 2002; Fuertes et al., 2007; Graugaard et al., 2004; Greenfield et al., 1988; Kim et al., 2008; Lelorain et al., 2012; Mead & Bower, 2000; Street et al., 2009). This study intends to fill the gap by illustrating interactions and demonstrating what is actually happening through the presentation of conversations.

Thirdly, studies that have included communication, interaction, and relationships as focused constructs or variables used preexisting coding structures (Algeria et al., 2008; Agnew et al., 1994; Beck et al., 2002; Castro et al., 2007; Graugaard et al., 2004; Greenberg & Stone, 1992; Lelorain et al., 2012; Mead & Bower, 2000; Owen, 2008; Quirk et al., 2008; Rosen et al., 2012; Shaw, et al., 2009; Street, 1992; Street et al., 2009; Sutcliffe et al., 2004); some used software programs as a primary analytic tool (Becker et al., 2008; Blake et al., 2010; Castro et

al., 2007; Graugaard et al., 2004; Koch-Weser et al., 2010; McCabe et al., 2008; McKinlay et al., 1996; Quirk et al., 2008; Tagliaventi & Mattarelli, 2006). CA's theoretical assumption and methodological premises that emphasize naturally occurring data, microanalytic analysis, and emerging themes based on what was actually happening in a session are compatible with the open-ended, inductive approach to data analysis in this study.

Fourth, while a majority of studies focused on broader and overarching themes that emerged from the data, CA studies tend to focus on micoanalytic, detailed talk and interactions. Some have illustrated a range of interactions, from institutional practices to ordinary interactions. This study intends to combine both levels of analysis to give a comprehensive view of initial sessions in family medicine and counseling. The above conclusions gained from the reviewed literature help provide insights for the design of this study. The next chapter will demonstrate the methodology and research procedure.

CHAPTER III

Methodology

Sample

This study aimed to collect five to eight initial audio/videotaped sessions conducted by doctors-in-training in family medicine, and five to eight audio/videotaped initial sessions conducted by counselors-in-training in facilities that provided services related to mental health counseling, addiction treatment, psycho social adjustment, and wellness. Thus, the study expected to recruit a minimum of ten initial sessions in total. Sample sessions conducted by doctors-in-training included residents in family medicine from year one to year three in the northeastern region of the country. The detailed criteria for doctors-in-training/residents to be in the study were:

➢ Residents in a family medicine program must be 18 years old or older.

➢ Residents are fulfilling training requirements in family medicine at their residency at the time of the recruitment.

➢ Residents are conducting clinical sessions and seeing patients as part of their work routine on a weekly basis.

➢ Residents have not had work experience and/or have not been employed in human service related fields prior to their residency. These fields include medicine, psychology, counseling, nursing, and social work.

➢ Audio and/or videotaping are allowed in the setting where a resident is completing his/her residency.

Recruitment of sessions conducted by counselors-in-training included trainees at both the master's level and doctoral level, who are fulfilling field placement requirements in a CACREP-

accredited counseling programs. Note that in order to ensure that the samples are as equivalent as possible between family medicine and counselor education, this study gave priority to the recruitment of sessions conducted by doctoral level counselors-in-training. Initial sessions conducted by master's level of counseling trainees who were doing a field placement in internship were recruited in the study when there were not sufficient participants recruited from doctoral level counseling trainees. The detail of inclusion criteria of counselors-in-training/interns were:

➢ Counseling interns must be 18 years old or older.

➢ Counseling interns are fulfilling a field placement requirement during the time of the recruitment. Note that for master's level counseling trainees, only those who are completing a field placement for internship are eligible for research participation.

➢ Counseling interns are conducting clinical sessions and seeing clients in a clinical mental health facility or a university-level counseling center on a weekly basis.

➢ Counseling interns have not had working experiences and/or employment related to human service related fields prior to their field placements. These fields include medicine, psychology, counseling, nursing, and social work.

➢ Audio and/or videotaping are allowed in the setting where an intern is doing the clinical placement.

Patient/client populations in both professions can range from minors to elders, with a variety of physical, psychological, or social conditions. Inclusion criteria of patients/clients in this study were:

➢ The person is 18 years old or older.

> ➤ The person has a legal right and the ability to give consents to a treatment, counseling, or psychotherapy in a setting where the data collection occurs.

> ➤ The person has a legal right and the ability to participate in the research

Recruitment

This study collected recording data in naturally occurring settings where family medicine and counseling trainees conducted clinical practices for partial fulfillment of their licensures and degree requirements. Because the nature of this study is to look at the data of communication that occurred in a dyadic scenario, the data collection required two levels of recruitment: the trainee's level and the patient's/client's level. This study recruited volunteering trainees first, and then proceeded to the recruitment of client/patient participants.

Recruitment of trainees. This study aimed at recruiting trainees from both family medicine and counselor education training sites in the northeastern region of the country. There were two selected hospitals for recruiting doctors-in-training and three selected CACREP accredited counseling programs for recruiting counselors-in-training. The following table provides an overview of the recruitment from identified sites:

In family medicine:

Location	Site A	Site B
Description	A local hospital located in a city	A local hospital located in a city
Contact	The supervisor and a faculty member of the program	The supervisor and a faculty member of the program
Potential participants (trainees)	Residents: year one, year two, and year three	Residents: year one, year two, and year three

In counselor education:

Location	Site A	Site B	Site C
Description	A CACREP accredited counselor education program located in a large university	A CACREP accredited counselor education program located in a medium size university	A CACREP accredited counselor education program located in a medium size university
Contact	The director and a faculty member of the program	The director and a faculty member of the program	The director and a faculty member of the program
Potential participants (trainees)	Practicum (doctoral level only) and internship students (both master's level and doctoral level, but doctoral level preferred)	Practicum (doctoral level only) and internship students (both master's level and doctoral level, but doctoral level preferred)	Master's level of internship students

Although taping clinical sessions and receiving feedback from others are routine training activities, trainees' clinical works are often idiosyncratic and connect to individual characteristics, clients/patients issues, and a sense of professional practices and identity. Thus, this study recognized that the recruitment of trainees and samples of their sessions for research purposes requires a relational and personal approach between the researcher and the participants to ensure a mutual trust and protection of participants (Halse & Honey, 2005). The following five steps describe the procedures of recruiting trainees in both family medicine and counselor education.

First, the researcher identified potential qualified programs that were eligible for research participation for this study. Then, the researcher proceeded with an IRB process in the situated institution and obtain an IRB approval for each institution. After an IRB approval was obtained, the researcher contacted the director of the identified program and requested assistance with distributing the information regarding the recruitment of trainees via email. The information

included the rationale of the research, purpose of using recording data, inclusion criteria, required steps of data collections, and the researcher's contact information, with an additional note that interested participants should contact the researcher directly by phone or email with their decision to participate or not while remaining anonymous. This step intended to ensure that potential participants were truly volunteering for participating in the study without any concern of their performance or evaluation. All volunteer trainees were given opportunities to ask questions throughout the process of recruitment.

After the trainee indicated that he or she was fully aware of the participants' rights, potential risks and benefits of participation, and procedures of data collection before proceeding with documentation of an informed consent, both the researcher and the trainee completed the documents of informed consent and obtained a copy for record.

Recruitment of patients/clients. First, trainees who gave their consent to participate in the study informed the researcher regarding schedules and locations of their first sessions. The researcher was present at the location of the trainee's first session on the day of the appointment. Prior to the start of the session, the researcher spoke to a staff member at the location and explained the researcher's intent to collect recording data from both the trainee and the client/patient. In order to ensure the neutrality of this requesting process, the researcher selected a staff member who was not a treatment provider or a therapist at the location. Then, the researcher requested the staff member to ask potential client/patient participants whether they were willing to speak to the researcher regarding an opportunity of research participation. The researcher was not present at the time when the staff member spoke to the patient/client. In addition, the patient/client was informed that his or her participation was voluntary and their decision would not affect his or her treatment at the site. After the patient/client indicated to the

staff member that he/she agreed to speak with the researcher, the researcher then proceeded with the step of the recruiting the patient/client.

During the recruitment, the researcher conducted the procedures with the patient/client participant in a room where the trainee was not present. In this step, the researcher provided the recruitment letter and explained the purposes and procedures of the research, with a particular emphasis that the patient's/client's decision to participate or not remained anonymous.

Data Collection

Procedures. Typically, as a part of the training requirements for program accreditations or training purposes, trainees in both professions tape their clinical/counseling sessions for supervision (www.acgme.org*;* www.cacrep.org). In some cases, the trainees present their tapes and discuss their sessions with their supervisors. As a result, this educational structure provided an access to audio/videotapes for this study.

The following steps entail how taped sessions were obtained. First, trainees who gave their consent to participate in the study informed the researcher regarding their schedules and the locations of their first sessions. The researcher was present at the location of the trainee's first session on the day of the appointment to recruit client/patient participants. After the patient/client gave their consent to participate in the study and completed the consent document, the researcher then set up the recording device and left the room where the initial session was conducted. After the completion of the session, the researcher went back to the room to obtain the recording device and the data.

Types of initial sessions. As mentioned in "Glossary" (see appendix VII),an initial session is defined as the first encounter between clinicians and clients by various studies (Budman et al., 1992; DeGood, 1983; Esogbue & Elder, 1979; Odell & Quinn, 1998; Rahman,

2000; Saltzman, et al., 1976; Whitlock et al., 2004; Zisook et al., 1978). Depending on the treatment settings and institutional protocols, a counseling initial session at a clinical mental health facility or a university counseling center may range from 30 minutes to 50 minutes in duration. Residents in family medicine often conduct brief, routine visits for both physical and mental health concerns on a regular basis. An initial routine visit could range from 15 to 20 minutes.

A full bio-psycho-social evaluation (BPS) in family medicine is a unique feature of institutional practice differentiated from general routine visits. It has been implemented in some family medicine programs (Borrell-Carrió et al., 2004; Doherty et al., 1987; Prest & Robinson, 2006). Note that a BPS appointment may be a result of a routine visit where the doctor-in-training identifies some behavioral health issues or recognizes that the presenting health concerns might connect to the patient's psychosocial environment. In a BPS session, residents and patients engage in an in-depth assessment and communication related to the patients' life history, family background, social adjustment, and wellness; typically, such in-depth conversation cannot be done in a routine, short visit due to the time constraints. A BPS is an one-time only assessment and time can range from 45 to 60 minutes due to the nature of the in-depth discussion (M. Arthur, personal communication, September 15, 2014). Initial sessions in this study included three types of visits:

➢ An initial counseling session conducted by counselors-in-training in clinical mental health treatment facilities.

➢ An initial routine visit conducted by doctors-in-training in hospitals where the doctors received trainings in family medicine.

➢ An initial full bio-psycho-social evaluation conducted by doctors-in-training in a training hospital where the doctors received trainings in family medicine.

Descriptive Information on Data

This study collected all of the taped sessions in the northeast region of the country. For family medicine, this study collected audio and/or video tapes from two family medicine programs in two identified hospitals. For counselor education, this study collected audio and/or video tapes from two counselor education programs in two identified universities.

There were a total of 13 taped initial sessions collected in this study. Eight taped sessions were conducted by doctors-in training, and five were conducted by counselors-in-training. The total time of the initial interviews in this sample was 454 minutes, with 217 minutes for doctor-patient interactions and 237 minutes for counselor-client interactions. The total pages of transcriptions were 324, with 152 pages for doctor-patient interactions and 172 pages for counselor-client interactions. The author has the full corpus of transcription in her possession.

The 13 sessions include 11 initial clinical sessions and two biopsychosocial (BPS) evaluations. Due to the nature of in-depth discussion, a full BPS evaluation in family medicine is a unique initial encounter that is different from an initial, routine visit. For example, residents and patients engage in-depth assessment and communication related to patients' life history, family backgrounds, social adjustment, and wellness in a BPS session. A full bio-psycho-social evaluation is a one-time only assessment and time typically ranges from 45 to 60 minutes. In this sample, the two BPS sessions were 43 and 61 minutes, respectively. Initial clinical sessions in family medicine ranged from 11 to 36 minutes, and initial counseling sessions ranged from 35 to 62 minutes in this sample.

There were a total five doctors-in-training and eight patients involved in the eight doctor/patient sessions. All doctor/patient sessions were conducted in city hospitals across two states in the northeastern part of the country. The IRB reference number is 14-195. The following table provides a brief summary of each session. S indicates "Session," followed by a numeric code. In addition, each session has a specified code that indicates the code of the trainee and the patient/client. For example, session one was conducted by D1P1, the specified code of the session would be D1P1. D indicates "doctors-in-training," followed by a numeric code. P indicates "person," followed by a numeric code:

	S1: D1P1	S2: D2P2	S3:D3P3	S4:D3P4	S5:D4P5	S6:D5P6	S7:D5P7	S8:D5P8
D	D1: female, 2nd year resident	D2: female, 2nd year resident	D3: female, 2nd year resident	D3	D4: female, 3rd year resident	D5: male, 1st year resident	D5	D5
P	P1: Male	P2: Male	P3: Female	P4: Female	P5: Female	P6: Female	P7: Male	P8: Male
Length	43 mins	61 mins	25 mins	15 mins	36 mins	11 mins	13 mins	13 mins
Nature of the session	Bio-psycho-social evaluation	Bio-psycho-social evaluation	Initial routine visit	Initial routine visit	Initial routine visit	Initial routine visit	Initial routine visit	Initial routine visit
Data type	Video	Video	Audio	Video (Partial)	Audio	Audio	Audio	Audio
Total transcription pages	27	57	9	9	23	8	10	9

The five taped initial sessions conducted by counselors-in-training consists of three counselors-in-training and five clients. All counselor-client sessions were conducted in local mental health treatment facilities across two states in the northeastern part of the country. The

following table provides a brief summary of each session. S indicates "Session," followed by a numeric code. C indicates "counselors-in-training," followed by a numeric code. P indicates "person," followed by a numeric code:

	S1: C1P1	S2: C2P2	S3: C2P3	S4: C3P4	S5: C3P5
C	C1: male, 3rd year doctoral level of training	C2: female, 3rd year master level of training	C2	C3: male, 2nd year master level of training	C3
P	P1: Male	P2: Male	P3: Female	P4: Male	P5: Male
Setting	Drug and alcohol treatment	General mental health counseling	General mental health counseling	Drug and alcohol treatment	Drug and alcohol treatment
Length	62 mins	41 mins	46 mins	35 mins	53 mins
Nature of the session	Initial counseling through referral	Initial counseling and assessment	Initial counseling and assessment	Initial counseling and assessment	Initial counseling and assessment
Data type	Audio	Audio	Audio	Video (trainee only)	Video (trainee only)
Total transcription pages	33	28	26	46	39

Data Analysis

Transcription

In CA, methods of transcription are tied into the subsequent analytic process because transcription should reveal the detail of utterances such as pause, overlap talks, breath, and pitch though texts. This study involved four steps of transcription. The first step involved transcribing the audio conversation into text verbatim. The transcribed text were laid out with a number of lines for data report and analysis (Buttny, 2004; ten Have, 1990). In addition, this study used the

typical CA format of the transcription text, which displayed text in Courier New with font size 12.

The second step involved a review of the audio conversations and notations of non-verbatim utterances, such as chuckles and laughter. Since conversations involve different elements of utterance such as speed, inflection, tone (fall and rise), overlap speech, and pause, the third stage of transcription involved recording the sequential feature of talk and microanalytic interactions (see the Appendix VI for details). This format provides an orthographic review of the verbatim and noted elements of utterance (Atkinson & Heritage, 1984; Buttny, 2004; Sacks, Schegloff, & Jefferson, 1974). The fourth step was to compare textual information with the review of visual recording. Imagines, body gestures, and gaze were noted and compared against the textual information. The presented analysis or report of the result from individual trainee-patient/client dyad will be coded as follows:

➢ D = doctors-in-training, followed by a numerical code

➢ C = counselors-in-training, followed by a numerical code

➢ P= a person who made an appointment for the session, followed by a numerical code

The theme of each conversation was formed through dialectical processes between excerpts of the transcriptions and discussions of theoretical constructs drawing from literature. Since the conversation analysis mainly looks at the organization of talk and sequences of action, presentation of the results will be clusters of examples of interactions (ten Have, 1990). For example, in order to present how a patient/client presents his/her symptoms, and how a clinician responds, the excerpts of the conversations will be presented as the following format, which is different from a plain text format. "Dr" represents "doctor," and "Pt" represents "patient" (ten Have, 1990):

```
(3.1)
17.  Dr: ¨t¨hhhh |^I |vdon't think we've |^met before |^h'v we
18.       (1.0)
19.  Pt: Well I've had this: u-sore throat on'n off, for weeks
          no:w.=
20.  Dr: =|^Oo dear.
21.  Pt: En I've got a cough- writs- it's- I've been you know
22.       choking you know'n I'm[coughin]g- I'm getting no relief
          from=
23.  Dr: [Mm|^hm,]
24.  Pt: coughing it's just taw- choking that (.) [( ) back]of=
```

This back and forth, recursive process of transcription provides a foundation of analytic structure that has methodological and analytical reasons. The repeated listening to and reviewing of orthographic and conversational processes forces the researcher to attend to the detail and sequence of interactions. In this process, the researcher scrutinized, revised, observed, and tracked back and forth between the recordings and transcriptions in order to find analytical evidence of descriptive claims of interactions (ten Have, 1990).

Analysis of Talk and Interaction

Consistent with previous studies of doctor/patient interactions (Beach et al., 2005) and therapist/client interaction (Buttny, 1996), the steps of analysis in this study included analyzing the overarching talk phenomena (global themes) and the process of talk and interaction (local themes). After the completion of the four steps of transcriptions, all transcription texts were compiled and reviewed. The researcher firstly focused on the overall process, and then a detailed look at the beginning stage of the session, as well as interactions and conversations that captured the significance of the therapeutic relationships and interventions. The following bullet points provide a brief summary of steps of analysis:

> ➢ Initial reviews: the researcher reviewed the tapes while conducting transcriptions.
> Initial observations that capture significances of interactions were noted.

➢ Global themes: after the completion of the transcription, the researcher reviewed the transcription texts by looking at general talk and interactions based on themes, patterns, and lexicon usage. Line by line readings and coding of textual information were conducted to capture sequences, transition of topics and talk features that characterized changes and shifts.

➢ Local themes: the researcher conducted a detailed review of interactions and conversations that captured the significance of talks and acts between trainees and patients/clients, signs and marks of relationships, therapeutic relationships, and subsequent interactions. Theoretical constructs discussed previously, such as question and answer, asymmetry, empathic utterances, and co-construction of talks and actions, were used to assist in the review process.

The recursive reviews of transcriptions assisted the researcher in forming relevant analysis as well as capturing detailed interactions that presented the characteristics of context between speakers and the co-constructed moments. Upon the completion of the steps of analysis, the researcher compiled all the themes and selected examples for demonstration. First, the researcher compiled all the excerpts and organized them under each research question. Next, the researcher reviewed the examples and grouped the excerpts based on shared themes. In this process, the divergent and convergent themes began to emerge. Themes that contained examples from both counselor-client and doctor-patient interactions were noted as convergent themes; themes that only existed in one profession were noted as divergent themes. The researcher reported all the selected themes, except themes that contained more than five examples. In this case, the researcher selected examples that demonstrated salient talk features and interactions for data reports and analyses.

Analytic Principles

      Attending to details of interactions. As indicated earlier, the unique process of transcriptions in CA, including notations and markers, provide an orthographic review of the textual verbatim and noted elements of utterance, which demonstrates a sequential feature of talk and microanalytic interactions. This presentation of textual and orthographic utterances provides layers of meaning, from a macro, thematic level to a micro and detailed level. Such reading should compare with the presentation of talk and how it is demonstrated in the interactions (ten Have, 1990). Microanalysis, which was seen as inconsequential and neglected by previous studies (Heritage & Maynard, 2006), but in fact is the bedrock of social interaction, were given particular attention in this study.

      This study paid particular attention to connecting detailed meaning and making sense of particular episodes of talks in the process of describing a talk phenomenon. Interpretations were based on such details and resources of knowledge and elaborations. In addition, the analytical process involved a combination of inquiry with other instances of talk. This procedure helped the researcher attend to local meaning, explicit interpretation based on the detail of interactions, resource of knowledge, elaboration, and continuing particular analysis in comparison with other instances (ten Have, 1990).

      Context. Upon CA's methodological suggestions, contextual information such as gender, age range, identified ethnicity, or reason for visit (physical or psychological, or both) should be presented through an empirical based analysis (Maynard, 1991). In other words, social identities and other dimensions of practices, as well as contextual information, are embedded in talk and interactions at the moment; thus, the relevance and salience of these identities would be revealed in question and answer processes, in organization of talk, and the sequence of interactions

(Schegloff, 1991). In such cases, these dimensions and information will be revealed through the actual interactions (if relevant at the moment), as opposed to descriptive background knowledge. An example can be found in Beach et al.'s (2005) excerpt where the interactions revealed the patient's gender and family situation (p. 896). "DOC" represents as "doctor," and "PAT" represents as "patient." Note that there is no line number indicated in the text:

(3.2)
```
DOC: hhh How have you been feeling (U)lately. Have- have you had
     any fevers(U) or chills or night sweats, loss of appetite,
     anything like- any constitutional symptoms.
PAT: No.(U) I'm tired but I'm the mother of three kids.
```

As previous discussions indicated, a researcher's pre-existing knowledge of particular contextual information often guides how the talk is read and analyzed (Schegloff, 1991, 1993). The analytic structures in this study were based on the principles recommended by previous CA studies. First, to avoid any preconceived notion of membership knowledge, this study focused on what was said and acted, and how it was done at the moment in the coding process (Schegloff, 1991, 1993; ten Have, 1990). In addition, this study compiled the coding of local interactions and the coding of social structure and institutions. Analytic procedures encompassed the two and connected ordinary talk structure and institutional practices, which demonstrated the procedures of interactions and detail of conducts at the moment (Schegloff, 1991, p. 53).

Analytic Focuses

Analytic focus were based on the research questions of this study. The three overarching questions are first, how are the conversations between trainees and clients developed and maintained in their initial encounters, how are therapeutic relationships and therapeutic discourses developed in initial sessions, and third, how do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability?

The three overarching questions encompassed the whole analytic process and were "constant" throughout the analytic process because they explored the structures of the interactions. Examples of analytic results were selected based on "virtuoso moments" of interactions, suggested by ten Have (1990).

There are three chapters of analyses that present more detailed and unique features of interactions that relate to communication in counseling and family medicine, as well as relate to the focus of this study. The three analytic chapters explore the following talk phenomena: Chapter IV: How are the conversations between trainees and clients developed and maintained in their initial encounters?

Section One. How are the interactions presented and constructed in the process of communication?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Section Two. How do individual trainees negotiate between professional norms and interactions present at the moment in order to achieve therapeutic tasks and goals in initial sessions?

Chapter V: How are therapeutic relationships and therapeutic discourses developed in initial sessions?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Chapter VI: How do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Note that emerging themes and phenomena may help provide preliminary analytic perspectives. However, one should go beyond "prisoners of our perspectives" (Buttny, 2012, p. 10). Other features of talks and interactions that go beyond the proposed analytic notions that emerged from data were included in the analysis.

The analysis of the tapes focused on the overarching themes, and then a detailed look at the process of the interactions, as well as interactions and conversations that capture the significance of therapeutic relationships and interventions. The theme of each conversation will be presented through dialectical processes between excerpts and discussions of the interactions in the three analytic chapters.

Validity of Analytic Process

To ensure the validity of data report and analysis, the researcher included several steps of collaboration (Hays & Wood, 2011; Heritage & Maynard, 2006; Hoffman, 2010; Riessman, 2008). First, the researcher constantly reviewed literature throughout the research process. Dynamic themes and phenomena of interactions that emerged from the data were selected and analyzed with a review of relevant literatures (Luttrell, 2000; Riessman, 2008).

In addition, the researcher collaborated with experts during data analysis for consultations. For example, the researcher shared excerpts of transcriptions and the preliminary findings from the data, and engaged discussions with the experts to capture any discrepancy and nuances of interactions from the data.

Conclusion

This study examined how talk and interactions were presented in initial sessions among trainees-patients/clients dyads in two human service professions, family medicine and counselor education. Through the procedures of the methodology, this study expected to discover production of language and linguistic strategies that occurred in two groups of health practices. Data report and analysis focused on exploring how talk and practices were conducted, how health communication was co-constructed, and how co-constructions of interactions revealed negotiation and production of identity, meaning, and discourses. Global themes and features of talks in local contexts identified from narrative data will help inform both fields regarding effective communication and practices.

CHAPTER IV

Results

The report of the results is organized based on the process and sequence of an initial

session, as reflected by the sequence of research questions. The presentation of the results is

structured using a funneling approach: first, the formation of the conversations in an initial

clinical encounter; second, the development of the therapeutic relationship and discourses; and

thirdly, the presentation of disclosure, challenging communications, and vulnerability as a result

of co-constructed interactions.

The analytic chapters demonstrate the findings of the data based on three overarching

research questions within three chapters, chapter IV, chapter V, and chapter VI. Chapter IV

contains two sub-sections corresponding to two sub-questions. In addition, each chapter presents

both convergence and divergence of practices between family medicine and counselor education.

As explained in the previous chapters, counseling and family medicine share similar professional

training and practices. Thus, convergence demonstrates shared themes of talk, interactions, and

linguistic strategies found in initial sessions conducted by trainees in both professions.

Divergence indicates distinctive features of practice in counseling and family medicine as a

result of the unique context of the session and professional norms. The three sections correspond

with the three research questions:

Chapter IV: How are the conversations between trainees and clients developed and maintained in

their initial encounters?

Section One. How are the interactions presented and constructed in the process of

communication?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Section Two. How do individual trainees negotiate between professional norms and interactions present at the moment in order to achieve therapeutic tasks and goals in initial sessions?

Chapter V: How are therapeutic relationships and therapeutic discourses developed in initial sessions?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

Chapter VI: How do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability?

What are the convergent and divergent practices between family medicine and counseling among novice practitioners?

The primary method of data report and analysis is conversation analysis throughout the three analytic chapters. First, the transcriptions include verbatim transcription and the Jeffersonian transcription system (Atkinson & Heritage, 1984; Buttny, 2004; Sacks, Schegloff, & Jefferson, 1974). The themes of talk and interactions were found based on overall review of the transcription in conjunction with reviewing the recording data. Excerpts of conversations are demonstrated as evidence of the theme so that readers see how the language was used by the trainee and the patient/client. By showing the interactions and linguistic strategies, readers can begin to see the formation of interactions, therapeutic discourses, and variety of strategies that trainees used to achieve goals.

There were a total of 34 themes found in the data in response to the three questions. In the first question of this chapter, there were a total of 15 themes discussed with examples. Five themes were found in convergence, and six themes were found in divergence, with regard to the formation of interaction in an initial clinical context. There were four themes discussed in question two that demonstrate individual trainees' negotiation between professional norms and interactions present at the moment in order to achieve therapeutic tasks. There were a total of nine themes identified and discussed with examples in the second analytic chapter. Seven themes were found in convergence and two were found in divergence that illustrate the development of therapeutic discourses and relationships. In the final analytic chapter that reports unique talk features such as disclosures, presentation of challenging communications, and vulnerability, seven themes were found across sessions in counseling and family medicine, and three divergent themes were found in the data.

The analysis of the tapes focused on the overarching themes, and then a detailed look at the process of the interactions, as well as interactions and conversations that capture the significance of therapeutic relationships and interventions. The theme of each conversation will be presented through dialectical processes between excerpts and discussions of the interactions in the three analytic chapters. There are three additional notations regarding the presentation of the examples. First, in order to specify the participants in the session, the author uses the specified code to describe the session. For example, the author may refer to the session between D1 and P1 as "D1P1" and so forth. Secondly, this study uses the Jeffersonian transcription format in the transcription text; the examples selected from the transcriptions will be displayed in Courier New font size 12. Thus, readers will see different font styles between the excerpts and the analytic text. Thirdly, line numbers correspond with the original transcriptions. In order to be consistent

with the line number from the original text, some excerpts displayed here may not seem in alignment with the numbering system.

Section One: Formation of Initial Sessions

The first section of chapter four answers the first overarching research question: how are the conversations between trainees and clients developed and maintained in their initial encounters? Specifically, this section of chapter four reports the emerging themes regarding the formation of the session found in both family medicine and counseling. There are a total of 15 themes discussed with examples. Five themes were found in convergence, and six themes were found in divergence with regard to the formation of interaction in an initial clinical context. There are four themes discussed in question two that demonstrate individual trainees' negotiation between professional norms and interactions present at the moment in order to achieve therapeutic tasks. Chapter four reports the convergence, and then divergence, of practices, followed by a report of individual trainees' talk features. Notice that in the convergent themes, the discussion and presentation of examples is organized according to the discussed themes as opposed to the context of family medicine and counseling. However, in the divergent themes, where distinctive features of practices are presented, the discussion starts with doctors-in-training, followed by counselors-in-training.

Formation of Initial Sessions: Convergence

There are a total five identified convergent themes shared by both professions in terms of how interactions were created and presented in an initial encounter. The five themes are history taking, behavioral health and the biopsychosocial approach, requesting details, recapitulation, and casual conversations. Each theme is discussed in detail with representative examples.

History Taking

Both counselors-in-training and doctors-in-training in this sample engaged in a significant amount of history taking in the initial sessions. Though there were variations in how the individual trainee formulated their session, by and large, all trainees in this sample used history taking to initiate the talk within the initial session, to get to know the client/patient, and to complete institutional tasks. The following five excerpts show the details of such process.

The first three excerpts are from doctor-patient sessions where trainees conducted history taking as a routine practice and a necessary therapeutic intervention. Specifically, history taking was an institutional protocol that assisted trainees in engaging in the therapeutic process; at the same time, it shapes the process of interaction.

The first excerpt was from a regular doctor's appointment conducted by D3. After identifying a potentially critical condition, the history taking occurred right at the beginning of the session:

```
(4.1)
1   D3:  hi L(___)?
2   P4:  hi
3   D3:  I'm so sorry for the long wait.
4   P4:  it's ok.
5   D3:  I'm doctor (_____). how are you doing?
6   P4:  not so good.
7   D3:  you're not looking so goo:d. do you mind if I talk to
         you real quick.
8   P4:  uh huh.
9   D3:  u:m  (.) what's your past medical history.
10  P4:  a lo:t.
```

The history taking was immediately introduced in the interaction, followed by P4's indication of "not so good"; the timing reflects D3's concerns about P4's medical condition. First, after P4's report feeling "not so good,"D3 confirmed P4's chief complaints, as reflected through her response, "you're not looking so goo:d." Then, D3 quickly started the task of history taking by

firstly obtaining permission (line 7). In this process, D3 used politeness to initiate the

conversation, despite a somewhat critical condition reported by P4. The politeness was also an

indication of the transition of the course of the conversation, as D3 started taking charge of the

conversational sequence. For example, as opposed to starting the history taking immediately with

statements or questionnaires, D3 requested permission first: "do you mind if I talk to you real

quick." After obtaining P4's permission, "uh huh," D3 proceeded with her first question (line 9).

History taking in this session was used as an opening when a critical condition is identified. In

addition, it guides the trainee for subsequent therapeutic directions. Besides the critical condition

presented at the moment of the visit, history taking was used to inquire about the recent critical

condition.

In a routine doctor's visit between D5 and P7, D5 conducted history taking right at the

beginning of the session due to his knowledge, prior to the visit, of P7's critical condition. Note

that in order to be consistent with the line number from the original text, some transcription lines

displayed in this excerpt may not seem in alignment with the line numbering system:

```
(4.2)
10   D5:   a:h (.) s:o ah pt (.) my name is (_____) I work with
11         doctor (_____) it's very nice to meet you. I've
12         never met you before. he was telling me about ah all
13         of your medical problems and ah (.) he told me that
           you went to the (.) ER.
14   P7:   um hm
15   D5:   can you tell me what happened - what led you to the
           ER.
```

As the interaction indicates, D5 had obtained the information of P7's condition at the ER through

D5's supervisor. The history taking in this process reflects the trainee's concern about the

patient's health condition; at the same time, it directs the subsequent therapeutic interactions

concerning the direction of assessment and the patient's reason for the visit.

Similar to D3, in this session, D5 first introduced himself before conducting history taking (lines 10–11). However, different from D3, who identified the patient's condition through observation and the patient's chief complaint provided during the interaction, D5 introduced the agenda of history taking with references to health information obtained from other sources, as indicated in two of his presentations. The first one presented D5's knowledge of P7's health history, "he was telling me about ah all of your medical problems," and the second one was a specific incident that happened recently, "he told me that you went to the (.) ER."

In addition to displaying concern about critical conditions, history taking is part of the standard protocol in an initial clinical encounter concerning pregnancy. In the first appointment between D4 and P5, D4 stated her therapeutic agenda of taking the medical history of P5, who came to the hospital for her first prenatal visit. Again, line numbers in this excerpt correspond with the original transcription:

```
(4.3)
23   D4:   alright (.) now we're just gonna go (.) today is more
24         for me to just confirm a little bit of the history
           that we've already got and I have a couple of
25         questions in terms of medications (.)  and then we're
26         going to some la:b work(.) we're going to order an
27         ultrasound and also going to do the cultures(.) pap
28         smears (.) stuff like that.
29   P5:   ok.
30   D4:   alright? so (2) u:m (1) so this is your fifth
31         pregnancy and you have four babies already. and u:m
32         (.) are they in good health.
33   P5:   yes they are.
```

In this interaction, D4 laid out the plan of treatment, with the starting point of history taking (line 24), medication (line 25), and gynecological exam (lines 26–28). To begin the history-taking process, D4 confirmed P5's pregnancy history (having four children), followed by an inquiry of their current health (lines 31–32).

Notice that in the above three examples, patients took a relatively passive position compared to their doctors in the process of history taking. For example, the trainee played an active role in initiating inquiry (D3P4), problem presentation (D5P7), and therapeutic agendas (D4P5), whereas patients confirmed the request (P4, line 8), received the information (P7, line 14), or gave consent to the proposed treatment plans (P5, line 29).

History taking was also part of the routine practice in counselor-client initial sessions in this sample. Two examples illustrate this. The first excerpt was a session between C3 and P5. Similar to D4, C3 provided a brief statement of the therapeutic intent regarding history taking before asking subsequent questions:

```
(4.4)
1052 C3:   u:m we usually go over a pretty big substance use
1053       history, so what I am going to do to speed things up
1054       (.)I'm going to go down the list and just say yes or
1055       no. and then we will go through them and go over
1056       whatever information I need to now
1057 P5:   okay.
1058 C3:   alcohol?
1059 P5:   yeah.
1060 C3:   speed?
1061 P5:   adderall.
1062 C3:   meth.
1063 P5:   no.
1064 C3:   inhalants. gas pain,
1065 P5:   no.
```

Similar to D4 in the previous example, C3 used the collective pronoun "we" (line 1052) to initiate the introduction of the task of history taking. This use of this pronoun suggests a sense of shared responsibility for fulfilling the task of history taking. In addition, as the process indicates, C3 provided a brief reminder to P5 that the two would engage in a mechanical process of history taking, with primary close-ended questions with yes and no answers (lines 1054–1055). Again, in this process, C3 took an active, leading role in the process of history taking, and P5 simply confirmed the proposed plan (line 1057). As the subsequent interactions indicate, the question

and answer process was conducted through lists of questions related to chemical use with very

little interactive or interpersonal dynamic.

Using the symptom checklist provided by the institution during an initial session shapes

how C2 asked questions and completed history taking. Similar to C3, C2 utilized a series of

close-ended, yes or no questions when conducting history taking with P3:

```
(4.5)
637  C2:  okay (.) let me ask you a couple more questions just
638        to kind of get some of these things on my thing done.
639        I know we've been kind of talking about some of this
640        stuff. within the past month or so have you had any
641        changes in your sleep patterns?
642  P3:  no.
643  C2:  ok (0.3) what about changes in your eating habits.
644  P3:  no.
645  C2:  nightmares.
646  P3:  no.
647  C2:  flashbacks
648  P3:  no.
649  C2:  fear of being alone
650  P3:  no.
651  C2:  homicidal ideation
652  P3:  no.
653  C2:  guilt
```

Evidenced in both examples of C3P5 and C2P3, history taking is a routine, mechanical, mundane

"bucket list" of a therapeutic task, as reflected by C3's mechanical question formats, as well as

C2's indication of intent of completion (line 638).

Taken collectively, the data suggest several shared characteristics across counselors-in-

training and doctors-in-training. First, history taking was part of the routine tasks and protocols

in initial sessions across two professions in this sample. Secondly, trainees provided a brief

introduction and statement that prepared patients/clients to engage in this process. Thirdly,

trainees in both professions engaged in a mechanical question and answer process during history

taking. Finally, although history taking was a collective and collaborative process, trainees in this sample took a relatively leading position in this therapeutic task.

Behavioral Health and the Biopsychosocial Approach

In addition to history taking, the behavioral health issues and the integration of the biopsychosocial (BPS) approach appear in a majority of sessions across both professions in this sample. The present study found two characteristics of talk and interactions related to the BPS approach. First, the concerns related to behavioral health and physical health often co-occurred during problem presentations. Secondly, trainees utilized the processes of history taking and summarization of therapeutic agendas to convey the BPS approach and achieve therapeutic goals. Finally, the BPS approach included both a report-supporting style as well as a rapport-relational style. The following excerpts show how these themes were manifested in trainee-client/patient interactions during their initial encounter.

The two sessions between D3 and P3 as well as between D5 and P7 showed the process of how patients brought up mental health issues in a regular doctor's visit related to their concerns of physical health. The first excerpt shows the patient's report of mental health issues during history taking:

```
(4.6)
20   D3:   So I'm just going to review your past medical history
21         really quickly. what medical issues do you have.
22   P3:   um (.) suffer from (.)
23         depression an:d anxie:ty. um (0.5)
24         and that's about it.
```

Although D3 specifically asked about the "medical issues" in her question, P3's answers were primary related to mental health issues (line 22–23). In responding to P3, D3 first assessed the medication history regarding the reported mental health diagnoses, then presented the possibility of initiating counseling services for P3:

(4.7)
```
25  D3:  do you take anything for your depression and anxiety?
26  P3:  I take klonopin for anxiety but I don't take anything
27       for depression.
28  D3:  ok. u:m do you want to start taking something for
29       depression?
30  P3:  no. I've been trying things throughout the yea:rs and
31       nothing has seemed to (.) consistently work.
32  D3:  ok.
33  P3:  so um (.) I think it's (0.4) you know. depression
34       doesn't go away. but it's more that anxiety that (0.4)
35       affects me on a daily basis so I've been managing.
36  D3:  do you talk to a counselor about this?
37  P3:  I'm i:n the process of getting all that together.
38       someone's going to come out (.) today actually to talk
39       to me about counseling services.
40  D3:  ok good good good. so what brings you in today.
```

When answering the question about medication history for depression, P3 made a note that

"nothing has seemed to (.) consistently work," followed by another issue concerning anxiety,

"but it's more that anxiety that (0.4) affects me on a daily basis so I've been managing."

Accordingly, both issues were ongoing health problems and medication did not seem to be

effective. Supporting that, D3 in this interaction allied with the typical biomedical approach

when P3 presented the mental health concerns. First, D3 inquired about the medication history

with regard to P3's mental health issues (line 25). Then, D3 made a suggestion for possible

medication for treating depression (line 28–29). After confirming that medication did not help

(line 30–31), D3 then inquired about the possibility of engaging in talk therapy (line 36).

In another regular doctor's visit between D5 and P7, the topic of mental health issues,

psychological stress, and psychosocial adjustment gradually emerged both during the history

taking and within the physical examination:

(4.8)
```
173  D5:  do you- have you been having any other problems
174       recently like upper respiratory infections like cough.
175       stuffy no:se. nothing like that?
176  P7:  °no°
```

```
177  D5:  ok. and no - no like fevers
178  P7:  I sweat at night a lot. my pillows are soaking wet and
179       I'll be like (.) dang (.) did I do that (.) that's
180       been happening frequently. I guess almost every night.
181       I mean out of the last few days I think at least three
182       or four times I remember I had to put the pillow aside
183       because it's too wet ((chuckles)) you know,
```

Notice that when D5 asked questions about fever (line 177), P7 neither confirmed nor denied the

symptom. Instead, he provided extensive narrations about night sweating (line 178). Although

neither D5 nor P7 discussed the reason of night sweating further in that moment, this process

provided an indication of P7's ongoing psychological issue, which was revealed later in the

session. In the following excerpt, P7 disclosed his ongoing mood issues and their connection to

his sleep problem while D5 was performing the physical examination:

```
(4.9)
199  D5:  perfect. yeah they're the experts when it comes to
200       everything with the joints. let me just take a quick
201       listen to you s:ir (.) to your heart and make sure
202       everything is ok. (1) °just breath normally° (10) deep
203       breath for me (2) perfect (2) one more (3) one more
204       time (3) one more time (3) ok. you mentioned you had
205       no sore throat or anything like that.
206  P7:  I got a lot of stress that's my problem. it's- it's
207       damaging. I've been better this year but I'm getting
208       to the point where I have to learn how to manage my
209       stress because there's a whole lot of stuff.
210  D5:  um hm
211  P7:  I be angry at people. a:h hh. it's just pressure.
212  D5:  do you feel like these episodes that you are getting
213       are related to the - the stress - it sounds like when
             you
214       get stressed you may get a little anxious you know -
215  P7:  uh huh.
216  D5:  you think that may be related.
217  P7:  that's why I want to sleep at night for one. start off
218       with that because I can't sleep at night and I never
             could
219       (.) that I could think of.
```

Similar to P3 who revealed her mental health issues during the assessment of physical health provided by D3, P7 revealed his stress and mood disturbances during the physical examination performed by D5. First, D5 was checking P7's lung function and heart rate, as indicated by the repeated breathing requests (line 202–203). As can be seen while doing breathing exercises for the purpose of the examination, P7 produced the talk related to his stress, mood issues, and sleep problem, as indicated in line 206–209. As result of P7's disclosure, D5 also changed his therapeutic direction from primary physical health to inquiry into mental health. In line 212–214, D5 displayed his question that specifically connected to stress, followed by his conclusion about the link between anxiety and the stress. When P7 confirmed the knowledge provided by D5 (line 215), D5 then reinforced the knowledge by including P7 into the statement, "you think that might be related." As a result, P7 provided further descriptions and narrations of sleep problems he has experienced.

The above two examples indicate that in a primary care setting, the concerns related to behavioral health and physical health often co-occurred during problem presentations within the initial visit. The disclosure of mental health concerns from P3 and P7 appeared during the therapeutic inquiry related to physical concerns. As opposed to be in a leading position in the process of history taking, doctors-in-training in this process seemed to play a supporting role in inquiry and providing interventions.

While behavioral and mental health issues are the primary focus in all initial counseling sessions in this sample, this study found that conversations related to physical health and medications appeared in a number of interactions between counselors-in-training and their clients. The examples show that the BPS approach was part of the routine task in history taking.

The following two excerpts indicate such a process. The first example is the interaction between

C2 and P3 during history taking:

```
(4.10)
682 C2:   are you experiencing any emotional numbness?
683 P3:   no. ((laughs))
684 C2:   ((chuckles)) well (.) that's a good thing. what about
685       some somatic symptoms. that means like physical
686       problems (.) kind of maybe like a stomach ache (.) a
687       persistent headache (.) something like that. that kind
          of -
688 P3:   back. Yeah.
689 C2:   did you fully heal from your back injury before you
690       went back to work?
691 P3:   yeah. hh.
692 C2:   okay (.) what about u:m - how many drinks of alcohol
693       do you have per week.
694       (1)
695 P3:   u:m (6) I'd say (0.8) four.
696 C2:   four. a:nd (1) When is the last time you had a drink
697       of alcohol.
698 P3:   I can't remember. what's today.
699 C2:   today's Thursday the twenty first.
700 P3:   Wednesday.
701 C2:   Wednesday. okay.
702 P3:   my days are always off (.) just say Friday.
703 C2:   okay. what about marijuana. any marijuana use?
704 P3:   O:h I had so:me (.) very seldom.
705 C2:   like- Like recently within the last thirty da:ys or
706 P3:   yeah, I had some u:m (1) just one puff I had Friday
          night.
707 C2:   what about opiates (.) which are heroin (.) percocet.
708 P3:   no.
709 C2:   crack or cocaine.
710 P3:   no.
711 C2:   u:m Benzodiazepine or sedatives like valium klonopin
          zanex
712 P3:   no.
```

C2 transitioned from mental health-related questions to questions related to physical health in

this history taking, as indicated by her brief introduction of "somatic symptoms" and associated

examples (line 685–686). Line 703 to 711 show questions related to medication and chemical

uses. These questions are typically asked in doctors' offices or general health clinics. In addition,

the style of questions was like typical symptom checklists or questionnaires that appear in medical institutions.

As the above three examples indicate, the BPS approach can occur on a patient's/client's initiative, or as part of the mundane, everyday task in a health care institution. Trainees in this process took a relatively passive and supporting role in approaching the emerging behavioral health or physical issues. For example, D3 used a traditional biomedical approach in responding to P3's complaints. D5 presented a report style and knowledge presentation in responding to P7's extensive narrations about anxiety and sleep problems. C2 engaged in a mechanical question and answer process when inquiring about P3's medication and addiction history. Some interactions, on the other hand, displayed a more active approach.

The following examples illustrate a relatively relational style in the BPS approach. The second example of a counseling interaction in a drug and alcohol treatment facility shows the BPS approach as part of routine tasks in history taking. However, a more intentional descriptor was included in the question related to medication:

```
(4.11)
603  C3:  u:m any allergies?
604  P4:  pt u:m like penicillin I'm allergic to. other than
605       that no. pollen (.) basic stuff. other than that (.)
606       that's it.
607  C3:  so this - um other than Soboxin (.) are you on any
608       other medication.
609  P4:  u:m they put me on Prozac um and th::a (.) Seroquel
610       for sleeping (.) like I haven't even - you know I
            guess I
611       kinda - = a:h when I screwed up and got high after I
612       got out of rehab I just kind of stopped taking them. I
613       haven't even (.) got back on them.
614       (3)
615  C3:  u:mm so any other current- u:m (.) medication like
616       herbs (.) vitamins anything like that?
617  P4:  no. no.
```

Unlike C2, who asked lists of questions related to physical health based on the questionnaires provided by the situated institution, in this interaction, C3 engaged in additional talk with P4 regarding his medication history. For example, in line 607, C3 added the additional description, "other than Soboxin," before he asked about medication use. As is commonly known in drug and alcohol treatment facilities, Soboxin is typically used by clients who are in the process of recovery to treat narcotic addiction. The descriptor made the question more contextual and relevant to P4 because recovery was the primary reason for his counseling treatment. The question related to Soboxin showed an understanding and knowledge of contextual information regarding P4's visit.

Another doctor-patient interaction demonstrated a more narrative, rapport approach to the BPS evaluation. A BPS session between D1 and P1 indicates the trainee's intent to integrate the BPS approach into the therapeutic process. In this interaction, D1 started the session by indicating her knowledge of P1's current counseling treatment. The questions related to counseling brought up the topic related to P1's current social life:

```
(4.12)
9     D1:   =it's going well? that's good. whe:n was your last
10           se?ssion.
11    P1:   = yesterday.
12    D1:   = ?k(.) are you go,ing mo:re? (1) than you were 13
                 be?fore?
13    P1:   = No it's been the same (1), for two or three weeks.
14    D1:   = Ok, (.) an::d how is that helping? your anxie?ty.
15           (8)
16    P1:   u?.hhhhh,(4) ah(.) it's >probably< helping a litt?le
17           (.) bu.t I'd sa,y (.) not to:o effecti?ve. ( ).hh (3)
18           lately?(.) .hh I've seen an increase(.) with my
             depression.
19    D1:   ok.
20    P1:   (              )
21    D1:   what's goin,g on,
22           (2)
23    P1:   we:ll(.) =most of it has to do with(.) .hh my:
```

```
24          lo:ng(.) term(.)  friend (0.1) I've known for eight
            years
25          (4) > lately< we haven't been spea:king..hh (3) ( )
26          (6)
```

In this process, the history taking brought up topics that relate to a variety of aspects of P1's life.

These include treatment history (line 9–10), current mental health condition (line 14), additional

mental health issues related to depression (line 18), and a recent dispute between P1 and his

friend (line 21). As the session progressed, this history taking that intended to get to know P1's

psychosocial environment further developed to conversations related to his family dynamics,

home environment, education, and health practice.

At the end of the session, D1 provided a brief summary of her clinical observations and

therapeutic agendas. The summary also integrated multiple dimensions of health:

```
(4.13)
804  D1:  ok (.) well again I just want to let you know ag:ain
805        h:ow (.) amazing it is that you've come this f:ar with
806        sch:ool (2) u:m (.) and that you're doing all the
807        right things so make yourself healthier↑ and feel
           better (.)
808        you've been off medications for two years and it seems
809        like you know you have your ups and downs you're doing
           we:ll (.)
810        and if you ever did want to go back on medications
811        that's always an option too  (3) OK↑
```

As the summary indicates, D1 first highlighted P1's resilience (line 805), followed by ongoing

educational goals (line 806), quality health practices (line 807), and ongoing medication

treatment (line 808).

The selected examples indicate that physical health and mental health issues often co-

occurred in the process of problem presentations within initial sessions. This was especially true

in a primary care setting. Trainees were required to have additional skills that integrated physical

care and behavioral health when encountering such in the context of an initial session. In

addition, while the BPS approach was integrated into the routine tasks in both family medicine and counseling settings, variations of style toward the approach appeared in the sample. While some trainees presented a typical biomedical approach, knowledge presentation, and mechanical questions and answers, others incorporated contextual information about the client and/or used their interpersonal connections to highlight desirable health practices.

Requesting Details

A common therapeutic strategy shared by trainees in both professions is the process of soliciting details of information as the interaction progresses. This study found that trainees requested detailed information from their patients/clients under two circumstances. The first purpose of requesting detailed information was for conducting further assessment based on the reported health issues. Specifically, trainees requested detailed information from their patients/clients when identifying particular health issues that needed further attention. The second purpose of requesting detailed information was to maintain conversation with the patient/client and build rapport. In this circumstance, trainees' requests may not directly aim at completing a specific therapeutic task, but the conversations seem to have a relational function that maintained therapeutic interactions and helped the dyads achieve therapeutic tasks in the following interactions. The following five examples demonstrate the process of how trainees requested detailed information based on the two circumstances.

The first excerpt shows D5's requests to P7 to provide details of his allergic reaction, which resulted in his recent visit to an emergency room. In this interaction, D5 appears to intend to get a full picture of P7's symptoms at the ER:

```
(4.14)
29   D5:  just hot (.) warm? any pain anywhere?
30   P7:  not really just tight on the si:de (.) but I always
31        have that most of the time.
32   D5:  and then what happened.
```

```
33   P7:  and uh (.) I was starting to pass out so they came and
34        got me and put me in a wheel chair and brought me to a
35        room put me in a bed and it got really - really bad. I
36        got so sick↑ I couldn't -  I had to take off all my -
37        my shirt - my jacket I had to take all of it off.
38   D5:  you mentioned you we going to pass out.
39   P7:  yeah
40   D5:  you felt?
41   P7:  yeah
42   D5:  what were you feeling with that- like light headed?
```

D5 engaged sequences of detailed inquiry of P7's recollection of symptoms presented at the ER.

For example, D5 tried to differentiate the symptoms by listing different possible symptoms as

options for answers (line 29). Secondly, after hearing P7 mention "passing out," D5 continued

soliciting information about this symptom by repeating P7's words in the subsequent response

(line 38). Concerns of safety and related health issues can occur in counseling interactions. This

study found another example where the trainee requested details in a counseling context.

The detailed assessment with regard to safety and protection, such as suicide, homicide,

or abuse, are typical in counseling sessions, and especially critical in an initial session. This

study identifies that in counselor-client interactions, soliciting details occurred when trainees

identified issues of safety, such as a suicidal attempt or potential violence. For example, in C2

and P2's initial session, C2 asked further questions to assess suicide risk after P2's responses:

```
(4.15)
378  C2:  any (.) suicidal ideation
379  P2:  um I think about it a lot. that's also been a pretty
380        constant thing. I've never like seriously considered
381        it. it just pops into my head pretty frequently.
382  C2:  how often would you say that that happens.
383  P2:  um hhh. it can be like- it can be a lot of times a
384        day. not -  I mean it sounds a lot worse than it
385        probably is but it does pop into my head I would say
386        anywhere between. at its worse. like ten or fifteen
387        times a day. it's not always like a super serious
388        thing. it could be like a jokey kind of thing in my
389        head. Um - and   sometimes (.) you know (.) like zero
```

```
390         to three times a day. it depends on what is going on I
            guess.
391 C2:  do you have - have you ever kind of planned it out or
392         thought about it more than just that kind of popping
            up thought of suicide.
```

In this process, C2 engaged two types of solicitations after hearing P2's experiences of suicidal

ideation, "I think about it a lot. that's also been a pretty constant thing." First, like D5 who

provided possible lists of symptoms, C2 in this process tried to find out behavioral indicators of

suicide such as frequency of thoughts (line 382) and a concrete plan (line 391). Secondly, C2

repeated the words that P2 had said, "pop up," in her assessment of a concrete plan, "have you

ever kind of planned it out or thought about it more than just that kind of popping up thought of

suicide."

In another session between C2 and P3, the experience of an abusive marital relationship

came up during the conversation. After P3's lengthy description of her husband's recent agitated

behaviors, C2 asked further detailed questions that specifically evaluate P3's safety:

(4.16)
```
249 C2:  has he ever physically hit you. harmed you. or caused
250         you any bodily harm,
251 P3:  no. it's never gotten to physical. its threats. he'll
252         threaten with me with weapons. he's come after me with
253         a hammer already. a icicle. he's already put – he had
254         an iron(.) it wasn't turned on (.) he put it in my
            face (.)put
255         like you know (.) if this iron was turned on you would
256         be burnt (.) yeah well (.) it's not - you know s- s
257         just things like that.
258 C2:  and how do you handle those -
259 P3:  threat encounters.
260 C2:  yeah (.) how do you handle the threats.
261         (6)
262 P3:  well once in a while. like two times. I think it was
263         twice I called the police
264 C2:  ok
265 P3:  because I got very frightened.
266 C2:  sure. sounds –
```

There were six seconds of shared silence after C2's questions about P3's response strategies toward her spouse's behaviors. Though it is unknown what each speaker was thinking and feeling internally during the silent moment, the silence during the trainees' request of detailed information indicates a potential unsaid emotional and relational dynamic regarding the subject. As the above three examples indicate, trainees in both professional contexts requested detailed information from their patients/clients when identifying particular health issues that needed further attention. These health issues can be both physical and psychological.

On some occasions, trainees requested detailed information about a story or events that were not directly related to health concerns. However, such conversations seemed to help the trainees get to know their clients and gradually established a relational foundation for future interactions.

The first excerpt that demonstrated this is between P1 and D1. P1 indicated his recent falling out with a friend on Facebook. In addition to checking in with P1's emotions associated with this incident, D1 continued exploring the details of the conflict:

```
(4.17)
29   P1:   u:m we had a disagreement about something an:d(.).hh
30         since that time w:ee um. hh (3) haven't really
31         communica(.)d at all .hh
32   D1:   when was the last time you communicated with him.
33         (2)
34   P1:   the:e nineteen, or twentie(.)th.
35   D1:   (.) of this mon↑th.
36   P1:   [um][hm]
37   D1:   [ Oh   ]            so a cou↑ple of da↑ys ago(.) O:k,
38         so this is when you(.) re (.) in:crease(.) -  > thee s
           when you've been feeling
39         a bit more anxious and more depressed
40         and sa:d < (.)
41   P1:   ° yes°
42   D1:   = would you mi:nd(.) going in:to: (.) [any > de:tails
43         abo]ut what ha:ppen↑ed < (3) ((hand gesture)) o:rr (1)
           a(.)
44         > little bit of the gist < of what ha:ppen↑ed
```

In this interaction, D1 engaged in a series of detailed solicitations about the incident, as shown in her question about the timeline (line 35 and 37), the impact of the incident on P1's mood (line 39), and a descriptive request about the details of the incident (line 43–44).

In addition to getting to know the person better, requesting detailed information related to the clients' daily social life and personal perspectives implied trainees' interest in the subject. In a BPS session, D2 specifically requested that P2 talk about his life goals:

```
(4.18)
1288 P2:  I want to do something.
1289      (0.4)
1290 D2:  have you thought about it?
1291 P2:  no. (1) I want to do so much but I can't do nothing.
1292 D2:  give me three things that you want to do with your
1293      life.
1294 P2:  first of all I want to help the homeless.
1295 D2:  O:kay. (1) What's the second thing.
1296 P2:  the second thing is I want to bu:y (0.2) stuff.
1297 D2:  buy stuff?
1298 P2:  you know like
1299 D2:  like what stuff.
1300 P2:  buildings. and just give it to the homeless.
1301 D2:  ok
1302 P2:  stuff like that.
1303 D2:  ok. (0.2) so what's the third thing you want to do.
1304 P2:  I don't know, (.) I just (.) I just want to live a
          normal life (.) I guess.
```

While presenting active psychological symptoms, P2 was able to engage in a conversation about his life goals. As demonstrated by his conversation with D2, P2's goals to help homeless populations (line 1294 and 1300) reflect the obstacles of his present living conditions at the time of the session.

As the above examples indicate, soliciting detailed information was a common therapeutic strategy shared by trainees in both professions. Soliciting details provided two therapeutic functions, the continuance of assessment when the presenting issues needed further attention and rapport building within initial sessions.

Recapitulation

  Recapitulation is the repetition and recurrence of words, phrases, and stories disclosed by speakers that emerge in the process of interaction previously or in the present time. Recapitulation was another strategy that the trainees in this study used for getting into the therapeutic agendas or introducing the therapeutic interventions during initial sessions. This study found three features of recapitulation. These include recollection of stories and events, repetition of the phrases and words to highlight the significance of the statement, and shared lexicon as confirmation of therapeutic agendas. A total of seven examples are used to demonstrate how trainees used this strategy.

  Recollection of stories and events. As mentioned previously, the BPS session in family medicine is a comprehensive assessment session where a doctor conducts an in-depth inquiry into the patient's psychosocial history, family system, and related health concerns. A doctor may have a brief conversation with the patient regarding their presenting concerns prior to the session. In the context of an initial BPS session, doctors-in-training may use the patient's stories and events disclosed previously to open up the conversation at the moment. Two examples from doctor-patient interactions in a BPS session are used to demonstrate this strategy. The first two excerpts show trainees' recollections of a story or events brought up by patients/clients previously.

  First, reiterating patients' words can be used to open up the conversation. In a BPS assessment, D2 began the session by providing a brief summary of P2's words as a source to open up the conversation:

```
(4.19)
3 D2:     [yeah (1) ok (.) SO (.) you said things haven't been
4         good lately.]
5 P2:     ((looks at cellphone and types)) n:o.
6 D2:     what's been going o:n
```

It is evident that the pauses and a stressed "so" occur prior to D2's presentation of the

recollection (line 3–4). In this process, P2 was engaging activities with his cellphone. When

presenting her knowledge of P2's condition, D2 used the second-person pronoun, "you" (line 4)

to reinforce the ownership of the condition, followed by her further inquiry (line 6). In the

beginning stage of the BPS session, "You said" seems to assist D2 in opening up the

conversation with P2.

The second example is illustrated by another BPS session conducted by D1. In this

interaction, D1 used such a strategy to conduct further discussion related to P1's education in the

middle of the conversation:

```
(4.20)
135  D1:  right(.) well (.) I'm really proud↑ tha:t you are
136        going to a ther:apist↑ and talking to someone about↑
           it↑
137        (2) It's a (.) big ste:p (.) to take (1) u:m .hh (.)
138        remind me aga:in what you are doing in school?
139        (2)
140  P1:  um (.) computer information systems.
141  D1:  o:hh ok. how is that goi:ng (.) I remember last time
142        you said you had a problem with the professor?
143  P1:  yeah that was the last session.
```

First, D1 provided praise by highlighting P1's action of engaging in psychotherapy (line 135–

136). As line 142 indicated, D1 recalled P1's report of his school experience in a previous

regular visit to explore his education experiences in this BPS session. This recollection reflected

two types of relational discourses. First, D1 remembered the context of the conversation (line

141), and secondly, D1 remembered the content of the story that P1 reported in the previous

session. The relational discourses manifested by the recollection of P1's previous disclosure was

used to expand the narratives of P1's psycho-social health and social relationships.

Repetition. Repeating certain information provided by the speaker reflects the

significance of the information and helps the speakers engage in detailed discussions. In addition

to recalling the patient's disclosure and utilizing it in the present moment, trainees used the

disclosure in the process of interaction to conduct further assessment. One example from the

session of C2P2 demonstrated this process. During assessment and history taking, C2 repeated

specific information provided by P2 and then solicited further details:

```
(4.21)
148  P2:  I just try to be what I think a good person is -
149  C2:  um (.) what is that.
150  P2:  to be th:at - I don't know, I just try to be there.
151       you know for my friends and famil:y. my girlfriend -
152       and do -  you know (.) do things for them. u:m (.)
153       listen to them. care about - you know their problems
154       and stuff - try to help them in any way I can. You
155       know. u:m so I try to do that kind of thing.
156  C2:  ok.
157  P2:  u:m (.) yeah that's pretty much it.
158  C2:  you said you have a girlfriend.
159  P2:  I do.
160  C2:  how long have you been together.
```

After helping P2 explore his idea about what it meant to be a good person (line 149), C2 then

sorted out specific information from P2's narration, and used such information to shift the

therapeutic direction by repeating P2's words. As a result, the topic shifted from "being a good

person" to the discussion of P2's relationship (line 158–160). The conversation regarding his

relationship brought up further disclosure later in the session.

Shared lexicon. The significance of a topic can be jointly constructed through

recapitulation of the words during a therapeutic interaction. The following three examples

demonstrate such a process, where the trainees and clients repeated the phrases that have been

said. Borrowing words from the speaker during a conversation not only reflects the importance

of a particular subject, but it can also highlight a shared interest or perspective on the subject.

One doctor-patient interaction and two counselor-client interactions are used to illustrate this

sub-theme.

The first example is an interaction between D2 and P2. In this instance, P2 described his

dream with animated details. D2 repeated P2's words and showed her understanding of P2's

question and his urge to find out the answers:

```
(4.22)
128  P2:  like it was (1) B::IG! (.) like HU::GE! it was
129       BR::OWN! and BE:IGE! no BRO:::WN and like a rust
          color,
130       like (lu) like make a [rust color?] and BR::OWN and a
          [rust color]
131  D2:                        [    yeah   ]
          [    ok    ]
132  P2:  and the wing was so HU::GE (.hh)!
133  D2:  um h:m
134  P2:  and it did - it didn't look like it was BRO:KE:N! (.)
135       so I don't know wh:y he couldn't F:LY,
136  D2:  yeah (.) why he couldn't fly huh. =
137  P2:  = couldn't FLY I want to know WH:Y =
```

In this interaction, P2 displayed a high degree of energy when describing his dream, as indicated

in his high volume and repetitions of certain adjectives (line 128–130). When sensing P2's urge

to find out why the object in his dream could not fly, D2 shared P2's question and repeated it in

line 136. Highlighting the question asked by P2 conveyed D2's understanding of the significance

of P2's urge; in addition, the therapeutic discourse was developed as a result of this shared

understanding.

In some interactions, borrowing the clinicians' words can help clients elaborate the

subject and discover emotions associated with events. Two interactions presented by C3 and P4

demonstrate this process. First, in the discussion of P4's former treatment program, C3 conveyed

his understanding of the situation. P4 then used C3's words to indicate his agreement with C3's

observation. Thus, a shared understanding of the subject was jointly achieved between the two:

```
(4.23)
561  P4:  you know one guy was in there and he said he was doing
562       good. this and that. and he got busted the next day
563       with like (.) fricken (.) six ounces of coke
```

```
564  C3:  oh
565  P4:  and like sixty grand in ca:sh. yeah ((chuckles))
566  C3:  they were just bull shitting. [nobody really cares
567       about the recovery.]
568  P4:                               [bullshitting (.) they
569       didn't -         ] no (.) it's just a joke to
570       everybody. they were there because they had to be.
571  C3:  um hm
```

The shared lexicon appeared in the process of interaction. After P4 provided an example about

the incident that occurred in the previous program, C3 used the word "bullshitting" to paraphrase

his understanding of the mentality that occurred in the treatment program (line 566). Then, P4

repeated the word said by C3 and elaborated on it to indicate a lack of effectiveness of the group

process and his perception toward the program (line 568–570).

Repeating the counselor's word for further elaboration occurred again in another

interaction between C3 and P4. In this example, P4 described witnessing a close friend of his

who died from an overdose. The phrase "horrible news" was first introduced by C3 and then

repeated twice by P4, followed by an elaborated recollection of the incident and grief:

```
(4.24)
1334 P4:  yeah. you know I was kind of upset. I went upstairs
1335      it's almost like I got teary eyed but like I had to
1336      force myself to cry almost. it was just weird -weird -
1337 C3:  weird - probably - it sounds like a really weird
1338      experience.
1339 P4:  yeah.
1340 C3:  you get this horrible ne:ws -
1341 P4:  horrible horrible news. Like the worst news I've ever
1342      heard in my entire life you know and I'm just kind of
1343      like damn. I go in the ro:om and I got teary eyed a
1344      little bit wasn't- I wasn't like bawling like a baby.
1345      you know what I mean -
```

Line 1337 to 1338 indicated C3's reflection of P4's experience after he described the details of

witnessing his friend's death, with an additional comment, "you get this horrible ne:ws." As can

be seen, the word "horrible" was picked up and used by P4 in his subsequent narration (line

1342-1345), indicating shared knowledge and affective component of understanding about the

impact of the loss.

   Recapitulation of the words during therapeutic interactions can also be used as a strategy

to confirm therapeutic agendas. During the conversation of setting therapeutic goals, C3 asked

P5 to state his goals for counseling. After a period of silence, C3 introduced the goal of sobriety

followed by P5's repetition and confirmation:

```
(4.25)
720  C3:  so from coming here to counselling what would you
721       really expect (.) what do you really want out of
722       coming here
723  P5:  u:m I guess to learn how (.) I think. Sometimes
724       I don't even know why why - I think the things I do.
725       like even when I know they are wrong and I just kind
726       of want to know why I do that.
727  C3:  learn about your thought process and how that-
728  P5:  like wh::y I just spontaneously will
729       (0.5) even if I don't have to. you know what I mean?
730       just why -
731  C3:  why that is happening. stuff like that.
732  P5:  yeah
733  C3:  what else?
734       (7)
735  P5:  to
736       (1)
737  C3:  to stay clean?
738  P5:  to stay clean. yeah.
```

In this interaction, C3 intended to formulate counseling goals with P5. Initially, an open-ended

question was introduced to encourage P5 to narrate his goals (line 720–721). Then, P5 answered

the questions with a more extensive narration without showing definitive answers. For example,

the utterance "u:m" (line 723) was produced before "I guess" (line 723), followed by a pause and

"I think" (line 723), suggesting P5's stage of contemplation. It appears that C3 summarized P5's

goal with a succinct sentence and a prompt question (line 727), which was completed by P5's

continuation of his thought process (line 728). This co-authoring process occurred again in the

next sequence. Line 730 indicated P5's intent to explain his goal further and his invitation of

C3's authorship of the therapeutic goal, as indicating by his clarification, "you know what I

mean" (line 729), followed by an unfinished question (line 730).

The next phase of the interaction indicated the process of how the new discourse,

sobriety, was first prompted and introduced by C3, and then later repeated and declared by P5.

Line 733 indicated C3's turn to introduce an additional goal, as it was packaged by a question,

"what else?" At this point, it becomes clear that P5 might have had a hard time articulating his

therapeutic goal, or producing it further; this was indicated by two sequences of silences (line

734 and 736) and one unfinished utterance (line 735). After the second period of silence (line

736), C3 finally introduced the goal from his perspective, "to stay clean," which was

immediately declared and affirmed by P5 (line 738).

Recapitulation in this sample seems to consist of recollection of stories and events

disclosed previously, repetition of the phrases and words that emerged at the moment of

interaction, as well as a shared lexicon to confirm therapeutic agendas. The three strategies were

used to help trainees to introduce therapeutic agendas and therapeutic interventions during initial

sessions.

Casual Conversations

As the previous discussion regarding talk and interaction in social institutions has

indicated, professional practices and institutional talk are often formed, shaped, and reshaped

through speakers' interactions. In addition, ordinary interactions and institutional talk often

simultaneously occur in a single episode of interaction. This study found that some features of

ordinary interactions such as casual conversations existed in the majority of initial sessions. The

analysis indicated that casual conversations provide two functions in the context of initial

session. First, casual conversations occurred during clinical assessment and seemed to assist

trainees to get to know the person holistically. In addition, casual conversations that occurred

during the therapeutic tasks functioned as an "intermission" from the ongoing therapeutic

agendas. Six representative examples are provided to demonstrate the two functions. Three

examples were selected to illustrate holism and intermission, respectively.

Holism. The first excerpt is from a discussion of hobby, music, and favorite music genre

during psychosocial history taking in the session between C3 and P5:

```
(4.26)
912  C3:  = what do you like to do for fun? You were talking
913        about how you love to be outside. you love spending
914        time with friends and family
915  P5:  oh yeah. just-  anything outdoors. I love to hunt and
916        fish. I love to take my dog down to the creek and
917        pla:y. I love being at bonfires and stuff. I just like
            to be outside.
```

After knowing P5's hobbies (line 913–914), C3 continued asking about P5's leisure activities.

While "what do you like to do for fun" is a question often asked in a social interaction, it was

used in the initial session as a part of the assessment protocol and a method to get to know the

client.

As P5 disclosed his love of music, C3 continued exploring P5's musical preferences in

the subsequent interaction:

```
(4.27)
926  C3:  do you like to listen to music?
927  P5:  Oh yes. I listen to music.
928  C3:  what kind of music do you like to listen to?

929  P5:  anything other than hip hop. I -I listen to rock (.)
930        mainly. Classic rock country (.) pretty much anything.
931        I love going to concerts and stuff.
```

Accordingly, the interactions related to hobbies and music shown above, which typically exist in

a casual interaction, were reproduced in an initial counseling session. However, there were some

exceptions in the context of clinical encounters, where the typical practice of ordinary interaction did not apply. First, while in casual conversations speakers mutually produce topics, in the context of clinical encounters, the initiation of such social interactions was introduced by the trainee. Secondly, while in casual conversations, speakers mutually exchange information of stories and events, the question and answer process in this case was uni-directional. That is, it was mainly C3 asking questions and P5 providing answers, and not the other way. C3 did not share his hobbies or favorite music to P5 in the process. The strategy of utilizing a casual conversation in a therapeutic context is a creative way to get to know the client in an initial encounter. While the casual conversation in this case was atypical and asymmetrical in the context of casual interaction, in a therapeutic context, this uni-direction with regard to exchanging personal and social information is necessary, as the focus of counseling is the client, not the therapist.

Small talk and casual conversations were found in a number of doctor-patient interactions in this sample. Again, it appears that trainees engaged in casual talk to get to know the patient holistically without sharing their personal information. For example, during a BPS evaluation between D2 and P2, the subject of video games was introduced by D2, after the conversation about P2's childhood dream:

```
(4.28)
552  P2:  I see that the the thing is I had that one th - before
553       when I was growing up (.) I always wanted to be a
554       bounty hunter (.) I al - I al - I always love to be
          (.) a sni:per
555  D2:  ((nods))
556  P2:  that was my biggest (0.3) I'd love to do with my life.
557       ((looks at D2 with the left ring finger and the little
558       finger points toward the ceiling))
559  D2:  um hm
560  P2:  is the:re ((looks at D2 with the left ring finger and
561       the little finger points toward the ceiling))
562  D2:  um hm
```

```
563  P2:  I love them (0.4) jobs. ((looks at D2 with the left
564       ring finger and the little finger points toward the
565       ceiling))
566  D2:  yeah
567  P2:  [cause    - ]
568  D2:  [do you ever ] play video games and stuff like that?
569  P2:  oh I wou - no. I play video games no more. No I
570       stopped playing them.
571  D2:  did you play them when you were a k:id.
572  P2:  Yeah (.) a lot (0.4) I had a lot of violent games. a
          lot of violent ga:mes. [ so ]
```

In line 552 to 554, P2 described his childhood dream to be a bounty hunter and a sniper, with accompanying body language of the act of shooting (line 560–561). It is unclear about D2's intention of the follow-up question (line 571). However, the sequence of interaction shows that D2's question was produced as a result of P2's talk and acts. Similar to the session of C3P5 who presented an "atypical" ordinary interaction, D2 did not share personal information, nor did she share the reason behind the questions she asked, especially the question related to the video games. The uni-direction of casual conversations was also presented in this example.

In addition to the emerged topics and the subjects that were discussed in the session, casual conversations manifested through non-verbal behaviors and paralinguistic features of talk. In the session between D1 and P1, P1 described his brother's behaviors at home with animated details. D1 displayed several paralinguistic utterances that are commonly found in ordinary interactions:

```
(4.29)
673  P1:  I find it even more distasteful when he (.) spits and
674       rinses spits and rinses an doesn't bother to wash it
675       $ out $[ ((chuckles))]
676  D1:          [    $ ugh $ ]
677  P1:  and he said (.) he says I'm petty for [     that
678  D1:                                        [
679       ((chuckles))]
680  P1:  I'm petty? ! dude I mean (.) come on -
681  D1:  !there's a l:oot of people that would agree with you!
          ((nods and chuckles))
```

A slight variation of this example from the previous ones is that both D1 and P1 in the process mutually participated in ordinary talk and acts. In this interaction, P1 showed a pleasant mood, as indicated by his animated description of the brother's behaviors (line 673–674) and chuckles (lines 675). It is clear that D1 shared this fun, pleasant dynamic, as shown through her exclamation (line 676), chuckles (line 679), and animated speech (line 681). That said, in terms of information exchange, this ordinary interaction appears to be uni-directional as D1 did not participate in sharing personal information.

Intermission. Small talk is often introduced in the midst of ongoing therapeutic tasks, such as general assessment and physical examination, as an "intermission" to the mundane tasks.

There are three examples selected for the review. The first example can be found in the following interaction between C2 and P2. Specifically, small talk appeared in the process of history taking where both C2 and P2 engaged in casual conversations as an "intermission" of the ongoing assessment:

```
(4.30)
338  C2:  it's supposed to be turning around for us with the
339       weather.
340  P2:  I don't believe it.
341  C2:  yeah I know I don't believe it until I see it either.
342  P2:  we'll have like one seventy three degree day and then
343       it snows. yeah (.) but eventually. maybe I'll also be
344       a cyclist again.
345  C2:  u:m (.) I'm going to ask you about just some current
          symptoms.
```

Right before the topic of weather, the two discussed P2's hobbies. Then, the small talk of weather emerged in the middle of the assessment, which functions as an intermission to mundane tasks that involved a series of assessment questionnaires. Notice that as soon as the topic of weather was wrapped up and the topic was transitioning to leisure activity (line 344), C2 recaptured the therapeutic task and introduced her next assessment question (line 345).

In regular doctor's visits, doctors-in-training often encountered a therapeutic task that involved both assessment and physical examinations. Two examples from doctors-in-training are used to show how trainees negotiated between casual conversations and ongoing tasks. The first example is the interaction between D1 and P1 during history taking. The small talk-related video game was introduced in the middle of the task:

```
(4.31)
472  D1:  are you an xbox kind of person (.) or a play station.
473       ((chuckles))
474  P1:  $ mainly PS4 (   ) $
475  D1:  Ok. u:m I wanted to ask you when did you get diagnosed
476       with anxiety and depression again? I'm sure it's in
          your ch:art.
477  P1:  ° when I was early teen years I think ? °
```

Again, similar to the interaction between C2 and P2, small talk about xbox and video games occurred after the assessment of P1's hobby, followed by D1's reformation of therapeutic agenda (line 475–476). Also, similar to C2, D1 quickly recaptured her ongoing assessment by engaging in history taking in the next line (line 475).

Casual conversation as an intermission in ongoing therapeutic tasks can be found during physical examinations, as shown by the interaction between D3 and P3. In this interaction, D3 was fulfilling two therapeutic tasks: the completion of P3's family history and physical exam. While D3 was waiting for P3 to get ready for the exam, the topic of lotion, skin care, and history taking simultaneously emerged in the sequence:

```
(4.32)
151  P3:  ok. oh lordy. I need some lotion.
152  D3:  the weather is very cold out isn't it.
153  P3:  it is.
154  D3:  do you know what helps. Vaseline.
155  P3:  what's that.
156  D3:  Vaseline is really good for dry skin.
157  P3:  oh yeah. I know.
158  D3:  especially if you put it on at night so you don't look
159       all (.) shiny.
```

```
160  P3:  ((laughs))
161  D3:  um (.) no history of cancer in the family right?
```

As P3 was changing her clothes in getting ready for the physical exam, the two engaged in small talk, including comments about the weather (line 152) and lotion (line 154). A question related to family cancer history was introduced by D3 immediately after the skin talk, indicating D3's intent to continue the therapeutic process.

Casual conversations in the context of initial clinical sessions appear to accomplish three therapeutic functions: shared emotions, getting to know the person holistically, and an "intermission" in mundane therapeutic tasks. While trainees engaged in casual conversations in the context of an initial session, it made the ordinary interaction "atypical" in the sense of social interactions where speakers mutually produce topics and exchange information. This is not the case in the sample of this study.

Summary of Formation of Initial Sessions: Convergence

This study found a total of five convergent themes shared by both counseling and family medicine in terms of how interactions were created and presented in an initial encounter. Trainees in both professions formed their initial sessions through history taking, requesting details, recapitulation, and negotiations between task-oriented interactions and casual conversations. The behavioral health issues emerged across both clinical contexts, and trainees used the BPS approach through institutional protocols or considerations of the therapeutic context. The next section will present the divergent themes with regard to the process of interaction in an initial context.

Formation of Initial Sessions: Divergence

While shared strategies and features of talk were found across counseling and family medicine in this data, divergence of practices during interactions in the initial encounters were

also identified. This study found six divergent practices. These include the presentation of prior knowledge of patients' health and health records; rapid responses through preventive measure and the report of treatment plan; knowledge presentation and education; opened-ended questions in opening statements; paraphrase, summation, and reflection; and co-created therapeutic discourses. The data presentation will start with doctors-in-training first, followed by counselors-in-training.

<div align="center">**Divergence: Doctors-in-Training**</div>

The first three themes are the presentation of prior knowledge of patients' health and health records, rapid responses through preventive measure and report of treatment plan, as well as knowledge presentation and education. These three themes appeared in doctor-patient interactions. The next three themes, opened-ended questions in opening statements, the use of paraphrase, summation, and reflection, as well as co-created therapeutic discourses were found in counselor-client interactions.

Presentation of Prior Knowledge of Patients' Health and Health Records

Although trainees in both professions engaged in extensive history taking in an initial context, analysis showed different features of interactions between doctors-in-training and counselors-in-training. Doctors-in-trainees in this sample referenced existing information about the patients in the situated institution and incorporated that knowledge into the process of history taking. Referencing the patients' health history not only provided a source for an opening statement in an initial encounter between doctors and patients, but it also functioned as a means to gain supplemental knowledge and assisted doctors-in-training in identifying the focus of assessments in their subsequent interactions. The information about the patients may be gained from colleagues and medical records that contained the patient's health history and prior visits.

Using prior knowledge of the patients' health information in the process of history taking

provided three functions: opening, supplemental information, and clarification. Each function

will be discussed in a separate section.

Opening. Referencing existing records of patients' health history was used to open the

conversation in an initial doctor-patient interaction. Two examples are provided to demonstrate

this. The first example is a BPS session between D1 and P1. In the beginning, D1 started the

session by indicating her knowledge of P1's participation in counseling. D1 first confirmed the

knowledge, and then checked in with P1 regarding his experience:

```
(4.33)
2    D1:   [(    )] ((chuckles)) $Ok$ (.)  so I was looking at
3          your chart and >I saw that you've been going< to: your
4          counseling? Se,ssion↑s.
5    P1:   (.) Uh huh
6    D1:   [Tha]t's good (.) an:d >hows that going<?
7          (3.0)
8    P1:   >I think its going, well<.hh =
```

Notice that D1 selectively presented the mental health record in this opening in the context of a

BPS session. The conversation started with D1's statement "so I was looking at your chart,"

followed by what she saw, "I saw that you've been going< to: your counseling? Se,ssion↑s."

After obtaining a confirmation of this knowledge from P1 (line 5), D1 continued with a follow-

up question (line 6) in order to initiate the conversation. Not only did D1's reference to P1's

health record and a detailed report of ways she found those records (line 2–3) open up the

conversation with P1, but this report was also relevant to the goal and the content of the

biopsychosocial evaluation, which includes the patient's psychosocial health and emotional well-

being.

In another example between D5 and P8, D5 incorporated his knowledge of P8's blood

pressure into an opening question in the beginning of the session:

(4.34)
```
1    D5:   how have you been doing?
2    P8:   I am doing ok.
3    D5:   g:ood (0.4) blood pressure a little high (.) yeah?
4    P8:   yeah that's why I want to talk about that. it
           fluctuates
5    D5:   um hm
```

Unlike D1 who informed P1 of the source of her information, D5 did not provide such a

statement but simply used the knowledge to start the conversation. In addition, both D5 and P8

seemed to share the focus of the visit without D5's further solicitation and confirmation. After

the greeting (line 1–2), D5 initiated the topic of blood pressure by simply presenting his

knowledge of P8's blood pressure prior to the encounter (line 3). As can be seen, P8 confirmed

the knowledge with additional description (line 4), without D5's further solicitation.

Supplemental information. Doctors-in-training may use their knowledge of a patient's

history as supplemental information that can assist in conducting both the assessment and the

diagnosis of a patient's presenting issues. Two sessions are presented where doctors-in-training

used this strategy to conduct further assessment for their patients.

First, in the regular visit between D3 and P4, D3 identified P4's critical condition as she

came in to the clinic. After a brief inquiry, D3 started reviewing the electronic record that

contained P4's health history in her subsequent assessment:

(4.35)
```
24   D3:   ok. let me just review your past history (.) one sec
25         (.) so - who's your doctor (.) oh (____) let's see (.)
26         so you have (.) diabetes. depress:ion. anemia. um (.)
27         high cholesterol. thyroid issues. um. do you smoke.
28   P4:   no.
```

In this process, D3 was looking at the record to solicit details of P4's history while confirming

what she saw through recounting the information (line 24–27). Her question to P4, "do you

smoke." was produced as result of the review.

The second example is demonstrated by D5 and P7. This example used previously is reexamined in this section because the process of disclosure reflects the theme. Before the start of the session, D5 learned that P7 recently visited the ER due to a severe allergic reaction. In this session, D5 provided an opening statement regarding his knowledge of P7 and how he obtained such knowledge in order to conduct a further assessment:

```
(4.36)
10   D5:   a:h (.) s:o ah pt (.) my name is (_____) I work with
11         doctor (_____) it's very nice to meet you. I've
12         never met you before. he was telling me about ah all
13         of your medical problems and ah (.) he told me that
           you went to the (.) ER.
14   P7:   um hm
15   D5:   can you tell me what happened - what led you to the
           ER.
```

P7's sense of concern and his intent of focusing on P7's reason at the ER was produced based on a previous record. After a brief greeting (line 10-11) and an acknowledgment of their first encounter (line 11–12), D5 presented his knowledge of P7's health history by referencing a colleague's name (line 12–13). Then, D5 narrowed down the focus of P7's recent critical condition at the ER by asking P7 provided details of the situation (line 15).

Clarification. Doctors-in-training also used prior knowledge of patients' health history to clarify information regarding the presenting health conditions. The following examples show that doctors-in-training used this strategy. First, using the patient's health record to clarify the health history occurred in D4's and P5's interaction. In this initial checkup, D4 appeared to find out P5's last menstrual period, as the information on the record was discrepant with P5's report:

```
(4.37)
13   D4:   alright (0.3) s:oo (.) first (.) things first (.)
14         yo:ur (.) first day of your last menstrual period.
15   P5:   it wa:s December sixth.
16   D4:   sixth not the eighth?
17   P5:   uh-uh.
18   D4:   alright so sixth (.) because some other place I had
```

```
19          the eighth so that's gonna - just anticipate our due
20          date by two days. before I start (.) do you have any
21          questions or concerns.
```

This example shows how health records can be provided and revised through interaction, which then can shape subsequent therapeutic decisions. In this case, clarification of the menstrual period in the first checkup helped D4 determine the due date. On the record, P5's last menstrual period was on the eighth of the month (line 18–19) and this information was revised through her current report and D4's clarification (line 16). Line 19–20 indicates D4's confirmation of the due date based on the information gathered through the current interaction. Trainees' clarifications using previous health records also appeared in general health concerns.

In the regular visit between D5 and P6, D5 intended to find out causes of P6's joint pains. Presenting the patient's previous health records was used in the process of assessment and diagnosis:

(4.38)
```
4    P6:  I have a lot of joint pain.
5    D5:  yeah?
6    P6:  in my back right here and both my knees. I don't know
7         what it is. I don't know
8    D5:  how long - how long have you been struggling with this
9    P6:  about two years.
10   D5:  yeah (.) because I - I was looking through your
11        records and u:m it a:h  it shows that we did a:h a
12        rheumatology consults↑ ah (.) ah (.) just a test a few
13        years ago and everything came back normal.
```

The conversation started with P6's chief complaints regarding joint pain (line 4) with a transition of interaction occurring after D5's inquiry about the timeline (line 8). In this process, D5 reported the record of the examination conducted "a few years ago" and the normal result (line 12–13) as a clarification and additional information for future diagnostic directions regarding P6's presenting symptoms. The above two examples demonstrate how the previous health

records were used for clarifying information, which provided evidence for doctors-in-training to determine the subsequent therapeutic interventions.

This study found that doctors-in-training used prior knowledge of the patients' health information in the process of history taking to accomplish three functions: opening, gathering supplemental information, and clarification. This study found very little evidence of such a strategy being used by counselors-in-training in the sample. Although counselors-in-training may have used the health records of their clients for case conceptualization, they did not, however, use prior knowledge of the patients' health information in the process of clinical interactions, which appears to be a normative practice in medical encounters.

Rapid Responses through Preventive Measure and Report of Treatment Plan

Conventional knowledge regarding a treatment process was illustrated previously through the following pattern: Assessment (problem identification) => diagnosis (problem confirmation) => intervention (problem solution). The data in this study showed a fluid and recursive sequence among assessment, diagnosis, and intervention. As the following examples illustrate, therapeutic intervention was recursive and fluid throughout the treatment process, especially when a health issue or risk was presented at the moment of interaction. This provides evidence that interactions in an initial context are shaped and revised according to the circumstances presented at the moment. In addition, this rapid response was presented through preventive discourse and trainees' report of their treatment proposals. Three examples from doctor-patient interactions demonstrate this practice.

The first excerpt is an interaction between D4 and P5 during assessment. After discovering that P5 was actively using substances during her pregnancy, D4 provided a direct intervention using an overt consequence offering:

(4.39)
```
286  D4:  any weed use.
287  P5:  I smoke weed.
288  D4:  are you still smoking?
289  P5:  uh hm. I know my limit to stop before the baby
          ((laughs))
290  D4:  are we quitting before (.) because otherwise CPS is
291       gonna be involved again.
292  P5:  yeah
```

Line 286 indicated D4's specific focus on checking whether P5 is still actively using, with the question of the present tense "are you still smoking?" Instead of providing a language that confirms her answer, P5 used "um hm" (line 289) followed by an additional explanation that is in alignment with D5's therapeutic standpoint. Without further solicitation of the details of P5's using, D4 provided immediate responses with preventive measures on the issue of CPS. "are we quitting before" provided a therapeutic standpoint that P5 should quit smoking, even though D4 used the pronoun "we." "Because otherwise CPS is gonna be involved again." provided an overt consequence if P5 continued smoking. The sequence of this therapeutic process is summarized through the following formula:

Assessment (problem identification) => intervention (preventive measure)

Doctors-in-training's immediate therapeutic responses and direct interventions also occurred when symptoms were reported. This appears in the second excerpt from the session of D3P3. During assessment of P3's hemorrhage, D3 offered the treatment plan as a response to P3's complaint:

(4.40)
```
92   P3:  it's annoying to sit do:wn for long periods of time on
93        my bottom.
94   D3:  so I can give you a topical steroid to put in the area
95        so it can help you with the itching, but that's not
96        for long term use. do you use Colace or any stool
          softeners?
97   P3:  no
```

Although this interaction took place before the physical examination, D3 intended to report her

treatment plan that specifically aimed at relieving symptoms (line 94–95) after the chief

complaint was provided (line 92–93). Notice that D3 shifted the conversation back to the

assessment and diagnostic process, as indicated by her intent to find out the other possible

symptoms (line 96). The sequence of this therapeutic process is summarized through the

following formula:

Assessment (problem identification) => Intervention (treatment proposal) => Assessment

In another session between D3 and P4, where P4 presented relatively noticeable health

issues, D3 presented rapid and instructional utterances:

```
(4.41)
214  D3:  I'm just going to feel your neck. ok (3) I'm going to
215       get an x-ray on you. (2) ok. I just want to make sure
216       you aren't getting pneumonia or anything else like
217       that ok? ok we're going to take this off.
218       ((machine beeps))
219  P4:  my ears are hurting. they are sore and itchy too.
220  D3:  yeah? let me look in your ears.
```

Accordingly, a physical examination, "I'm just going to feel your neck" along with D3's report

of her intervention, "I'm going to get an x-ray on you" was shown during the interaction. Notice

that in this process, the proposal of conducting an x-ray has both functions, assessment and

preventive measure, as implied by D3's additional explanations, "I just want to make sure you

aren't getting pneumonia or anything else like that" (line 215–216). Then, P4 provided another

problem presentation (line 219), and D3 immediately responded with "yeah?" followed by her

proposed action, "let me look in your ears." The sequence of this therapeutic process is

summarized through the following sequence:

Assessment (problem identification) => Rapid responses (preventive measure and

differential diagnosis) => Chief complaint => Assessment (problem identification)

As the above three examples illustrate, assessment, diagnosis, and treatment process was recursive and fluid. This was especially true in the context of an initial doctor-in-training's session where a health issue or risk that needs immediate attention was identified. In addition, doctors-in-training's therapeutic intents, such as prevention and interventions, were reflected through recursive protocols, rapid responses and reports. This study found very little evidence of this strategy appearing in counseling sessions.

Knowledge Presentation and Education

In addition to providing preventive measures and a rapid response through interventions, doctors-in-training in this sample utilized knowledge presentation and education to convey their therapeutic stance in the process of assessment. Trainees' knowledge presentations included both health knowledge and trainees' observations of patients' behaviors. The style of knowledge presentation and education in talk and interaction is very similar to the report style of speech. It is direct in terms of the content delivery of known and public knowledge to the listener. However, affect presentation and the intention of the speaker to deliver such knowledge is implicit unless they are addressed. The following three excerpts show this feature of interaction.

The first example was displayed by D5 and P8. The two discussed drinking in relation to P8's liver function. D5 indicated alcohol's impacts on liver, and then added the factor of Hepatitis C in his explanation of the how the two may exacerbate P8's liver condition:

```
(4.42)
191  D5:  ok. a:h - do you - are you having any problems with –
192       you mentioned that you have no abdominal pain right?
193  P8:  no abdominal pain.
194  D5:  alright cause you-  when you drink about two or three
195       beers a day (.) alcohol usually affects your liver.
196       and Hep C also affects your liver.
197  P8:  yes.
198  D5:  so you are hitting it from both sides.
199  P8:  oh:hhhh. that makes sense.
```

While the Hep C was an ongoing health issue and a diagnosis that P8 had no control over and no ability to eliminate on his own, having two or three beers a day was a health practice. D5's therapeutic stance on reducing alcohol use was conveyed through the explanation of alcohol's impact on the liver (line 195–196), followed by the conclusion "so you are hitting it from both sides." The conclusion of "hitting it from both sides" indicated that two or three beers a day in conjunction with the existing Hep C diagnosis may result in more damage to the liver. D5 connected the factor of alcohol and Hep C without presenting his view on P8's drinking behaviors, or providing direct, prescribed language with regard to cutting consumption of beers. In this case, the knowledge presentation was direct in the sense of content delivery and expertise, but D5's therapeutic standpoint was not directly expressed in the interaction.

The next excerpt showed some variation with regard to how a doctor-in-training communicated her therapeutic intentions. In the session of D2P2, D2's showed her concern, followed by her knowledge presentation with regard to her observations of P2's mental health condition across different timelines. It is relevant that the patient eventually left the hospital and did not voluntarily admit himself in the unit. After P2 expressed his refusal to be admitted to a hospital, D2 summarized her observations and presented her overt therapeutic standpoint with regard to the decision:

```
(4.43)
1646 P2:   they want to keep me as long as they want to keep me
1647       that's the problem (.) ((smacks the sofa with one
1648       hand)) now I can't g:oo (.) another twelve months in a
           place?
1649       (0.7)
1650 D2:   it could only be a couple of da:ys
1651 P2:   pt .HHH
1652       (2)
1653 D2:   but I'm worried about you (2) okay? when I saw you
1654       back when you had your girlfriend (.) I think you were
1655       a lot better. I see you no::ww (.) and things are
           changing
```

```
1656        (0.5) a lot (0.5) you used to have better control over
1657        voices (0.4) you used to have better control over your
1658        impulses (.) you weren't as angr:y (4.5) and you don't
            want
1659        to hurt anybody (.) but there's no guarant:ees (.) and
1660        if you get ma:d (.) that you won't do something that
1661        you will regret (.) ri:ght?
```

In this process, D2 explicated her proposal of hospital admission through a sequence of

knowledge presentation and affect disclosure. D2 begins by expressing her concerns (line 1653),

then she provides her knowledge of P2's previous conditions to bring up her observations of P2's

stability (line 1653–1655). She then presents the uncertainty of P2's stability at current time,

"there's no guarantee," followed by use of a future tense to describe the scenario (line 1659–

1661).

In an interaction between D4 and P5, D4 displayed the therapeutic stance through

sequences of knowledge presentations with regard to marijuana use as related to depression after

hearing P5's reason for using:

```
(4.44)
358  P5:   I only smoke weed to keep me calm and keep me low
359        stress.
360  P5b:  (no more weed)
361  D4:   no:w the problem with the weed too (.) they think the
362        weed actually increases the greater depression (0.5)
363        yeah (.)  it's all about the chemical balances in your
364        brain. and: you know for the time you are highhhh. you
            kinda of
365        (.) dull down to everything else. you know
366  P5:   I'm like in a little zone and I'm just me.
```

In response to P5's standpoint and reason for using marijuana (line 358–359), D4 provided a

counter-argument. "no:w the problem with the weed too" showed D4's standpoint on P5's using

drugs, followed by the knowledge behind this standpoint, "they think the weed actually increases

the greater depression." As can be seen, the word "they" was used in the context of knowledge

presentation, implying an objective, third party standpoint. The absence of an actual third party

in this conversation implies the distance of D4's standpoint. At the same time, the speech indirectly conveyed D4's intention with her use of the word "problem" in the beginning of the knowledge presentation. Notice that a jointed narrative in describing the physical effect of marijuana was shown through P5's elaboration of her experience. Her statement, "I'm like in a little zone and I'm just me," reflected D4's earlier explanation of the weed, "you kinda of (.) dull down to everything else."

As the above examples indicate, doctors-in-training in this sample displayed immediate responses and instructional linguistic features to communicate interventions under risk assessments and the identification of health issues. Counselors-in-training in this sample displayed divergent utterances and strategies to achieve therapeutic agendas. Specifically, they used reflective, observant, summative, and adjoining linguistic features that were found among counselors-in-training in this study.

Divergence: Counselors-in-Training

Opened Ended Questions in Opening Statements

Unlike doctor-patient sessions where trainees used prior knowledge or the health records of patients during history-taking to start the conversation or form therapeutic directions, counselor-in-training in this sample engaged in taking their clients' health history with open-ended questions without referring to clients' medical records. A total of three examples are provided to show this practice.

In the session of C1P1, C1 started the conversation by asking P1 to talk about himself:

```
(4.45)
1    C1:   al:right well (0.5) u:m why don't we start. U:m (1) pt
2          maybe we just talk a little bit about what's going on
3          with you.
4    P1:   u:m (.) I'm trying to keep my thinking less thinking
5          (.) thinking.
```

Notice that C1 used two types of pronouns in this request, the first-person plural for the action of

talk (line 2) and the second-person singular as the focus of the session (line 3).

In another counseling session where the treatment facility primarily focused on the issue

of addiction, C3 started the session by asking about the reasons for P4's visit:

```
(4.46)
17   C3:   u:m (0.3) s:o (0.3) from there on out what brings you
18         in today.
19   P4:   um (.) addiction (.)
```

An interesting note on this particular sequence is that although C3 provided an open-ended

question that was ostensibly designed for soliciting a more elaborative, descriptive response,

P4's brief answer did not provide any new information, as coming here for "addiction" was

common knowledge shared by both clients and counselors, given the treatment context.

A more elaborate response can be found in C3 and P5's session situated in the same

treatment facility. In this process, C3 presented a similar utterance to start the conversation:

```
(4.47)
1          (3) ((C3 came in the room))
2    C3:   alright (2) ((sits down, puts the document on the
3          desk, and picks up a writing board)) do you mind just
4          briefly telling me what you are here (.) for today.
5    P5:   u:m (0.3) we:ll (0.5) I've been heroin addict (0.4)
6          and I a:hh (0.3) went t:o (0.2) treatment at (_____)
7          (0.4) there back in (.) the end of Januar:y into the
8          beginning of February (.) for two wee:ks and since I
9          have been ou:t .hh( 0.3) I have been - I started using
           aga:in (.) it was like
10         - it wasn't an everyday thing I used to (.) inject it.
```

Unlike P4, P5 provided more narration with regard to the reason for his visit, including details of

his treatment history (line 6–7), relapse (line 9), and use history (line 10).

As the initial session progresses, interventions followed after assessment and history

taking. Two features of talk and interactions, paraphrase, summation, and reflection, as well as

jointly created therapeutic discourses, were found in the counselors-in-training in the sample.

Paraphrase, Summation, and Reflection

In terms of the formation of the session, this study found that counselors-in-training in this sample used paraphrase, summation, and reflection of their observations at a here-and-now moment to convey their therapeutic intention, which diverged from doctors-in-training who primarily utilized health education and knowledge to convey a therapeutic stance. This study selects three examples to demonstrate this talk feature.

The first example is an interaction between P3 and C2, where P3 described her husband's controlling behaviors. After hearing P3's narration, C2 summarized P3's statement with a reflection that focused on P3's affective experience of the relational dynamic between the two:

```
(4.48)
225  P3:  he'll be there (.) I hope I can trust you to come
226       right back home after work (.) I mean you know (.) I
227       need that car. (0.2) !how do I know you will! I said
          (.) (_____)
228       I already told you that I would (.) okay? don't keep
229       doing this to me. don't ask me this again (.) and he
          will anyway.
230  C2:  sounds like you feel controlled (0.5) like he's trying
231       to control your behaviors and kind of monitor
232       everything you're doing.
233  P3:  yeah (.) he's trying to (.) control my existence. I
234       mean it -  it's got:ten worse because he feels - I'm
235       pulling away from him more. I don't even listen to him
          anymore.
```

C2's response, "sounds like you feel controlled" indicates C2's speculation of P3's emotional state and an interpretation of the relational dynamic. Notice that C2 did not provide any knowledge component regarding the controlling intimate relationship, but simply provided her observation based on what she heard from P3 in the process. As the issues of power and control were introduced by C2, more details of the relational dynamic between P3 and her husband were revealed. The narration continued to develop as P3 elaborated her sense of being controlled (line 233) and her growing resistance toward the relationship (line 234–235).

After P3 provided more examples related to power and control between her and her husband, C2 summarized the collection of examples provided by P3 and highlighted her interpretations of the intentions behind presenting behaviors:

```
(4.49)
317 C2:  it sounds like he takes a lot of different things (.)
318      like the do:g. your jo:b. phone calls from others. The
319      ca:r. the basement situation and uses those things as
320      and- he finds excuses to kind of -  to get you to do
321      what he wants. which is to have you there.
322 P3:  right.
```

"it sounds like" was again used by C2 to initiate her therapeutic responses that contain observations of the husband's behaviors (line 318–321) and P3's power position in this relationship.

The second example occurred within the session of C3P5. In the following interaction, C3 paraphrased the psychological experience of craving while P5 talked about relapse:

```
(4.50)
53  C3:  and your addiction takes hold. you are like you know
54       what? this is what needs to happen right now.
55  P5:  y:eah
56  C3:  I have got some extra cash for me to go make this
57       happen.
58  P5:  exactly. yeah (.) exactly like I said (.).hh I - I was
59       three weeks (.) cle:an. I mean I used to be on (.)
         suboxone.
60  C3:  um hm
```

Without providing knowledge and psycho-education regarding relapse, or providing preventive measures, C3 simply adjoined P5's narration by paraphrasing the psychological process of relapse (line 53–54), followed by a first person narration, "I have got some extra cash for me to go make this happen." Recall that in the session of D4P5 discussed earlier, the pronoun "they" was used to present medical knowledge in order to convey the clinician's therapeutic intent.

Notice that in this example, the first-person pronoun was used by C3 to highlight a perspective-taking statement and his intent to understand P5's lived experience of relapse.

A similar strategy can be found in the session of C3P4. In this interaction, P4 described his lack of engagement in previous treatment programs. C3 further elaborated the experiences of mandated treatment:

```
(4.51)
54   C3:   so you were kinda doing it (.) just to [me:et (.) the
55         expectations (.) of the legal system.          ]
56   P4:                                        [yeah (.) just
57         - just (.) yeah (.) absolutely (.) ju - yep
58         (.)absolutely.](.) just to get by with her
59         (.) that was it (.) probation.
60   C3:   um hm (.) that seems like something
61         when you look back
62         on it (.) it was kind of like (1) there-  there's a
63         little bit of you wish you did mo:re↑
64   P4:   yeah
```

Overlapped speech occurred (line 54 and 56) when C3 paraphrased the experiences of mandatory treatment (line 54–55). Then, P4 acknowledged the paraphrase by adding an elaboration of his experience, "just to get by with her (.) that was it (.) probation." It is evident that after getting a confirmation from P4 that C3 had an accurate understanding of P4's experience, C3 provided a therapeutic intervention through a reflective statement, "there's a little bit of you wish you did mo:re↑" This reflective statement provided two therapeutic functions. First, it indicated C3's faith in P4's autonomy of the treatment as opposed to mandatory. Secondly, it reinforced C3's therapeutic direction that helped P4 engage self-efficacy for his recovery.

As the above examples illustrate, the divergent practice of the therapeutic process in terms of the formation of the initial session between doctors-in-training and counselors-in-training is evident. While doctors-in-training utilized health education and knowledge to convey a therapeutic stance in the process of assessment, counselors-in-training used paraphrase,

summation, and reflection of their observations. Note that this is not to say that such a strategy is absent in doctors-in-training in this sample. However, this study found that doctors-in-training tended to use such a strategy in the middle stage of the session, where patients' disclosures occurred. Thus, readers will find more detailed discussions of this process in chapter V and VI.

This phenomenon is also parallel to the selection of therapeutic materials. Health education and knowledge are public knowledge and institutional language, which require selections and sorting relevance for content delivery. Presenting facts seems to be a primary method in health education, whereas paraphrase, summation, and reflection require attention to detailed materials produced or occurring in a here-and-now moment. More affective components of language appeared in this type of conversation.

Co-Created Therapeutic Discourses

While doctors-in-training referenced medical knowledge and patients' health history in conveying therapeutic agendas, counselors-in-training presented their therapeutic stances and interventions through the knowledge and information that emerged during interactions. The following three examples demonstrate this theme.

The first excerpt shows the sequences of how the concept of guilt was introduced and discussed in the process of interaction between C3 and P5:

```
(4.52)
305  C3:  um hm. so (.) you are at the point where you were like
306       yeah  before you were like this a functioning (.
307       )functioning addict (.) right?
308  P5:  yeah
309  C3:  and now you are at this point where you have had
310       issues in your relationshi:p. you have had issues with
311       other family members. you said you were stealing you
312       have done some bad things you were saying
313  P5:  right.
314  C3:  and now you are kinda sitting with all of this gui:lt
315       and (.) some other things. it sounds like there is
316       more and more to it than just guilt. it's it's really
```

```
317        made you question this whole thing and want to work on
318        staying clean.
```

In this interaction, C3 used information presented by P5 in the session and engaged in a series of

confirmations before he introduced the therapeutic intervention. First, he confirmed with P5 the

state of being a functioning addict (line 305–307). Next, C3 confirmed with P5 that the state of

function was falling apart due to emerging relational conflicts with significant others (line 309–

311) as well as emerging behavioral issues associated with relapse (line 311–312). The

therapeutic standpoint was introduced with two components. Accordingly, C3 mentioned the

guilt (line 314–315), followed by a reflective statement, "it sounds like there is more and more to

it than just guilt". Finally, the goal of recovery was added as a conclusion after the sequence of

confirmations and reflections (line 317–318).

The co-created therapeutic interventions through trainees' use of knowledge that emerged

in the session appeared in another session related to addiction and recovery. After P1 linked his

addiction to the history of abuse, C1 used the information to analyze the meaning of reality and

accountability:

```
(4.53)
172  C1:  ok so let me ask you this because I just want to make
173        sure that I understand and that there is a clear
174        distinction. .hhhh (1) the way you perceive reality
           today
175        (0.5)  is it driven from the abuse or (.) o:r are you
176        taking that abuse and att:aching it to your reality
177        today and saying because of that -  you know (0.3) I
           don't want
178        to be responsible. I don't want to move on. and I'm
179        trying to get a real reading because at times it
           sounds like -  ok
180        and now I've heard – I have heard - you say that no
181        longer (.) can I blame. okay?
```

By using P1's account of abuse in relation to the issue of addiction, C1 intended to make "a clear

distinction." C1 first elaborated his question of the link, "is it driven from the abuse or (.) o:r are

you taking that abuse and att:aching it to your reality today." Then, he provided a statement that appeared to highlight P1's accountability, "I'm trying to get a real reading because at times it sounds like - ok and now I've heard – I have heard - you say that no longer (.) can I blame." Accordingly, "a clear distinction" referred to the current time and accountability versus the past and abuse history. C1 seemed to redirect P1's focus by adding perspectives of accountability and reality in relation to the issue of addiction.

The production of a therapeutic stance through knowledge that emerged in the interaction can be found in C2's statement in the middle of the session. After P3 provided various examples of the ongoing threats and agitation in her martial relationship, C2 presented her perspective based on the examples gathered from P3:

```
(4.54)
422  C2:  I wouldn't normally say this on a first session (.)
423        but I'm going to (.) just because some of this stuff
424        that you've said to me about the police visits and him
425        being violent.pt He sounds like (1)he sounds like an
426        (.) abusive person. and it sounds like you're in –
427        regardless that it hasn't physically happened. There
428        hasn't been an actual physical injury yet (.) but it
429        sounds like he in some ways is a domestically violent
430        (.) person (.) to you. like (.)psychologically. I mean
431        (.) that must be really scary that he was threatening
432        you with various weapons your husband I mean. and so
433        (.)  you kind of said I'm a little bit worried about
434        this divorcing and how he's going to handle it.
```

After the comments of the unusual situation (line 422), C2 presented her therapeutic standpoint regarding risk and harm based on examples and incidents provided by P3 (line 423–425). Then, C2 added therapeutic standpoints, "he sounds like an (.) abusive person." (line 425–426) and highlight concerns about safety with, "that must be really scary that he was threatening you with various weapons" (line 431–432), after the presentation of the examples provided by P3.

Unlike the trainee's direct response regarding the involvement of the child protection service to prevent the patient's use of marijuana in the example of D4P5 that was mentioned previously, C2's therapeutic intervention regarding a safety plan occurred after the presentation of list of examples provided by P3 that indicated potential harm. After the summary of examples and the presentation of a therapeutic standpoint, C2 introduced the issue of safety with a stressed tone in the following statement:

```
(4.55)
437  C2:  my encouragement to you would be to maybe make (1)
438       like I don't know we could do it in
439       he:re or you know whatever, but talk about a safe way
440       to have that happen.
```

As the above examples indicated, counselors-in-training appear to use knowledge and information that has emerged during interactions to convey their therapeutic stances and interventions, which is different from doctors-in-training's references to medical knowledge and patients' health history in presenting therapeutic agendas.

Summary of Formation of Initial Sessions: Divergence

This study found a total of six divergent practices occurring in initial sessions across family medicine and counseling. Doctors-in-training used prior knowledge of patients' health and health records, rapid responses and reports, as well as knowledge presentation and education in providing therapeutic interventions. Counselors-in-training appeared to present open-ended questions, the use of paraphrase, summation, and reflection, as well as co-created therapeutic discourses in their initial sessions.

Within the collective norm and professional practices in the formation of therapeutic interactions, individual variations existed. The next section will present the second component of the first research question: how do individual trainees negotiate between professional norms and

interactions present at the moment in order to achieve therapeutic tasks and goals in initial

sessions?

<center>**Section Two:**</center>

<center>**Individual Trainees' Negotiations between Professional Norms and Interactions**</center>

This section intends to explore the additional strategies or atypical practices used by

individual trainees during initial sessions in order to achieve therapeutic aims while maintaining

interactions. The analytic process involved an overall review of the data across the two

professions, followed by identifying strategies used by individual trainees. Note that while some

strategies were used by particular trainees at an individual level, others were shared by trainees

across two professions.

The report of the findings follow based on themes, with examples displayed by a single

individual trainee or trainees across two professions. A total of four themes were identified that

show individual trainees' negotiation between professional norms and interactions at the

moment. These four themes are transforming here-and-now moments to therapeutic agendas,

prioritization, transferring ownership of therapeutic actions, and humor. The first three strategies,

transforming here and now to therapeutic agendas, prioritization, and transferring ownership of

therapeutic actions were found in sessions conducted by individual trainees, with the first

strategy presented by a doctor-in-training, and the remaining two presented by individual

counseling trainees. Humor was found in individual trainees across the two professions,

presented by two doctors-in-training and counselors-in-training, respectively.

Transforming Here-and-Now Moments to Therapeutic Agendas

This study found that one doctor-in-training used materials that occurred in a here-and-

now moment to conduct further assessment, which did not exist in other doctor-patient

interactions in the sample. Managing here-and-now interactions and transforming the presenting

dynamic into therapeutic processes occurred in the session of D2P2 where the dyad was

discussing P2's coping strategy while sensing threats. During the conversation, P2's cellphone

rang and he started talking on the phone in the middle of the session:

```
(4.56)
1179 D2:  [like people that] are
1180      bigger than you [you would have no] problem kicking
          them out?                          ]
1181 P2:                  [YEAH I feel
1182      like   .hhh (( shakes his head))] taking them DOWN
          ((P2's cellphone rings; P2 smashes the backpack and
1183      picks up the cellphone))
1184 P2:  FUCK (.) YO [((looks at the cellphone))] [it's my
          boy.]
1185 D2:              [          you're good.     ] [(
1186      )] you are go:od.
1187 P2:  yeah. HEY ((talks to the cellphone))
1188 D2:  just tell him we're busy.
1189 P2:  I am with – I am with the doctor right now talking to
          – to my doctor right now
1190      (3)
1191 P2:  that – THAT's Y:O
1192      MA:A:N↑↑↑
1193      (2)
1194 P2:  I AM O::UT A:HH (.)
1195      alright (.) K. ((hangs up))
1196 D2:  who was tha:t
1197 P2:  huh?
1198 D2:  who was that.
1199 P2:  one of my friends.
1200 D2:  one of your friends.
1201 P2:  well at least he wants to be my friend (1) I don't
1202      trust him either.
1203 D2:  you don't trust anybody.
1204 P2:  no.
```

After a rather intense phone conversation between P2 and his friend (line 1191–1195), D2

inquired about P2's relationship with the person (line 1196). She then quickly provided her

observation, "you don't trust anybody" (line 1203), after P2's comments about his not trusting

the friend yet. This interaction was relevant to the topic of P2's sense of safety and response to

threats discussed prior to the phone call. In addition, it connected to the conversation later when P2 started discussing his relationship with this friend and his past experience at a treatment program.

Accordingly, this interaction is unusual in the context of an initial session in two ways. First, the uncertainty of the therapeutic relationship is present in the context of a first encounter. Conventionally speaking, a relatively polite, formal discourse is typical in a first encounter. P2 did not conform to such a typical social norm in this interaction. In response to P2's behaviors, D2 appeared to be present and relatively forthcoming toward her intervention. This is different from a relatively formal and polite discourse presented by other trainees such as D3, D5, C2, and C3.

Prioritization

Clinicians in an initial session constantly encounter the need for prioritization and decision-making. Both involve attending to clients' concerns, building rapport and trust, and completing therapeutic tasks. In some situations, trainees may choose to attend to the present conversations and building relationships before the completion of the other tasks. This unique practice appeared in C3 and P5's session where C3 conducted the assessment from the questionnaires near the end. Accordingly, C3 used the majority of the session to conduct the assessment, complete history taking, and explore life stories disclosed by P5. As a result, one of the required tasks for the initial session, the completion of the BPS assessment form, was conducted near the end of the session:

```
(4.57)
654 C3:    a little – a little few more steps to go.
655 P5:    yeah. yeah (.) yeah
656 C3:    but you are almost there.
657 P5:    yes. that's how I feel. (4) yeah
658        (4)
659 C3:    well I am (.) supposed to go through this the
```

```
660        biospychosocial with you. $so$-
661 P5:    oh rea:lly
662 C3:    yes.
663 P5:    okay.
664 C3:    so again (.) this is kind of like pretty dry stuff. so
665        I am going to run through it as quickly and as
666        painlessly as possible
667 P5:    alright.
668 C3:    we talked about a lot today. a lot of information.
669        There might be some I can skip over. u:m Do you have
670        any children?
671 P5:    no.
```

Throughout the session, C3 had used the BPS model to conduct the session, despite not following the order of the assessment questionnaire provided by the institution. In this particular interaction, C3 summarized the therapeutic goals with P5 (line 654–656). After a period of silence (line 658), C3 introduced the agenda – the BPS assessment questionnaires that he is "supposed to go through" (line 659). Notice that C3 cautioned P5 that going through the BPS questionnaire "is kind of like pretty dry stuff" (line 664) with an emphasis that he will "run through it as quickly and as painlessly as possible" (line 665–666). Supporting that, C3's explanation also appeared in another session that C3 conducted. This indicates an individual level of prioritization and decision-making processes when using institutional protocols. C3's priority appeared to be getting to know the client in a semi-structured clinical interview format while building a relationship, followed by the completion of assessment questionnaires.

Clinicians in an initial session constantly negotiated different priorities. These included, but were not limited to, attending to clients' concerns, rapport building, and conducting a variety of therapeutic tasks. C3 appeared to be unique with regard to attending to present conversations and relationship building over completion of institutional tasks.

Transferring Ownership of Therapeutic Actions

The second strategy, transferring ownership of therapeutic actions, was found in the

session of C1P1. In the counseling process, counselors try to create a therapeutic environment

that helps a client engage in self-reflection and gain insight. By and large, counselors try to

support clients to make their own decisions, as opposed to prescribe the decisions. Transferring

ownership is a unique presentation different from conventional counseling practice. The trainee

first introduced therapeutic agendas and then reinforced the client's accountability to own such

therapeutic actions by claiming to use the client's words.

This strategy is displayed through turn-taking and the sequence of interactions between

C1 and P1. The following examples demonstrate how the therapeutic action was first proposed

by C1 and later transferred to P1 as his words. First, the two discussed P1's behaviors of using

his phone to search for pornography. C1 offered his therapeutic intervention regarding limiting

the function of the phone:

```
(4.58)
791  C1:  because the real use of a phone is to make calls (.)
792        receive calls (.) you know. but if I'm someone that
793        likes to use it to look up porno:graphy and I'm trying
794        to get away from that (.) u:m probably the first thing
795        I'm gonna do is get a ph:one that I can just make
796        calls and receive calls off of.
797        (2)
798  P1:  I get it.
799  C1:  see (.) so -
800  P1:  ((coughs)) you're right just get one of the phones
801        where they call and can't get – get-  on Google or
              nothing.
802  C1:  well I'm not telling you what to do. I'm just saying
803        if you're trying to mo:ve (.) away from that (.) then
804        just like you did in your recovery (.) you've got to
805        put safety nets around you. you don't keep drugs in
806        your house. You don't keep alcohol in your house.
```

Notice that C1 used the first-person pronoun in explaining the intervention related to limiting exposures to the source addiction. This is evident in line 792–796, "I'm someone that likes to use it to look up porno:graphy and I'm trying to get away from that (.) u:m probably the first thing I'm gonna do is get a ph:one that I can just make calls and receive calls off of." After C1's proposed intervention, to "get a ph:one that I can just make calls and receive calls off of" (line 795–796), P1 displayed his agreement with C1 and confirmed his action to get a phone with basic functions (line 798 and 800). Then, C1 retracted his position by noting P1 that "I'm not telling you what to do" (line 802) followed by another proposal of action concerning drinking and using drugs (line 805–806).

In a later interaction, P1 again expressed his agreement with C1, following an elaboration of his understanding of the proposed intervention with regard to choice:

```
(4.59)
883 P1:   your suggestion is right. don't get a phone because
884       here it is Friday. I get a phone at Metro PS
          smartphone.
885       trade in this phone that I got access to. but man (.)
886       then I say boy (.) you - then it goes back to here.
          you're  choosing
887       (.) a choice. over here's a choice and all my choicea
888       was based upon what. using. where we come from –
          people taught
889       us how to use. you learn it. people taught us all
890       these things. now here is on this side (.) recovery
          (.) you  got to
891       gravitate to (.) like you're saying. people teaching
892       ((claps)) you how ((claps)) to live.
893 C1:   well I'm really just repeating everything that you're
894       saying and you're saying it. I'm just repeating it.
895       And that's what happens. a lot of times when we shar.,
896       when we talk. I mean (.) we - we're saying it but
897       we're not getting it.
```

It is evident that P1 perceived C1's intervention as C1's intent to make a suggestion, not repeating P1's own words, as indicated by his first reaction "your suggestion is right" (line 883).

In addition, P1's elaboration of the issue of choice contains two statements regarding using and recovery. For using, the statement of "people taught us how to use. you learn it" (line 888–889) was parallel to his statement concerning recovery, "now here is on this side (.) recovery (.) you got to gravitate to (.) like you're saying. people teaching ((claps)) you how ((claps)) to live" (line 890–892). Both statements share something in common, that is, P1's position of being a "follower" in the state of using, as well as in the state of recovery. This is consistent with his repeating amenable positons toward C1's proposals. P1's emphasis on being in agreement with C1's position and C1's emphasis of "just repeating" P1's words indicate nonalignment between the two in terms of the ownership of the therapeutic discourses.

Instead of acknowledging P1's position as a follower by highlighting P1's agreement with the given suggestions (line 883), C1 again negated the position of leading by highlighting P1's ownership of the intervention, which was given by C1 previously (line 893–894). Though the thought process behind C1's transferring ownership to P1 is not clear, C1 emphasized his standpoint of being a repeater. Meanwhile, the statement "we're saying it but we're not getting it." (line 896–897), which appeared at the end of the talk, suggests C1's therapeutic purpose that encouraged P1 to be an active agent of recovery, or to take ownership of therapeutic actions. Notice that the use of the pronoun "we" at the end implied a collaborative, shared responsibility of such ownership.

Transferring ownership of therapeutic actions was a unique strategy that appeared in the session of C1P1 where C1 repeatedly provided therapeutic interventions, but retracted the ownership and proclaimed the client as the owner of the therapeutic statements. This strategy may be used to highlight the client's responsibility and reinforce the changes. At the same time,

it may reflect the trainee's discomfort with the power in a therapeutic position and the use of such for making suggestions.

Humor

Humor appeared in multiple interactions across both professions in this study. The analysis showed that humor had several therapeutic functions that intersected with the therapeutic tasks happening at the time of interaction. Trainees appeared to use humor for the following therapeutic goals: soliciting answers and details of health history, conveying therapeutic agenda in a non-threatening way, and conveying understanding and acceptance. A total of four trainees used humor as a strategy in their initial encounter with their patients/clients.

Soliciting answers and details. This study found that two doctors-in-training used humor in the process of history taking while obtaining information from the patient. The first example is the interaction displayed by D1 and P1. During the assessment regarding P1's family history of psychiatric diagnoses, P1 responded with the word "nut." D1 then used humor to express her intent to obtain diagnostic language from P1:

```
(4.60)
692  D1: u:m any ahh (.) other (.) anyone else in your family
693      have a:ny (.) u:m psy- psych history at a:ll or have to
694      be hospitalized (1) for a:ny like (1) psych (.) issues?
695  P1: a:hh .hh
696  D1: anyone on your mom's side or your dad's side?
697  P1: my mom side. her sister you know our aunt she's she's a
698      total nut ((chuckles))
699  D1: ok (1) can y::ou ex:plain fur:th:er ((chuckles with
          hand gestures))
700      $ I can't write that on the chart $ ((chuckles))
```

In this excerpt, the humor was first introduced by P1 by displaying casual language and laughter (line 697–698), then was co-created in the process of interaction. For example, D1's speech pattern changed from a formal, institutional question, "anyone else in your family have a:ny (.) u:m psy- psych history at a:ll or have to be hospitalized" to a casual, animated expression (line

699–700) after P1's ordinary speech, "she's a total nut." While engaging in a relatively ordinary

interaction, D1 intended to accomplish the therapeutic agenda concerning P1's family history, as

evident by her request for details (line 699) and her comments to P1's answer (line 700). While

engaging in the humorous interaction, the dyad seemed to share the unspoken knowledge

regarding the word "nut" as an informal expression not appropriate to be used in formal,

institutional documentation.

Humor can also be shown through a dramatic, animated utterance as a way to relieve

potential anxiety concerning the questions. In the session between D4 and the couple, P5 and

P5b, D4 intended to assess P5b's family history. A series of laughs was presented by the couple,

followed by D4's animated expressions:

```
(4.61)
435  D4:  alright. ((talks to P5b))(__) is this your first baby?
436  P5b: no.
437  D4:  how many babies do you have.
438       (3)
439  D4:  !o:h the list is going to be lon:g!
440  P5:  ((laughs))
441  P5b: ((laughs)) (.) nine.
442  D4:  !NINE! (2) alright what's the ages.
443  P5:  ((laughs))
```

The answer was provided through a sequence of humor. After the question about how many

babies (line 437), a moment of silence occurred (line 438), suggesting possible hesitation. A

sequence of humorous interactions occurred after the brief silence. First, D4 broke the silence by

providing an animated comment, "!o:h the list is going to be lon:g!" The answer was revealed

after the couple's laughter (line 440–441). Then D4 reinforced the humorous atmosphere by

adding another animated expression: "!NINE!" Instead of presenting a rather formal,

mechanical, question and answer format of interaction during assessment in the initial clinical

session, both D4 and the patients seemed to jointly create the humorous atmosphere to process

the question concerning number of children, which can potentially be an anxiety-provoking conversation in an initial encounter.

When trainees intended to solicit details of health information that they did not get in the first place when the question was introduced, animated speech and humorous interactions were provided to obtain the responses from the client/patient. Two doctors-in-training appeared to use such a strategy in the context of history taking.

Conveying therapeutic agendas. In some situations, humor can be used to convey therapeutic agendas. This was found from the same two doctors-in-training, D1 and D4, discussed in the previous section. The first excerpt was during D4's evaluation of P5's past experience of domestic violence. After knowing P5b, the partner of P5, who provided support for P5 during the midst of crisis, D4 displayed her affirmation of P5b's behavior through humor:

```
(4.62)
250  D4:  and the CPS case is already closed.
251  P5:  yeah. they basically gave me an option (.) choo:se the
252       kids or him. I chose my babies.
253  D4:  ((talks to P5b))!u:m! good (0.4) Good. good job (__) I
254       like you already
255  P5:  ((laughs))
```

Line 253 shows D4's animated and overt expression of "liking" P5b. Such process brought therapeutic connection between D4 and the couple. At the same time, by exaggerating her tone of voice, D4 was also conveying her intent to create alliance and her therapeutic stance in terms of how the couple should react toward violence.

Using humor to convey trainees' agendas can be found in P1 and D1's interaction where P1 was describing his annoyance toward his brother who, according to P1, tried to enforce healthy practices at home. When P1 indicated one of the practices is cutting down on soda and snacks, D1 displayed her agreement with humor:

(4.63)
```
262  P1:  .hh my brother though .hhhh he's he's a real pain in
263       the [ ass↓           ]
264  D1:       [((chuckles))] $ why is he $
265  P1:  ahh .hhh he's O:C:D (.) very OCD: and he has a
266       pho:bi:a: of germs (.) the house being dir↑ty, I mean
267       he does a lot of cleaning but he doesn't do anything
268       else I mean (1) I mean right now he's in his fitness
269       or health fit attitude↑ he doesn't want (2) .hhh any
270       soda↑ any snacks↑ or any fat↑ an -
271  D1:  [that SHOULD HELP↑ YOU. ((chuckles))
```

The humor was jointly achieved through the discussion of health practice and the role reversal of language use. Notice that P1 used the word "OCD,' which is a formal, diagnostic term referring to obsessive compulsive disorder, in an interaction that is rather ordinary and laid back. In addition, D1's response neither confirmed nor disagreed with P1's perception of his brother. Instead, a humorous utterance with animated speech, "that SHOULD HELP↑ YOU," was used to reinforce her therapeutic goal that P1 should cut snacks and stay fit.

The two doctors-in-training, D4 and D1, appeared to use humor in the process of assessment and interventions. This included soliciting health information as well as displaying therapeutic discourses in a non-threatening way.

Conveying understanding and acceptance. Humor can be used to convey understanding and acceptance of clients' symptoms in the context of initial sessions. The laughter occurred during questions and answers regarding symptoms that may relieve anxiety and the intensity of the topic. Three examples from counselors-in-training are presented.

The first example occurred between C2 and P3 where P3 indicated her feeling of unease and guilt regarding her extra-marital relationship. Later during assessment, C2 asked questions related to a list of emotions:

```
(4.64)
653  C2:   guilt
654        (1)
655  P3:   ((laughs))
656  C2:   $I'm going to go with yes on that one based on the
657        face you just made$ ((laughs))
```

A second long silence occurred after the question of "guilt" was asked, followed by both P3's

laughter and C2's comments. The laughter was an indication of a shared understanding and a

sense of acceptance of P3's presenting issues.

Similarly, shared laughter and the trainee's humorous comment on the client's behavior

can be found in the conversation related to P4's history of being expelled from an elementary

school:

```
(4.65)
335  P4:   they told me (.) you know I was gone and I can't come
336        back. they sent me to another school. ((laughs))
337  C3:   $ so what happened there? ((laughs)) what did you[do
338        to get expelled?      $]
339  P4:                                                   [just
340        just  I   -  fighting] I'd fight (.) get into [fights]
341  C3:                                                 [ ok   ]
```

As can be seen, the shared moment began with P4's initiation of laughter, followed by C3's

display of the same reaction. Later in the session, P4 described the process of his relapse and

how he dealt with the lies from his friend and colleagues. C3 adjoined the conversation with

humor and laughter. In this process, humor seems to help explain a difficult behavior that can

potentially elicit negative social judgment:

```
(4.66)
1091  C3:   [.hhhh ((smiles)) $make up some excuse $]
1092        $maybe
1093        ((laughs)) this sounds believable to yo:u but -
1094  P4:   yeah (.) it sounds believable to me but they're
1095        probably like -pt ((laughs))
1096  C3:   $he's full of shit$ ((laughs))
1097  P4:   yeah.
1098  C3:   ((laughs))
```

Instead of using formal, institutional therapeutic language such as conveying understanding, exploring emotions from the disclosure, or reflective statements, C3 in this process utilized swear words (line 1096) and casual interactions through both verbal and nonverbal expressions (line 1093 and 1098). Humor in this process seems to assist both speakers in explaining and comprehending difficult or socially undesirable behaviors.

The above three examples showed that humor was used by counselors-in-training to convey understanding and acceptance of clients' symptoms and presenting behaviors in the context of initial sessions. Humor not only helped relieve some potential anxiety regarding the relational dynamics at the moment of disclosure, but it also helped trainees and clients process difficult subjects and psychological experiences. Using laughter and casual conversation may possibly help relieve anxiety and the intensity of the topic, as displaying symptoms and talking about problematic behaviors is an emotional and socially vulnerable experience.

Summary of Formation of Interactions

Chapter four demonstrated the process and development of talk and interactions in the initial clinical encounters between trainees and their clients/patients in the context of counseling and family medicine. Data analysis indicated both convergent and divergent practices with regard to session formation and maintenance. Convergent practices included history taking, behavioral health and the biopsychosocial approach, requesting details, recapitulation, and casual conversations. Divergent practices included the presentations of prior knowledge of patients' health and health records, rapid responses through preventive measures and report of treatment plan, knowledge presentation and education, opened ended questions in opening statements, paraphrase, summation, and reflection, and co-created therapeutic discourses.

Within the collective norms and professional practices, individual variations and unique strategies, such as transforming here-and-now moments to therapeutic agendas, prioritization, transferring ownership of therapeutic actions, and humor, appeared in the sample. These additional strategies or atypical practices used by individual trainees during initial sessions appeared to achieve therapeutic aims while maintaining interactions presented at the moment.

As the sessions progressed, therapeutic discourses and relationships emerged. As a result, trainees and patients/clients encountered more intensive interpersonal interactions and therapeutic processes. The next chapter will continue to explore the convergent and divergent themes between doctor-patient and counselor-client interactions.

CHAPTER V

Therapeutic Relationship and Discourse

The second analytic chapter reports the findings regarding the second research question: how are therapeutic relationships and therapeutic discourses developed in initial sessions? The emerging themes include both family medicine and counseling. There will be a total of nine themes discussed with examples; seven themes were found in convergence, and two divergent themes were found between family medicine and counseling. This chapter will first report the convergence and then the divergence of practice. Discussion and presentation of the examples will be organized according to the discussed themes as opposed to the context of family medicine and counseling. However, in the divergent themes where distinctive features of practices were presented, the discussion will start with doctors-in-training first followed by counselors-in-training.

Therapeutic Relationship and Discourse: Convergence

This section will demonstrate how trainees and their clients/patients jointly formed a therapeutic relationship in the context of the initial session. A total of seven identified themes are shared by both professions in terms of how a therapeutic discourse was created and shaped by the dyad in their initial encounters. The seven themes are discussing former therapists/clinicians, relational utterances and interactions, neutrality, validation, disclosure of personal perspectives and information, display of reactions, and repair. The first theme, discussing former therapists/clinicians, was primary presented by patients/clients; the rest of the six themes focused on trainees' talk and interaction.

Discussing Former Clinicians

Inquiring about treatment history is part of the protocol of assessment. At the same time, this procedure may inevitably elicit clients'/patients' recollection of their former therapists or other clinicians they have encountered. The analysis of therapeutic interactions in this study showed that the conversations regarding former and/or other clinicians occurred in initial sessions across the two professions. In some cases, clients/patients initiated such conversations in order to communicate personal perspectives with the trainee. The following four examples demonstrate this phenomenon.

The first example is illustrated by C2 and P3 during history taking. C2 inquired about P3's past history of counseling. The question led P3 to reveal her experience with the therapist:

```
(5.1)
323  C2:  okay. have you been in therapy before?
324  P3:  I was in therapy yeah ( 5 ) I guess it was around in
325       (1) like twenty years ago.
326  C2:  so you haven't been to any since all of these problems
327       have arose with him?
328  P3:  because I really don't want to go and meet with any
329       therapist because I really (.) like the one I had and
330       I couldn't g:o (0.5) back to him anymore because he
331       doesn't take my insurance I (.) really liked him I
            don't know if
332       you've ever heard of him (.) (_____) he was pretty -
333  C2:  good (.) you guys clicked (.) it sounds like.
334  P3:  yeah.
335  C2:  that's important.
336  P3:  he was very nice.
```

After hearing P3's positive comments regarding her former therapist, C2 validated P3's perspectives and shared her agreement about the significance of the "clicked" relationship. The word "click" was stressed during the interaction, indicating C2's attention to P3's positive experience.

Mentioning a former clinician can be found in a regular doctor's visit as well. In the beginning of the session between D3 and P3, P3 brought up her former doctor. A sense of grief about the unfinished termination was revealed:

```
(5.2)
5    D3:  so who's your doctor.
6    P3:  um (.) I don't know↑
7    D3:  you see someone new every day?
8    P3:  my doctor changed↑ on me. I didn't know she left I
9         didn't get to say goodbye↑ doctor (___) was my doctor.
10   D3:  oh really? she was wonderful.
11   P3:  yeah I love her.
12   D3:  she was really good.
```

Notice that in the initial response, P3 presented a different scenario that implied an absence of her knowledge regarding the identity of her doctor, as reflected by her statement, "um (.) I don't know↑" however, after D3's clarification (line 7), it became clear that P3 knew her doctor and remembered not being able to say goodbye (line 8–9). While mentioning her former doctor, the word "change" and "goodbye' were stressed with rising tone, implying a significant impact of the person on P3. This is also evident through P3's comment about the doctor (line 11). Similar to C2's reaction, D3 provided validation and a shared perspective on P3's experiences with her former doctor (line 12).

Bringing up former clinicians or previous therapeutic processes to the new therapist can be used to negotiate therapeutic directions or to convey personal perspectives regarding current therapeutic process. Two examples illustrate this. First, in the session of C1P1, P1 talked about the former therapist's approach as a way to call for guidance:

```
(5.3)
658  C1:  you wouldn't go.
659  P1:  I wouldn't go till one day you know. it started over
660       her (.) the therapist. just like you. the therapist
661       said you know what (.) let her gui:de me. and that (.)
          so it's so - there's the same process. I got to let
662       somebody guide me. cause I don't know. I don't know.
```

```
663        so this is familiar here. so they told me the closed
664        mouth told me you know what it is (.) I'm lost and I
665        always will be lost if I go
666        back to my thinking here. it said you know what, I
667        need help. guide me.
```

In this process, P1 first presented what the therapist had told him (line 660–661). Then, he

presented his agreement with this perspective (line 662). After this, the ownership of the

guidance was changed from the pronoun "her" to "it" when he presented his request for guidance

from C1 (line 666).

Clients' negotiation of their personal position in a therapeutic process can be found in

P1's disclosure of his prior conversations with his therapist in a BPS session with D1, who was

the physician of P1. The following excerpt displays D1 and P1's discussions near the end of the

BPS session where P1 brought up his concerns regarding the suicide attempt that he might have

conveyed to his therapist. It is unknown whether P1's therapist and D1 are acquainted, and

whether P1 intended to avoid any exchanges between D1 and his therapist. However, it was clear

that P1 intended to alleviate any potential concerns from clinicians by clarifying his position with

regard to suicide risk:

```
(5.4)
739  P1:  .hh one thing I've been think a lot is u:mm (2) when I
740        see my therapist I mention a few times h:ow (1) .hh I
741        just want to end it (.) or I (.) I just don't care
            anymore. .hhh
742  D1:  um hm
743        (2)
744  P1:  I (.) when I say that I don't I don't  mean - I don't
745        reference myself (.) like I just want to end my life
746        or anything? but I just want to be done with (.) you
            know (.)
747        whatever is causing my frustration (.) you know (.)
748        depression and (.) - she mentioned yesterday how
749        (.) .hh she noticed I'd been saying I don't care
750        anymore (.) quite often.
751  D1:  um hm
752  P1:  I don't know if she's wondering if (.) .hh you know
```

```
753          (.) if I'm going to do something unusual o:r (.) I
754          mean I'm not going to.
```

P1's intent to alleviate the concern over his suicide risk was shown through the following

sequence. First, he acknowledged the words he had said in his session (line 740–741). Second,

he provided additional explanations that he did not provide in his session with the other therapist

(line 744–747). Based on the two sequences of talk, P1 then concluded that he had very little or

no risk of suicide.

This section reported the emerging themes regarding patients'/clients' recollections of

their former clinicians. In an initial clinical encounter, patients/clients initiated such conversation

under the circumstance of assessment and history taking. In some cases, the topic related to

former therapists and clinicians was used to communicate personal perspectives with the trainee.

Although the theme is not directly related to trainees' talk and interaction in this sample, it is a

unique theme that is relevant to the research questions and the focused analysis of this study.

Discussing former therapists/clinicians indicates that the therapeutic relationship is fluid,

dynamic, and interactively achieved. Patients/clients conveyed personal, as well as institutional,

discourses through such discussions in an initial encounter with a new clinician.

Relational Utterances and Interactions

The second theme that emerged in the analysis of how therapeutic discourse was used

involved relational utterances and interactions. This theme contains two features. First,

therapeutic discourses were developed through trainees' explicit language regarding rapport

building. Secondly, relational dynamics were revealed through jointly constructed speech

features.

Three examples from this study are provided to demonstrate trainees' intention to build a

working alliance. In the session of C2P2, C2 provided a summary of her perspective on the

therapeutic alliance at the end of the session:

```
(5.5)
836  C2:  so (.) being that this is your first time in therapy
837        like I said at the beginning I think it's important
838        for the therapist and client to feel comfortable so
839        you know if you would like to reschedule we can
          certainly do that.
840  P2:  yeah.
```

C2 highlighted the importance that they need to "feel comfortable" so that they can move

forward with the schedule of the next session (line 839). This shows C2's emphasis on the

therapeutic relationship with regard to P2's decision to continue counseling with C2.

The emphasis on quality relationships can also be found in the session of D1P1. Similar

to C2, D1 summarized her perspective regarding the working alliance in her closing:

```
(5.6)
732  D1:  ok. well thank you very much for sharing all of this
733        information (.) I think it's really going to help (.)
734        our(.) u:m (.) patient doctor relationship and I think
735        it will (.) um (.) just (.) -  it makes me understand
736        you a little more and that's (.) a good thing (.) ok
737        (1)  u:mm (.)
```

The explicit language that emphasized the importance of the relationship can be found in C3P4's

session. At this point, C3 was about to conduct the routine BPS evaluation after a brief

conversation regarding P4's reason of the visit. Before the start, he emphasized his intent to use

the "relational approach" during the assessment:

```
(5.7)
140  C3:  alright so today (.) we're going to go through (.)
141        basically (.) it's a bio psycho social
142  P4:  ok
143  C3:  intake (.)u:mm (.) they can be pretty dry.
144  P4:  that's cool (.) alright.
145  C3:  we're going to make it (.) [$as relational as
```

```
146            possible& ((chuckles))]
147  P4:                              [  yeah (.) yeah (.) yeah
148                     (.)           ]
149                     that's co:ol (.) ma:n.
```

C3 indicated that the process "can be pretty dry," and followed with his proposal of using a

relational approach (line 145–146) as a way to alleviate the unfamiliarity and increase

P4's engagement in the process.

In some cases, linguistic features, such as word choice and overlapped speech between

speakers, indicate a shared energy and mutual understanding of the discourse. In the following

two examples, the interactions between D4 and P5, as well as between C3 and P4, demonstrated

the process and formation of the relational discourse. In the beginning of the session between D4

and P5, D4 used the word "we" to start the assessment:

```
(5.8)
11   D4:  goo:d (0.8) so we're pregnant.
12   P5:  yes
13   D4:  alright (0.3) s:oo (.) first (.) things first (.)
14        yo:ur (.) first day of your last menstrual period.
```

Notice that D4 used the pronoun, "we," in the process of assessment. P5 quickly responded "yes"

without hesitation. "so we're pregnant" (line 11) in this interaction connoted a shared

understanding of the working relationship and therapeutic process in the context of a first

prenatal check-up in a doctor's office.

Another interactive feature identified that used relational discourse was overlapped

speech, as illustrated by C3 and P4. In this example. P4 was talking about his mother, who also

had issues of drug use. C3 displayed his understanding through non-verbal behaviors and

overlapped talk:

```
(5.9)
376  P4:  this is what he thought. I think back on with those
377       proba – you know (.) [probably some thing (.) probably
378       a drug use she was taking]
```

```
379  C3:                              [yeha yeah       ((nods))
380                                                ]
381  P4:  ((sniffs)) you know she'd steal my da::d. you know she
382       was just wheww.hhh she was a nut case. she still is.
383       she still is. she has a lot of issues (.) big time.
384       that's probably where I [ get my  addiction  from.]
386  C3:                          [  yeah(.)yeah (.)((nods))]
```

The overlapped talk appeared twice in this instance, suggesting C3's attentiveness and desire to

get to know P4's story, and P4's continuance of sharing a personal story. This overlapped talk

suggests a high involvement and shared energy on the subject between speakers. In an initial

counseling context, such high involvement indicates the trainee's intent to create alliance.

As the above three examples indicate, trainees' relational utterances and interactions in

this sample included explicit language regarding rapport building, which was displayed through

jointly constructed speech features such as the use of collective pronouns and overlapped speech.

Neutrality

In a clinical session where clients display behaviors that are not socially desirable,

therapeutic discourse is created through clinicians' non-judgmental, non-reactive standpoints.

This strategy was found in sessions across both professions. Three examples were selected for

demonstration, with one doctor-in-training and two counselors-in-training.

First, in the BPS session between D2 and P2, P2 displayed intense anger while describing

his reactions toward others' behaviors. D2's non-judgmental, non-reactive approach toward P2's

intense emotions was evident during the interaction:

```
(5.10)
422  P2:  and you know (.) if somebody do me bad I think I hold
423       on to it? (.) and I don't let it g:o
424  D2:  yeah
435  P2:  and so when I go to sleep (.) I have bad nightmares
426  D2:  ((nods))
427  P2:  about that per?son
428  D2:  °ok°
429  P2:  and I'm like ge:t to that person and I just want to
```

```
430          rip(.) him a:part
431  D2:  ok.
432  P2:  you unstand what I'm say:ing?
433  D2:  yeah (.) I hear you.
```

Despite P2's intensity of emotion and the behaviors presenting in the process of the interaction

(line 429–430), D2 repeatedly confirmed her understanding of P2 through nodding (line 426),

saying "ok," (line 428 and 431) and answering P2's question (line 433).

Trainees' non-judgmental reactions are found in initial counseling sessions where clients

disclosed personal stories or behaviors that were not socially desirable. Two excerpts

demonstrate this process. In the session of C2P2, P2 disclosed "the shittiest thing" he has done

and the main reason that he sought counseling:

```
(5.11)
676  P2:  I'm here might as well. ah s:o – uh - I've cheated on
677          my girlfriend before.
678  C2:  ok
679  P2:  and I've been cheated on. like I know how (.) awful of
680          a thing (.) it is. u:m (2) but I've done it. ah °a few
681          times°
682  C2:  ok. on your current girlfriend.
683  P2:  uh. yep.
684  C2:  ok
685  P2:  she - she knows about it. we've talked about it.
             gotten through a lot of it (.) but it's part of the
686          reason I'm here.
687  C2:  ok (.) can you tell me about that.
```

"ok" was utilized in a sequence followed by P2's sequence of disclosures. First, C2 displayed

"ok" with P2's disclosure of having an affair in his first relationship (line 678), followed by a

few times afterward (line 682 and 684). After the sequence of neutral responses, C2 displayed

intent to know P2's thoughts regarding his reason for seeking counseling (line 687).

C2's neutral, non-judgmental standpoint was shown in another session between C2 and

P3. In this interaction, P3 brought up her issue of having an extra-marital relationship and

intended to solicit C2's explanation of her behaviors:

(5.12)
```
378  P3:  but as far as being interested in hi:m for something
379       perman:ent? No. I don't know about that (.) at a:ll.
380       (persistence)
381  C2:  so-
382  P3:  so what am I doing. I mean - why - why do I want him
383       to go.
384  C2:  well (.) it sounds like he's - he's I mean people tend
          to like to do things that feel good and that are
385       comforting. and it doesn't sound like the relationship
386       with your husband has those elements. but this
          relationship with this friend (.) it sounds like it
387       does. so it makes a lot of sense that you would want
388       to go to a picnic with him or go
```

After P3's disclosure (line 378–380), C2 appeared to introduce a sequence of interactions with a display of "so" (line 381). Then, P3 interrupted the sequence by asking a question (line 382–383). After P3's question that explicitly solicited C2's professional opinion (line 382–383), C2 provided a general statement about human nature (line 384–385), followed by her focus on validation of P3's need to seek fulfillment and comfort (line 386). C2's intent of validating P3's psychological experience was evident through her use of the descriptor "a lot of" (line 387) for describing P3's potential decision to go out with her friend.

A therapeutic relationship requires the clinician's active statements and actions during the therapeutic process. In some cases, neutrality and non-reactive discourses are necessary when clients/patients display behaviors that are not considered socially desirable. This strategy may be particularly important to convey an attempt at understanding in an initial session where the dyad is still building a relationship.

Validation

The fourth feature of relational discourse that existed across trainees' initial sessions was validation. The analysis showed that validation occurred during patients'/clients' disclosure of significant life events and their emotional reactions associated with the disclosures. Validation

functioned as a relational intervention that conveyed trainees' understanding of the matters and conveyed empathy. Four interactions were selected to illustrate the practice, with two from doctors-in-training and counselors-in-training, respectively.

In doctor-patient interactions, validation occurred in the process of history taking when adverse life events were disclosed. This study found such practice occurred in the two BPS sessions conducted by doctors-in-training. In the session of D1P1, P1 was describing his family history and his experience of separation from his parent:

```
(5.13)
318  P1:  .h I mean the the separation and (.) you know my
319       mother leaving to New York City for the first time.
320  D1:  right.
321  P1:        [and  our (.) and    ]
322  D1:        [I'm sure that was  ] tough. how old were you
323       when (.) your mom left.
324  P1:  probably sixt:een [(.) between sixteen] and
                   (          )]
```

As soon as P2 disclosed an experience of separation in his early childhood (line 318–319), D1 provided immediate validation, as can be seen in her confirmation (line 320), overlapped speech that indicated high involvement (line 322), and a follow-up question (line 323).

Similarly, in another BPS session, D2 displayed validation in the midst of the conversation when P2 disclosed his homelessness since a young age:

```
(5.14)
617  D2:  [  ((looks at P2 and nods   ] ok. so from sixteen you
618       lived on the street for eight y:ears? (.) then where
619       did you live.
620  P2:  ((shakes his head)) in the streets
621  D2:  so always right up until you moved here two years ago.
622  P2:  ((nods))
623  D2:  that's a hard life.
624  P2:  and I lived it.
```

Validation in this interaction was shown though both verbal and non-verbal utterances. After learning that P2 was homeless in previous conversations, C2 displayed her understanding of the

content of the story through body language (line 617), followed by solicitations of the details

(line 618–619). Then, D2's display of understanding of P2's psychological experiences was

produced through a stressed tone on the word "hard," indicating her sense of empathy, shared

feeling of hardship, and understanding of P2's difficult life history.

The third excerpt is a conversation between C2 and P3, who disclosed having an extra-

marital affair. The earlier interaction has created a foundation for C3's validation provided in the

subsequent interaction. In this process, C3 expressed her validation regarding P3's situation:

```
(5.15)
501  P3:  yeah I am. I don't think I made - I don't think I make
502       good - good decisions.
503  C2:  well↑ and again I've only been in here with you for
504       like thirty minutes but it-  it sounds like with this
505       givens - I can't say anything about anything about any
506       other things because this is the only thing that we've
507       really spoken about. but it sounds like there's a part
508       of you that wants to be connected and feel-  feel good
509       and have someone safe to be around. and so from where
510       I'm sitting (.) it makes perfect sense that you want
511       to take a friend that (.) even if he isn't interested
512       in you to your family's house fo:r a long weekend for
513       Memorial Day. I mean that makes - that makes a lot of
             sense to me.
514  P3:  oh.
```

The validation was accomplished through sequence of summary, reflection, and paraphrasing.

C2 first pointed out the fact that she only knew P3 for half an hour (line 503–504) and the issue

that P3 brought up in the session (line 505–507). Next, C2 provided validation with regard to

P3's need for a positive relationship such as "to be connected and feel- feel good and have

someone safe to be around." With this statement, C2 then came back to P3's original questions

concerning whether she should invite the friend over to the family party, with the statement "it

makes perfect sense that you want to take a friend." Notice that C2 did not provide any answer

for P3's decision, but simply validated her emotional and psychological experiences related to the intimate relationship.

A similar sequence of validation is found in C2's next statement:

```
(5.16)
515  C2:  people – you're human. you want to be loved. you want
516        to feel good. you want to be with people that make you
517        feel happy (.) and it doesn't sound like you get much
518        of that at all with your husband. so I  - I don't know
519        - I guess my challenge is that I don't know that
520        that's - decision - I mean yes - the decision to take
521        him (.) but at the same time it makes sense that
           that's what would you want to do.
522  P3:  right.
```

C2 first highlighted P3's need for a positive relationship (line 515–517) by presenting the reality of P3's current unsatisfying marriage (line 517–518). C2's validation is evident through her stressed tone on the word "love" (line 515) when describing human nature in general, as well as P3's need. While providing such validation, C2 appeared to display a neutral stance with regard to P3's decision, as displayed by her disclosure of challenges (line 519) and continued highlighting of P3's position (line 520–521). Again, C2 concluded the statement with an opened-ended remark with regard to P3's decision.

Validation toward clients' disclosures related to personal choices can also be found in a conversation regarding sobriety and relapse. In the session between C3 and P5, P5 described his frustration with not being able to stay completely clean due to his constant relapse. C3 then provided his validation with regard to the recursive process of recovery:

```
(5.17)
338  P5:  yeah. it it- pretty much. it -it does. I just feel
339        like (.) I am so close. like I said I have used one
           time in the last month. no suboxone. no Percocets. No
340        pills or nothin:g. just -  just not using. I mean –
341        it's like (.) I know that I can do it. like I said I
342        have always been able to overcome things and do them.
343        but (.) at the same time
```

```
344        (.) it's like (0.3) why hasn't it happened yet.
345  C3:   so you know at your core (.) you have this ability to
346        overcome things and do these things. but with your
347        addiction right no:w you are kind of hitting this
348        rough road with it. well you have been making some
349        huge accomplishments from the sound of it too. I mean
350        - you have gone how long without using? and you used
           one time -
```

C3 first reiterated P5's ability and statement to overcome the addiction (line 345) while pointing out the difficultly to overcome it when relapse is activated (line 346–348). The validation was provided right after this presentation, with C3's statement, "you have been making some huge accomplishments from the sound of it too." This validation provided two therapeutic discourses: the trainee's acknowledgement of the client's strength and challenges and the trainee's highlighting of the progress that the client has made in order to instill hope for recovery.

Disclosure of Personal Perspectives and Information

Another strategy that trainees used for forming a relationship during interactions was disclosure of personal perspectives and information. The analysis identified that this disclosure did not directly accomplish any therapeutic task; as such, it may have been intended to convey a sense of connection with the clients/patients. There are a total of five examples that demonstrate trainees' self-disclosure in the process of greeting, history taking, therapeutic intervention, and closing.

The first excerpt shows the trainee's explicit reaction toward the patient when she walked in the room:

```
(5.18)
1    D3:  hi I'm doctor (_____) I'm sorry to keep you waiting.
2    P3:  nice to meet you.
3    D3:  oh you're so pretty
4    P3:  thank you.
```

In this example, the self-disclosure was not necessarily about sharing personal information, but a decision to reveal a personal perspective and opinion. In this case, D3 revealed her personal opinion directly related to P3's appearance at the very beginning of the encounter. This type of compliment usually exists in casual conversations. In the context of an initial clinical encounter, clinicians' compliments of patients' appearances may function as an attempt to build connection and positive relational dynamics, as giving and receiving compliments is usually a socially desirable interaction.

In addition to greeting, the trainee's disclosure in the beginning of the session can be used to engage the client's thought process through small talk before the occurrence of a relatively formal, institutional interaction. In the session of D5P7, D5 first engaged in small talk with P7, then provided self-disclosure:

```
(5.19)
1    D5:   good morning sir.
2    P7:   I'm just looking at all the graffiti on the trains.
3    D5:   really?
4    P7:   yeah the trains sure go all over the place.
5    D5:   yeah? I have a train that goes by my house wakes me
6          every morning.
7    P7:   is that good or bad.
8    D5:   well I've gotten used to it.
```

After D5's disclosure of his living environment (line 5–6), P7 requested D5's thoughts on it (line 7). Notice that D5 neither approved nor critiqued it, but simply provided a neutral response, "well I've gotten used to it," before the start of the session. This neutral response not only limited further conversation about D5's personal information, but it also provided a transient space for the dyad to step back from casual talk and to move on to the therapeutic tasks. Similar to the example of D3P3 discussed above, D5's self-disclosure in the very beginning of the initial session may function as a way to connect and covey alignment with P7, as his disclosure, "I have

a train that goes by my house wakes me every morning" occurred right after P7's statement "the trains sure go all over the place."

Self-disclosure also emerged in the process of history taking and assessment. Three examples illustrate this process. The first excerpt is an interaction between C3 and P5 during intake. In this process, C3 mentioned his educational institution while inquiring about P5's educational background:

```
(5.20)
906  C3:  and what is your highest level of education?
907  P5:  u:m High school. I did one year at (_____).
908  C3:  oh you did?
909  P5:  yeah two thousand nine.
910  C3:  that's where I went for undergrad.
911  P5:  oh yeah?
```

Similar to D5, whose speech reflected a sense of alignment with his patient, P7, C3 in this process conveyed a sense of sameness by directly telling the client about himself, "that's where I went for undergrad." Different from the example of D3P3 where the trainee displayed her personal opinion toward the patient's appearance, C3 in this type of self-disclosure displayed his personal information that specifically connected to P5's life experiences. In addition, it occurred in the midst of the assessment, as opposed to at the very beginning of the encounter.

Using self-disclosure to connect with the client can be found in C2 and P3's session. C2 shared with P3 that she had the same type of dog after P3 brought up having pets at home:

```
(5.21)
37  C2:  high school. do you have children.
38  P3:  no.
39       (3)
40  P3:  pets. ((chuckles))
41  C2:  they can be like children. ((laughs)) what kind of
42       pets.
43  P3:  I have one dog and two cats.
44  C2:  okay. what kind of dog
45  P3:  a coll:ie.
46  C2:  $I HAVE a collie$ I have the black white and like tan
```

```
47       faced one.
48  P3:  mine is black and white.
49  C2:  ok
50  P3:  she's more like a border collie but large.
51  C2:  okay cool. yeah I love my - they're so nice aren'tthey?
         ((chuckles))
```

C2's question, "what kind of dog," was an indicator of her intent to seek a personal connection

with P3, as asking types of dog breeds is not a typical question related to general counseling

assessment. Notice that C2 displayed explicit, animated speech when she found out that she had

the same type of dog as P3. Similar to the session of C3P5, C2's communication of sameness

was conveyed through a direct self-disclosure. A variation between the two is that C2 displayed

more animated speech with a higher volume (line 46–47).

Trainees' display of seeking personal connection with patients/clients appeared in doctor-

patient interactions. During the process of intake, D5 asked P8's branch of service after P8

indicated earlier that he went to a VA hospital. This interaction brought up D5's disclosure of his

service background:

(5.22)
```
24   D5:  and ah (.) what branch of the service do you serve on
25        sir.
26   P8:  Air Force.
27   D5:  Air Force. I served in the Marine Corp for four years.
28   P8:  really.
29   D5:  yes. very - very nice to meet a fellow veteran. How
30        long did you serve.
31   P8:  just one tour.
32   D5:  yeah I did the same thing four years was enough for me
          ((chuckles)).
33   P8:  yep that's for sure ma:n but I enjoyed it.
34   D5:  oh I had a great time as well.
35   P8:  very. very much.
```

The sense of connection, as well as alliance building, was immediately displayed after D5

confirmed that P8 was also in the Air Force. In line 28, D5 repeated "very" twice and then

engaged in small talk sharing his personal experience in the service with P8.

Near the end of the session, both D5 and P8 exchanged the language, "thank you for your service," which has specific meaning in the context of military:

```
(5.23)
253  D5:  ok. so it's very nice meeting you sir. and thank you
254       for your service.
255  P8:  Oh thank you.
256  D5:  thank you thank you.
257  P8:  thank you thank you.
258  D5:  you say it and it means more coming from another
259       veteran right?
260  P8:  it does -it does. ain't nobody really understands
261       unless you've been there.
262  D5:  exactly. and that's why usually you know (.) sometimes
263       when somebody thanks me for my service and they
            haven't
264       been in the military. it's like, yeah (.) thank you
265       but (.) you don't know what it's like. ((chuckles))
266  P8:  exactly.
```

The statement, "Thank you for your service," in the encounter of D5 and P8 connected the two and revealed the dyad's shared identities. Typically in the context of the doctor-patient interaction, "thank you for your service" is an utterance that is usually used by patients as an expression of gratitude toward their doctors. In this interaction, D5 brought up "thank you for your service" with the intention of showing his connection to P8 and an indication of checking out if the two shared the same experience. As the sameness between the two emerged, D5 then commented about the meaning of the phrase (line 258–259). The exchanges of thoughts and shared language between D5 and P8 appeared between line 260 and 265, indicating a shared understanding of the lived experience in the armed forces.

The above five examples reveal that self-disclosure was used in the process of greeting, history taking, therapeutic intervention, and closing. The function of self-disclosure included giving compliments, conveying alignment and sameness, and sharing identity. In addition, trainees' self-disclosure often occurred immediately after the client/patient revealed some

personal information. In some cases, trainees' speech patterns changed during self-disclosure. The analysis identified that self-disclosures have been intended to convey a sense of connection with the clients/patients.

Displays of Reactions

Initial sessions often involve varied technical tasks and the sequencing of scientific operations including assessment, diagnosis, and treatment. The procedures require the objective knowledge and neutrality of the counselor-in-training and the doctor-in-training across both professional settings. However, interactions can be shaped, reshaped, and jointly achieved through presentation reactions between speakers. This study found that trainees' personal reactions, which included both utterances and non-verbal behaviors, conveyed personal standpoints regarding clients'/patients' presenting issues. In addition, personal reactions can be used as a strategy that communicates empathy and helps re-direct therapeutic agendas. There are a total of four phenomena that emerged in the trainees' display of personal reactions: managing personal reactions, affective presentations, convey therapeutic stance, and covert affirmation. A total of nine examples are presented to illustrate the four phenomena.

Managing personal reactions. In an initial session, trainees may encounter unexpected circumstances that required trainees to continue the therapeutic process with patients/clients while managing personal reactions. Three examples from a doctor-patient interaction will be used to demonstrate how D4 managed her reactions with regard to P5's problem presentations. A recursive process of displaying personal reactions can be found in the session between D4 and P5. Right before performing the gynecological exam, P5 disclosed her concerns regarding the piercing around her genital area. The following excerpts show the sequence of reactions and D4's negotiations of the concerns:

(5.24)
```
539  P5:  ok I have a question though. it's not going to
540       interfere with my piercing right?
541  D4:  your what?
542  P5:  my piercing.
543  D4:  your wha:t?
544  P5:  I have a piercing.
545  D4:  oh where did you have a piercing.
546  P5:  the clit.
547  P5b: ((laughs))
548  P5:  so (.) and it can't come out (0.5) it just got done
549       not even six weeks now
550  D4:  this won't interfere with that
551  P5:  ((laughs))
552  D4:  but pushing the baby out will (.) no:w the thing is
553       (.) by six months (.) of pregnancy (.) that piercing
554       has to come out.
```

It can be seen that D4 asked questions twice to clarify the situation disclosed by P5 (line 541 and

543), with a stressed tone in her explanation (line 552). Although an explanation was provided at

the moment, D4 brought up her concerns again later during the examination:

(5.25)
```
621  D4:  alright ((moves equipment)) are you sure at six months
622       we can't take that piercing out?
623  P5:  I'm scared (2) ((laughs)) my clit piercing.
624  D4:  scared. it's gonna come out.
625  P5:  the baby going to stay in there for the whole nine
          months.
626  D4:  I know but I'm afraid we're not going to be able to
627       take it out when it's ti:me and then the baby is going
628       to come out and then rip the piercing off.
```

Whether the piercing was going to come out or not remained questionable, as D4 again brought

it up between line 621 and 622 and followed with an expression of concern (line 626–628).

Near the end of the exam, D4 asked P5 about the procedures for the piercing. An overt

reaction was displayed in the process of interaction:

(5.26)
```
678  D4:  ((cross talks with the nurse)) we're almost done (5).
679       did they put any anesthesia? did they put any
680       lidoca:ine or anything for the piercing?
```

```
681  P5:  oh yeah. yeah
682       (3)
683  P5:  it hurt.
684  D4:  !OH I BELIEVE IT! I BELIEVE YOU! ((laughs)) I have no
685       question about that.
686  P5:  I screamed. (_____) laughed at me (3) it really hurt.
687       ((laughs)) I was like (.) scream.
```

The three interactions at different time points in the session collectively indicated D4's recursive negotiations of personal reactions toward an unusual circumstance disclosed by the patient in an initial encounter. Not only did she need to comprehend the procedure of the piercing, but she also needed to connect the risk assessment of the piercing to P5's delivery.

As the above three interactions from the session of D4P5 indicate, the trainee's management of personal reactions was presented through recursive processes between the display of concerns and asking questions. Note that self-disclosures discussed in the previous section and displaying personal reactions have a shared quality, that is, a revelation of the trainee's information regarding thought processes and perspectives. However, there are several different characteristics between the two. In this study, self-disclosure appeared to be direct language and presentation of information such as presenting compliments and revealing personal information. In addition, it seems to occur immediately after the patient/client revealed certain information that might connect to the trainee's personal experiences.

Displaying and managing personal reactions in this study showed a more circuitous and recursive process of subject discussion, including verbal expressions or non-verbal display. In addition, different from self-disclosure, where both the trainee and the client/patient engaged in conversations that were not directly related to the therapeutic issues discussed at the moment, displaying and managing personal reactions occurred in the subject relevant to the emerged therapeutic issues. The next three sub-themes will demonstrate these characteristics.

Affective presentations. In some cases, trainees displayed affective reactions when clients/patients disclosed undesirable life circumstances. An utterance such as "wow" produced by the listener is a type of response cry that expresses emotions on the speaker's behalf. A response cry produced by the listener indicates a commonly shared emotion and sympathy toward the reported circumstance (Goffman, 1978). Accordingly, this affective presentation appeared to be a display of empathic reaction or functions an "emotional witness" toward the circumstance. Three examples of trainees' surprise reactions are presented, with two examples from two counselors-in-training and one example from a doctor-in-training.

In the session between C2P2, P2 was describing his employment history. C2 showed her surprised reaction when hearing about P2's long hours and underpaid working conditions:

```
(5.27)
540  P2:  I liked it↑ I mean I was getting pai:d. it was
541       technically a part time so I think I got paid for
          thirty
542       hours a week and I was working anywhere between forty
543       five and sixty so yeah -
544  C2:  wow
```

A somewhat surprised reaction, displayed through "wow," can also be found in the interaction between C3 and P4, where P4 talked about his history of incarceration:

```
(5.28)
448  P4:  = I was still living in (_____) my dad had a shop up
449       here for a long time and a house. I came up here to
          visit
450       hi:m (.) got pulled over and got arrested. I went to
451       probation went to jail up here. got do:ne (.) finished
          all
452       tha:t and then I was good for a while then about two
453       thousand eleven I think I got arrested like fifteen
454       times in one month.
455  C3:  wow.
```

The two response cries, "wow," from two counseling examples indicated above reflect specific emotional experiences and social relationships. "wow" is an expression that displays surprise,

awe, and perhaps an overwhelmed reaction. As clients were describing their unpleasant life

circumstances such as a history of arrest (P4) and an underpaying and over-working job situation

(P2), trainees' "wow"s provided both institutional as well as personal discourses, that is, a public

"emotional witness" that reflects the affect associated with these circumstances, and an

overwhelmed reaction toward an unusual life experience that is perhaps unfamiliar to the trainee.

       Another overt, surprised reaction was displayed by D4 during the conversation about

P5's caffeine consumption and substance use:

```
(5.29)
330  P5:  I drink flavored water.
331  D4:  !yeah! um (1) now how much pepsi do you drink a day.
332  P5:  all da:y. I can go through a two liter in a day.
333  D4:  goodness gracious (.) lady.
334  P5b: yeah
335  D4:  goodness gracious. Um (.) alright and how much weed
336       have you been smoking since you found out you are
          pregnant.
337  P5:  I dropped down to two dashes a day.
338  D4:  TWO WHAT?
339  P5:  two dashes a day.
340  P5b: ((laughs))
341  D4:  you've got to talk down to me. ((chuckles))
```

In this interaction, D4's overt, surprised reactions were displayed after two pieces of information

presented by P5, the amount of caffeine consumption (line 332) and the marijuana use (line 337).

The repetition of "goodness gracious," (line 333 and 335) and the question, "TWO WHAT?"

with high volume revealed D4's surprised, perhaps astonished reaction toward P5's health

practice. In addition, it may have indicated D4's intent to clarify the word, "dash." "you've got to

talk down to me" conveyed D4's reaction in a less formal manner. At the same time, it revealed

both institutional and personal discourses toward this practice. Specifically, D4's speech feature

reflected an institutional as well as personal "emotional witness" that displayed a cautious,

alarmed, and overwhelmed reaction toward P5's health practice.

Convey therapeutic stance. Therapeutic neutrality refers to a clinician's refraining from personal standpoints toward the patient's/client's decision-making, regardless of the effectiveness and therapeutic values of the standpoint. A person-centered philosophy of therapeutic practice often avoids prescribing decisions and interventions because "telling clients what to do" is inconsistent with a person-centered approach; "telling clients what to do" inevitably leaks personal value judgments as opposed to empowering an individual to make a decision. That said, clinicians constantly negotiate between therapeutic neutrality and the necessity of providing therapeutic perspectives from a personal standpoint. This theme shared a quality from the theme of "affective presentations," where the negotiation in the two themes contain both institutional, public discourses as well as a personal, relational, yet therapeutic discourse. Two doctors-in-training in this sample displayed such negotiation, with an encounter of the issue related to the patient's intimate relationship. The two doctors-in-training, D2 and D4, displayed personal reactions to convey their perspectives on the patient's relationship.

The first example is the interactions between D2 and P2 during their conversations about P2's coping with anger. As the session progresses, the dyad talked about P2's support system and his recent break up. D2 displayed her reaction when P2 indicated that he was no longer in the relationship:

```
(5.30)
974  D2:  what ha:ppen:ed with your girlfriend.
975  P2:  I dumped her.
976  D2:  wh:y
977  P2:  because I didn't like her.
978  D2:  w:h:y
979  P2:  because she made me mad. the day we was here. the last
980       time we was here together I dumped her.
981  D2:  wha:t happened?
982  P2:  because she said something to me (.) she said
983       something stupid to me doc (0.6) when I left here (.)
984       and u:mm (.) she made me ma:d and I said you know what
985       (.) I don't want you no more.
```

```
986  D2:  she seemed (.) pre:tty suppor:tive
987  P2:  yeah.
988  D2:  I could fe:el it↑
989  P2:  but she's not
990  D2:  ok.
```

The negotiation between telling the patient what to do and maintaining neutrality can be found in the sequence of the interactions. Accordingly, D2's surprised reaction was displayed through three sequences, the two "why" questions (line 976 and 978) and one inquiry (line 981). After P2's explanation (line 982–985), D2 provided an observation different from P2's perspectives (line 986). This implies that D2 maintained different perspectives regarding P2's decision and perhaps indicate an attempt at persuading P2 that he needed to maintain the relationship with his ex-girlfriend who appeared to be a supportive figure in his life. Notice that D2 refrained from displaying her perspectives after P2 displayed his disagreement again (line 989). D2 limited personal reactions and turned to a neutral standpoint with an "ok" response (line 990).

A display of personal reaction that also conveys therapeutic standpoint regarding the patient's relationship can be found in D4 and P5's session where the issue of domestic violence came out in history taking. After knowing that the ex-partner was incarcerated due to domestic violence, D4 displayed a personal reaction that contained both a sense of concern as well as a wish:

(5.31)
```
231  P5:  I try to ignore his calls as possible as I can
          ((chuckles))
232  D4:  is he going to be involved when he comes out?
233  P5:  uh uh.
234  D4:  do you know when he's going to be out.
235  P5:  no I don't.
236  D4:  hopefully not (0.8) for a long - long time.
```

D4's concerns and a personal hope was revealed in sequence through questions (line 232 and 234) and a statement (line 236). This conveys D4's therapeutic standpoint that the ex-partner

should not be involved in P5's life now and the future in the context of domestic violence. In this example, the dyad seemed to share the therapeutic standpoint that suggests the discontinuance of the relationship with the ex-partner, as there was no refraining discourse and the patient's dispute found in the process.

Covert affirmation. Displaying personal reactions can function as affirmation of the events brought up by the client or clients' behaviors. By showing personal reactions, trainees acknowledge positive aspects of clients' lives as well as reinforce clients' reported behaviors. This study found that affirmation was displayed through non-verbal, para-linguistic features in two examples displayed by one doctor-patient interaction and one counselor-client interaction. First, in the interaction between D1 and P1, D1 showed her facial expression during P1's disclosure of his refusal to use substances:

```
(5.32)
437  P1:   I was offered [w:eed (.) crack cocaine(.)   (    )] but
          -
438  D1:                 [((          smiles             ))] you
439        were offered or you said you tried it.
440  P1:   [I was offered                    ]
441  D1:   [$Ok.$ ((looks at P1))     ((chuckles))] ((nods))
442  P1:        but I [   didn't do it.      ]
443  D1:             [O(.)k          ((nods))]
444  P1:                  no w:ay.
445  D1:          you have strong will power?
446  P1: ((chuckles)) when it comes to that (.) but when it
          comes
447        to (.) cutting down on soda =
```

Though D1 did not overtly express her affirmation, the smile (line 438), nodding and "ok" (line 443) displayed by D1 indicate a sense of agreement and support toward P1's choice. In this process, though D1 did not provide any statement or comment that responded to P1's report, her paralinguistic utterances appear to reveal a sense of support and positive reaction. "you have strong will power" both reflects P1's volition and reinforces P1's choice.

In an interaction between C3 and P4, a smile was displayed when P4 described being liked by the probation officer:

```
(5.33)
480  C3:  yeah (.) she's supportive of your (.) [recov-
481       recovery process.]
482  P4:                                         [oh yeah (.) big
483       time (.)   yeah  ] she really really  likes me for
484       some reason.
485  C3:  ((smiles))
```

As in a conversation earlier, P4 stated that he wants to be liked. The positive reactions provided by C3 seem to imply several discourses. First, C3 shared a joyful moment with P4, who disclosed a positive experience. It also acknowledged P4's desire to be liked by others. The paralinguistic utterances provided by C3 seem to reinforce P4's likable personality and, perhaps, strengthen the alliance between the two.

In the earlier discussion regarding validation, the examples indicated that validation occurred during patients'/clients' disclosure of significant and often undesirable life events and behaviors. Validation functioned as a relational intervention that conveyed trainees' understanding of the matters, and also conveyed empathy. In addition, validation was often displayed through language.

Examples of covert affirmation in this study indicated non-verbal, para-linguistic features of expressions that occurred when clients/patients displayed favorable, pleasant life experiences and desirable health practices.

Repair

When the session progressed, trainees and their clients/patients engaged in a more in-depth conversation. In some cases, intervention was necessary if severe symptoms were detected. This process often created potential tension and anxiety for patients/clients. It may also breach established rapport. When tension was displayed during an interaction, repair helped reestablish

the relationship and therapeutic agenda. This study found that trainees used repair as a strategy to

relieve tension and negotiate therapeutic direction. Two examples are presented.

      The first excerpt is an interaction between D2 and P2 in the BPS session. During the

process of history taking, P2 displayed intense emotions and occasional agitation. Later in the

session, D2 proposed the possibility of admitting P2 into a hospital. The tension arose when the

two negotiated the timeline.

```
(5.34)
1737 P2:  my voice is telling me not to do it my voice is - see
1738      my voice is telling me that something's not right with
1739      you now (.) you see?
1740 D2:  ok (.) so let's back up a bit (0.4) okay? (0.7) wh:at
1741      (0.3) do y:ou fe:el is not right.
1742 P2:  I don't know (.) every time, every time one- you talk
1743      about locking me up, it - it keeps me (0.2) crazy
1744      (0.8)
1745 D2:  ok.
1746 P2:  ju- just tomorrow I'll come in myself (.) I promise
1747      (1) [EARLY in the morning.]
1748 D2:      [you me:an -          ] ok. I just want you to
1749      know that I a:m (.) trying to do the best thing for
          you. ok?
1750 P2:  yes.
1751 D2:  yo:u (.) tell the voices (0.3) that (0.7) okay?
1752 P2:  um hm
```

The tension was de-escalated through a sequence of repairs. D2 at first used a non-directive and

non-reactive response, "so let's back up a bit," and then re-directed the conversation with the

question, "wh:at (0.3) do y:ou fe:el is not right." Then, D2 explained her intention, making it

explicit as a means to repair: "I just want you to know that I a:m (.) trying to do the best thing for

you. ok?" She then followed with her strategy to include P2 in the dialogue, "yo:u (.) tell the

voices (0.3) that (0.7) okay?" In this last sequence, D2 separated P2 and his voices into two

entities. As such, D2 encouraged P2 to initiate dialogue with the voices to alleviate the tension

that had been created.

In the initial counseling session between C2 and P2, C2 picked up on P2's disclosure

regarding "shitty" things that he has done. C2 intended to explore this further with P2's

disclosure. Repair occurred as a result of P2's comment toward C2's request:

(5.35)

```
662   P2:   and then. like I said before. like I sometimes act
663         shitty I think to sort of (.) uh validate my own
664         feelings about myself.
665         (0.6)
666   C2:   so you said act shitty- like what's the shittiest
667         thing you've done or you - the shittiest way you've
668         acted (.) to?
669   P2:   that's (.) a hu:ge question for the first time.
670         ((chuckles))
671   C2:   oh ok (0.9) let's scale it back -
672   P2:   = no that's okay. u:m
673   C2:   = so what's the - ok. so what's a smaller example of
674         something.
675   P2:   I can - I can do the shittiest one.
676   C2:   ok
677   P2:   I'm here might as well. ah s:o - uh - I've cheated on
            my girlfriend before.
```

P2's response "that's (.) a hu:ge question for the first time," directly challenges C2's request.

"let's scale it back" and "what's a smaller example of something" were repair strategies that

intended to re-establish the direction of conversation based on P2's reaction. After the rise and

fall of this tension, P2 changed his discursive position and decided to go back to the previous

direction, as shown in line 675, "I can do the shittiest one." "the shittiest one" turned out to be

the main reason that brought P2 to counseling.

The above two examples illustrated how the repair strategies were used when potential

tension and anxiety arose as the result of a more in-depth conversation between trainees and

clients/patients. Repair helped reestablish the working alliances and therapeutic agendas.

Summary of Therapeutic Relationship and Discourse: Convergence

This section demonstrated how trainees and their clients/patients jointly formed a therapeutic relationship in the context of an initial session. This study found a total of seven identified convergent themes shared by both counseling and family medicine. The dyads in both types of clinical sessions created and shaped the therapeutic discourses through discussing former therapists/clinicians, relational utterances and interactions, neutrality, validation, self-disclosure, displays of reactions, and repair. The first theme, discussing former therapists/clinicians, was primary presented by patients/clients and is relevant to the analytic focus on relational dynamics. The next section will present the divergent themes with regard to the therapeutic relationships and discourses in an initial context.

Therapeutic Relationship and Discourse: Divergence

This section will illustrate distinctive talk and interaction with regard to therapeutic relationships and therapeutic discourses in family medicine and the counseling profession in the sample. This study found that there are two practices, praise and a resilient approach, that were used differently across the two professions. The first theme, praise, was found only in doctor-patient interactions, and the second theme, a resilient approach, was found only in counselor-client interactions. Each theme is discussed in detail below with examples.

Divergence: Doctors-in-Training

Praise

A unique practice found in the initial sessions of doctors-in-training and their patients was praise. In addition to reinforcing a positive relational dynamic, praise was used to strengthen the therapeutic discourse by promoting health behaviors, instilling hope, and recounting therapeutic goals. Four examples are selected for demonstration.

First, in the BPS session between D1 and P1, D1 stepped out in the middle of the session to seek consultation with her supervisor, who appeared to have knowledge about P1. In this interaction, D1 came back from the consultation and provided praise:

```
(5.36)
558  ((D1 comes into the room and sits on the sofa))
559  D1:  U:mm (.) so I was talking to doctor (____) and s:he
560       said s:he remembers you (.) u:mm (.) she remembers
          that you
561       we:re really struggling be:fore (.) I think she saw
562       you after your father passed awa:y (.) she is really
          proud that
563       you have come this far with your sch:ooling. she's (.)
564       very prou↑d (.) so (.) I think that is amazing as well
          (.) um
```

The word "proud' was used twice (line 562 and 564) to emphasize P1's accomplishments with regard to his education, with the tone rising the second time (line 564). After the presentation of a third party's perspective (line 561–563), D1 added her own praise in the conclusion, "I think that is amazing as well." The example of praise in this interaction is unique in the sense of borrowing and reproducing the discourse of praise. D1 first borrowed her supervisor's word "proud" from consultation in introducing the praise; then she produced her own word "amazing" to reinforce the praise.

In a later interaction near closing, D1 summarized the therapeutic goals with three more examples of praise provided in the process:

```
(5.37)
783  D1:  right (.) ok well it's good that you express that you
784       feel this w:ay (.) you should continue to do so (1) ok
785       (1) put all your time and energy into (1) you know
786       school you're almost done you only have one session
          left (.) and
787       (.) in talking about these positive lifestyle changes
788       you are making (.) you said that you have been
789       exercising re:gular:ly (.) you're trying to cut out
          soda?
790       (2)
```

```
791  P1:  yeah I'm trying to get my soda to once a day compared
792       to my  usual four to six.
793  D1:  yeah (.) that's good↑
794  P1:  I usually only have one.
795  D1:  that's awesome. I'd like you to continue (.) do:ing
796       that um (.) if you feel like you (.) u:m (2) need to
797       be seen her sooner you just (.) ca:ll (.) and (.) make
798       an appointment and I'll see what we can d:o (2) okay?
```

Praise in this interaction was used to reinforce therapeutic actions and shape future behaviors. First, D1 referred to P1's expression of himself as "good" and encouraged him to continue (line 783). Secondly, D1 brought up the "positive lifestyle change" with stressed tones, followed by more praise, "that's good↑." Thirdly, after P1 expressed his ongoing effort to cut down soda, D1 added a third instance of praise with a stressed tone on "awesome" as support of P1's choices. In this interaction, P1's behaviors and choices were encouraged and promoted not only by the praise provided by D1, but also the underlying tone of the speech. All the praise had either a stressed or raised tone, indicating a degree of energy in the interaction.

An overt and highlighted feature of praise can be found in the interaction between D2 and P2. During the process of the BPS assessment, P2 intended to present all of his paperwork and documents to D2, who later made a remark on P2's behaviors:

```
(5.38)
282  P2:  (      ) (tha- )that's why I was so late to:day (.)
283       because I had to go to (.) this lady over here (0.5)
284       to welfare – OH >as a matter of fact I am glad you I
          am glad
285       you get about that too look at that I forgot< (0.5) I
286       forget everything ma:n =
287       (1.1)
288  D2:  LOOK AT YOU BEING SO organ:ized! =
290  P2:  = I'm TRYING to (.) because if I don't I will mis –
          miss [everything]
```

Accordingly, P2 had multiple pieces of paperwork related to his health issues, as well as his living situation. In the midst of searching for his paperwork and trying to remember the list of

tasks he needed to accomplish in this session, D2 pointed out that P2 was very "organized," with

a relatively high volume (line 288). Notice that P2 also raised his volume with a stressed tone in

his response, "= I'm TRYING to (.) because if I don't I will mis - miss [everything]." Similar to

the interaction between D1 and P1, D2 and P2 also produced a stressed or raised tone during the

occurrence of praise. There are some variations of praise found in this interaction. First, a degree

of energy was jointly produced by D2 and P2, as can be seen in P2's rising volume and stressed

tone, which did not occur in P1's response to praise. In addition, D2's praise reflects P2's

behavior produced during the process of interaction, whereas D1's praise reflects the outcome of

P1's health practices and outcome. Another instance of praise that reflects the patient's health

outcome can be found in an interaction between D5 and P6.

In a regular doctor' visit, D5 used praise to highlight P6's health outcomes, while

emphasizing the continuance of the treatment:

```
(5.39)
111  D5:  and um (.) I'll examine you. (0.4) do you mind getting
112       on the table? your blood - you blood pressure is doing
113       great today.
114  P6:  yeah (.) how about that.
115  D5:  !congratu:lations!
116  P6:  that means I still have to take that medicine?
117  D5:  yes ma'am. that's why you are -
118  P6:  that's why it's good.
119  D5:  that's why it's good.
120  P6:  I've lost some weight too.
121  D5:  !congra:tulations!
```

In the middle of the examination, D5 first brought up the outcome of the blood pressure (line

112–113) with a direct, animated comment (line 115). Notice that P6's immediate response was

to inquire whether to continue the medication (line 116). Then, the two jointly concluded that the

medication is necessary because "that's why it's good." (line 118–119). After this process, P6

provided additional information regarding the progress of her health, "I've lost some weight too," which produced more expressive praise from D5 (line 121).

Praise can be used to provide trainees' positive remarks on patients' social beliefs and practices outside the context of the clinical encounter, which is neither about the patient's behaviors produced in the process of interaction, nor the patient's heath outcome. In the regular visit between D3 and P3, P3 disclosed her occupation as a health aid worker early in the session. Near the end of the visit, D3 expressed her regards to P3, with overt praise of P3's choice of her occupation:

```
(5.40)
256  D3:   have a good - have a good day at work - or two days at
257        work.
258  P3:   no I'm actually off I've been at work sin:ce (0.5)
259        what's today - Wednesday? I've been at work since
260        Monday. yeah I just got of this morning at ten
261  D3:   that's really noble work though. I'm serious.
262  P3:   yeah (.) it's hard.
263  D3:   it's really nice of you. but yeah (.) you're doing
264        amazing work.
```

Accordingly, a positive relational dynamic was reinforced through D3's recurring praise. Overt praise of P3's occupation was indicated in line 261, with a stressed tone on the word, "serious." After P3's comment on the job (line 262), D3 provided additional support to reinforce P3's choice (line 263–264).

In the previous sub-section, examples of covert affirmation indicated trainees' non-verbal, para-linguistic expressions that acknowledged positive aspects of clients' life choices, as well as reinforced clients' reported behaviors. Praise converges with covert affirmation in ways that trainees provided acknowledgment and favorable reactions toward desirable events and situations, but diverges from it with regard to features of interactions and discourses regarding therapeutic intention. Covert affirmation occurred under the circumstances of both pleasant

stories and desirable behaviors told by the patient/client. Praise in this sample occurred at a

specific moment when the patient reported desirable health outcomes and practices. In addition,

praise existed primarily in doctor-patient interactions and little evidence was found in counselor-

client interactions. Thirdly, while covert affirmation was primarily non-verbal and para-

linguistic, praise in this sample presented via overt and expressive verbal language.

<div align="center">**Divergence: Counselors-in-Training**</div>

Resilient Approach

A strategy that often characterizes the relational discourses in counseling sessions is the

strength-based and resiliency approach. Three examples show how counselors-in-training

explored positive aspects of their clients' experiences during intake and goal settings within the

initial session.

The first excerpt characterizes the trainee's shift to a strength-based approach from the

client's self-defeating narrative. In this interaction, P2 indicated that he is "sort of a shit person."

C2 intended to shift the focus on P2's strengths and goodness:

```
(5.41)
132  P2:   I'm just feeling like I'm sort of a shit person all of
133        the time. u:m (.)  I think like the choices I make
134        like sort of general behavior is like either trying to
135        rally hard against that like trying to do really nice
136        things or it feeds directly into that and do kind of
137        crappy things in order to prove to myself that I am
138        the crappy person that I think I am.
139  C2:   it's like kind of a self-fulfilling
140  P2:   yeah
141  C2:   prophecy type of a thing.
142  P2:   right.
143  C2:   so (3) ok. so to (1) hm (.) how do you kind of – when
144        you say that you kind of do good things (.) what are
145        the things that you're talking about?
146  P2:   I am - I am just trying to be –
147  C2:   what does that look like -
148  P2:   I just try to be what I think a good person is -
149  C2:   um (.) what is that.
```

```
150  P2:   to be th:at - I don't know, I just try to be there.
151        you know for my friends and famil:y. my girlfriend -
152        and do -  you know (.) do things for them. u:m (.)
153        listen to them. care about - you know their problems
154        and stuff – try to help them in any way I can. You
155        know. u:m so I try to do that kind of thing.
```

First, C2 reframed P2's narration from being "a shit person" and "crappy" to a reflective statement "a self-fulfilling," and "prophecy type of a thing." Then, C2 selected the narrative from P2, "trying to do really nice things," and redirected the focus on P2's intent of doing good things (line 144–145). P2's statement, "I just try to be what I think a good person is" provided a ground for C2 to further explore P2's narrations of positive aspects of his behaviors. C2's selection of this narration and further exploration reflected the use of resilience.

The highlighting of the client's goodness can be found in C3 and P4's interaction. During their discussion of P4's frequent relapses in the past, C3 focused on P4's motivation for recovery, which is allied with the stage of determination in motivational interview techniques:

```
(5.42)
61  C3:   um hm (.) that seems like something when you look back
62        on it (.) it was kind of like (1) there-  there's a
63        little bit of you wish you did mo:re↑
64  P4:   yeah
65  C3:   but in a sense you really haven't - didn't have [the
66        opportunity] –
67  P4:                                                   [I
68        wish      ] y:eah (.) I wish I would have taken it
69        more seriously and got a handle on it at an (.)
70        earlier age.
```

A resilient approach, combined with a model of motivational interview on contemplation, which was widely used in addiction recovery treatment, was displayed in the sequence of interaction (Miller, 1983). First, C3 indicated that P4's wish to do more shows P4's motivation to engage the treatment (line 63). By pointing out P4's desire and motivation for recovery, the therapeutic discourse shifted from a mandate narrative to a statement of self-efficacy. In addition, it

combined both a discourse of hesitation and the discourse of change. After C3's validation (line

65–66), P4 presented a sense of choice about his recovery, which is evident in his narrative, "I

wish I would have taken it more seriously and got a handle on it at an (.) earlier age."

In another session between C3 and P5, P5 acknowledged his ongoing motivation to

achieve sobriety and yet the fact that he was not completely clean. C3 highlighted the progress

that P5 has made as a response:

```
(5.43)
423  P5:  They're saying (.) you know (.) they fought this for
424       ten years before they ever got clean. I kn:ow what
425       they mean. but (.) I just feel like (.) I don't want
426       to be(.)cocky or anything but I feel like I have mo:re
427       (.) than what (0.3) some addicts have. Like (.) I
428       didn't use – I mean I know any use is bad. but (.) I
429       didn't u:se (.) really (.) th:at much. as bad as that
430       sounds. Hhh.
431  C3:  No I mean but - but (.) for y:ou though - you say you
432       are (.) barely using. from going from multiple times a
433       day to once a day or whatever (.) to once in a month
434       (.) that's a pretty big accomplishment for you.
435  P5:  yeah
```

In this interaction, P5 provided two discussion points related to recovery. First, he validated the

recursive and yet long process to achieve sobriety (line 423–425). Then, he provided a statement

to show that he could be better, "I don't want to be (.) cocky or anything but I feel like I have

mo:re (.) than what (0.3) some addicts have." As soon as P5 revised his position with regard to

the justification of using (line 428–430), C3 shifted the discourse to the focus on P5's resiliency.

By starting with "No I mean but - but (.) for y:ou though," C3 firstly diffused the justification-

guilt narrative, followed by re-focusing on the sequence of progress that P5 has made, "from

going from multiple times a day to once a day or whatever (.) to once in a month (.)"

The above three examples demonstrate the strength-based and resiliency approach of counselors-in-training in this sample. This strategy explored positive aspects of clients, which characterized the relational discourse in counseling sessions.

Summary of Therapeutic Relationship and Discourse

Chapter five explored how trainees of family medicine and counseling and their patients/clients jointly formed a therapeutic relationship and created therapeutic discourses in the context of initial sessions. Data analysis indicated both convergent and divergent practices, and more convergent practices appeared than divergent practices. Convergent practices included discussing former therapists/clinicians, relational utterances and interactions, neutrality, validation, self-disclosure, displays of reactions, and repair. Divergent practices included praise and resilient approaches that were discovered in doctor-patient interactions and counselor-client interactions, respectively.

As therapeutic discourses and relationships emerged, some unique topics and features of interaction, such as the presentation of challenging communications, vulnerability, and adverse life events, occurred in the context of the initial clinical encounter. Trainees in both professions encountered more negotiations and perhaps more challenges in this process. The next analytic chapter will continue to explore the convergent and divergent themes between doctor-patient sessions and counselor-client interactions.

CHAPTER VI

Processes of Disclosures and Unique Features of Interactions

This third analytic chapter reports the findings regarding the third research question: how do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability? The emerging themes include both family medicine and counseling. There will be a total of 10 themes discussed with examples. Seven themes were found in convergence and three themes in divergence between the two professions. This chapter will report the convergence and then divergence of practice. The discussions and presentation of examples in the convergent themes will be organized according to the discussed themes as opposed to the contexts of family medicine and counseling. However, in the divergent themes, where distinctive features of practices were presented, the discussions will start with doctors-in-training followed by counselors-in-training.

Processes of Disclosures and Unique Features of Interactions: Convergence

As the initial sessions progressed, patients/clients often disclosed significant life events associated with the primary reason for their visit. In some cases, an established therapeutic discourse and relationship produced more interpersonal interactions between trainees and their clients/patients. This section will demonstrate how clients'/patients' disclosures occurred in the process of interactions, as well as dynamic interactions between trainees and their clients/patients as a result of the progression of the relationship. There are a total of seven identified themes shared by both professions. The seven themes are preparation, repetition, empathic reflection, brief utterances and non-lexical conversational sounds, managing discrepancies, disclosure in closing, and challenging interactions. The first four themes, preparation, repetition, empathic

reflection, as well as brief utterances and non-lexical conversational sounds, describe how disclosures occur as a result of interactions. The remaining three themes, managing discrepancies, disclosure in closing, as well as challenging interactions, show trainees' encounters and negotiations of unusual circumstances and interactions in an initial context.

Preparation

The first shared interactive feature is trainees' statements that were designed to prepare clients/patients for further disclosures. Preparation implies an upcoming occurrence of significant therapeutic discourse and a "signal" that requires clients/patients to provide relevant materials. Two examples demonstrate the process of preparation.

In the D4 and P5's interaction, D4 provided an introduction of her upcoming therapeutic task, which involved a series of questions that would require P5's disclosure of private and personal information:

```
(6.1)
98   D4:  alright. now (0.9) its' ok, we're going to start
99        getting some questions that are a little more of
100       personal. it's ok if (__) stays with us?
101  P5:  yes.
102  D4:  alright. so we have some history of depression and was
103       after babies or before babies or?
104  P5:  um (.) it was after my fourth pregnancy but I'd been
105       having depression before pregnancies.
106  D4:  alright so this is -
107  P5:  it's a family history- like we have suicide in the
108       family so it's like - everybody in the family has been
109       in(_____) for history of craziness.
```

Before P5's disclosure of extensive mental health issues in her family (line 107–109), D4's introductory statement intended to provide informed consent that introduced patients to the possibility of potential disclosure. This made P5 and her partner become aware that potential emotionally charged and sensitive questions might occur as result of D4's further assessment.

Notice that D4 specifically asked P5's permission about the presence of her partner (line 100),

suggesting a consideration to protect her confidentiality.

Statements that prepared clients' further disclosure can also be found in the session

between C1 and P1. In this interaction, C1 provided a brief summary of what had been

discussed, then proceeded to a more descriptive, detailed statement of intent that prepared P1's

further disclosure:

```
(6.2)
335  C1:  and that - I mean -  that takes time (.) but we'll
336        definitely get to that (.) but (.) what (.) once again
337        - and I am trying to get you to go just a little bit
338        deeper here(.) what is it - if you had to list some
339        things about your reality today (.) what are the
340        things that you don't like about your current
           situation.
341        (2)
342  P1:  well right now (.) the only thing in my life that's
343        missing really (0.5) is that the need to have a woman
344        to love and that probably goes to approval seeking
345        behavior. like oh I can do this. so it might go into
346        the sense of going deep into (.) I have power and
           control.
```

As the conversation went on, C1 continued to solicit P1's sense of vulnerability with regard to a

relationship:

```
(6.3)
350  C1:  ok. what do you think it is that stops you from moving
351        forward. because what I hear you saying is there is a
352        part of you that desires to have a relationship with a
353        woman. Am I correct in saying that.
354  P1:  right.
355  C1:  ok.
356  P1:  right.
357  C1:  what is it that sto:ps you or hinders you from
358        pursuing that.
359  P1:  me and the thinking going back to um (0.4)
360        insecurities (.) I won't be able to plea:se her. I
361        won't be able to get an erection. all that crazy
362        stuff. that's, and-  and that(.) going back to that,
           that's the crutch.
```

Accordingly, P1's disclosure of an issue concerning intimacy was accomplished through three sequences of therapeutic discourses. First, in his statement of preparation, C1 stated his intention, "I am trying to get you to go just a little bit deeper here," followed by his question that specifically encouraged P1 to engage in self-reflection, "what is it - if you had to list some things about your reality today (.) what are the things that you don't like about your current situation." Subsequently, this process produced P1's narrations regarding his sense of an obstacle regarding a relationship (line 359–362).

C1 followed P1's disclosure of the issue of an intimate relationship by soliciting the details by narrowing down the question with two sequences (line 351–352 and line 357–358). The first sequence provided his observation of P1's desire, "because what I hear you saying is there is a part of you that desires to have a relationship with a woman." The second sequence then focused on encouraging P1 to identify obstacles that P1 had encountered with regard to a relationship. At this moment, P1 revealed the vulnerability he encountered in intimacy.

The above two examples demonstrated that clients'/patients' disclosures occurred as a result of trainees' statements that functioned as preparation for clients/patients to provide relevant material. Statements of preparation implied trainees' awareness of an upcoming occurrence of significant therapeutic discourse.

Repetition

As discussed earlier in chapter four, trainees in both professions used recapitulation as a strategy for getting into the therapeutic agenda or re-introducing therapeutic interventions in the initial sessions. Trainees' repetition of story and events mentioned by patients/clients previously can also be used for opening up further disclosures in therapeutic processes. Two examples are selected to demonstrate this theme.

First, in the process of history taking between C2 and P2, the topic of guilt was brought

up by C2 as she recalled P2's previous words:

```
(6.4)
634  C2:  so you had said when I kind of asked you some of those
635        questions about like current symptoms you were having
636        when I asked about guilt you said yes. um (.) wha –
637        can you tell me about that. what do you feel guilt
          about
638  P2:  um (.) I feel guilt about (.) like - a lo:t of - it's
639        probably equal parts hh. imagined and real.
640  C2:  ok.
641  P2:  things. I've sort of always been you know (  ) a ton
642        of guilt. I don't know where that comes from or
643        anything. I was never made to feel guilty or like made
644        to feel like I was a bad kid or anything. I remember
645        one time when I was little (.) I got a B on a test.
646        and I was just like - in my head I made up that like
647        my dad was going to be furious about that and I felt
648        terrible. he was not going to like - it's not like he
          didn't care. a B is fine -
```

P2's elaboration of guilt and disclosure of related life events was produced through a sequence of

exchanges. First, C2 summarized the previous interactions that occurred earlier in the session,

with the opening "so you had said." Then, C2 repeated P2's words along with a summary of the

interaction. This process establishes the ground for her to request P2 to elaborate on the details of

the guilt (line 636–637).

Using clients' words and stories previously disclosed to explore further details can be

found in the session between D1 and P1. In this process, D1 first summarized previous words

and events disclosed by P1, then questioned the details of P1's relationship with his mother:

```
(6.5)
592  D1:  ok. so (1) so she left (.) twice (.) an:d (.)
593        obviously you said (.) you felt aban?doned. so how is
594        it living with her now
595        (5)
596  P1:  .hhh now that I think about it (.) yeah she left you
597        twice (.) but I had the heart to (.) take her in.
598  D1:  right.
```

```
599  P1:   you know  (4) (                   )
601  D1:   that's very (1) nice of you it's -
602        (5)
603  P1:   .hh I mean (.) she (.) she's talked (.) to uh (.) to
604        me and my brother about (.) finding another place and
           we have money put aside (   )(3) I guess you could say
605        I'm cautious about it (.) cause I don't know what
606        she's really thinking or wants to do and (.) .hh
           because of the (.) the past.
```

D1's repetition of P1's words produced a period of silence and P1's awareness in the subsequent interaction. First, D1 summarized the story disclosed by P1 with regard to separation from his mother. Notice that D1 added a stressed tone and a pause in between the words, "left (.) twice (.)" (line 592). Secondly, D1 recalled P1's words "aban?doned" (line 593) with an adverb "obviously," implying the significance of the emotion disclosed by P1. A moment of silence was produced as result of this recollection (line 595). Then, P1 initiated the talk with a similar speech feature on the word "twice" with a stressed tone (line 596). P1's elaboration of his psychological and emotional state with regard to the current relationship with his mother was produced as a result of this therapeutic discourse. A sense of vulnerability and caution was indicated in line 605–606.

In addition to getting into the therapeutic agenda or introducing therapeutic interventions in initial sessions, the recollection of stories and repetition of the phrases said by patients/clients were used to encourage clients/patients to open up further disclosures in therapeutic processes.

Empathic Reflection

The third relational discourse found in initial sessions in both family medicine and counseling is trainees' reflections during empathetic opportunities. Three excerpts are presented to display this discourse. The first excerpt illustrates C3's reflection on his observation of P5's facial expression when P5 was describing his ongoing conflicting relationship with his girlfriend due to his substance use:

(6.6)
```
177  C3:  = you kind of talk about it like (.) for you (.) I
178       look at your face when you tell the story and it is
179       kinda – you seem a little fl:at about it↑ (.) at the
180       same time in your voice I can hear this undertone of
181       guilt. it seems like almost (.) you have almost tried
182       to separate yourself from the guilt a little bit just
          as a way to function.
183  P5:  I – I'm telling you (.) I think (.) cause I have done
184       so:me (0.3) messed up things
185  C3:  um hm
186  P5:  in my addicti:on. stol:en from family members (.)
187       mostly.
188  C3:  yeah
189  P5:  and I just- I think tha:t kind of stuff really kept me
190       using just because (.) I felt so guilty about it when
191       I wasn't hig:hhh.
192  C3:  um hm
193  P5:  you know I would steal a hundred bucks out of my mom's
194       drawer go u:se I would feel great. then next morning I
          would be like wh.hhy did I do that
```

In this particular interaction, P5 was describing his conflicting relationship with his girlfriend in relation to his active heroin use. After C3 offered his observation of P5's affect and facial expression at the moment, P5 disclosed his past behaviors associated with addiction. P5's disclosure occurred through sequences of empathic reflection. First, instead of engaging in content discussion, C3 shifted the focus to his observation of P5's facial expression (line 178–179) and his perceived meaning of P5's tone of voice (line 180–181). Then, C3 paired the two observations together and provided his therapeutic interpretation, in particular, that P5's guilt and deflection served as a way to live through the addiction (line 181–182). The empathic reflection that conveyed the trainee's attention to the client's affect occurred at the moment of disclosure. In addition, it directed the attention to deeper affects and memories associated with the presenting issues. Note that after C3's empathic responses, P5 provided extensive narration regarding behaviors associated with relapse and guilt.

In addition to a reflection of clients' behaviors at the moment of disclosure, empathic responses that appeared in the process of disclosure related to clients' life stories. In another session between C3 and P4, C3 provided empathic reflection while P4 describing his childhood experience:

```
(6.7)
358  C3:  [she- she kinda  ](0.2) sounds like (.) she looks for
359       some
360       [  easy fix sometimes   ]
361  P4:  [yeah. yeah. absolutely.] now-now -sh - you know she
362       never done much of any kind of thera:p:y↑ or you know
363       she just always tries to go to a counselor and get a
364       bunch of pills and -
365  C3:  be done
366  P4:  yeah. be done with it.
367  C3:  as a son (kinda ) see:ing that it has to be kind of
368       frustrating.
368  P4:  yeah Oh yeah (.) big time. it's like mo:m's like she
369       always had a fricken pharmacy in (.) in her bathroom
370       and I just remember that growing up just pills and
371       pills and pills and pills (.) it was so bad that my
372       dad said she used to clean houses and she would (.)
373       clean houses and then take medicine from people just
374       to (.) you know try to not ea:t, o:r you know.
```

In this interaction, P4 recalled his childhood experience with his mother, who appeared to have psychological and addiction issues. C3's empathic responses concerning P4's role as a son brought up further disclosure of P4's childhood experiences. The empathic response was accomplished through adjoining and reflection. C3 first paraphrased his understanding of the mother's behavior (line 358–360). Then, C3 redirected the focus back to P4 by providing his observation of the potential emotions that P4 might have gone through, starting with his statement "as a son" (line 367).

In D1 and P1's interaction, the emphatic responses were rapidly produced in the sequence of P1's disclosure. Specifically, when an emphatic opportunity was presented, D1 provided

immediate empathy followed by questions that solicited details. In this interaction, D1 intended

to connect P1's anxiety and depression to grief and loss concerning loss of family members:

```
(6.8)
472  D1:  Ok (1) was there something that (.) cau:sed you to (.)
473       be:come (.) mo:re anxious or depre:ssed or (.) was
474       there (.) a certain e:vent (.) that (.) occurred in
          your life?
475       (3)
476  P1:  .h I can't say for sure .hhh (2) I know when we lost
477       (.) um cou:sin to muscular dystro,phy (2) I know I was
478       nine or ten at the ti:me (.)
479  D1:  ok.
480  P1:  that was a ° hard point. °
481       (3)
482  D1:  I'm sure it was hard(.) were you close with this
483       cou↑sin.
484       (6)
485  P1:  I was there (2) I went to (.) go up (.) to see him
486       during his final minutes or hours (.) not too soon I
487       had to leave his room I went into the hallway by the
488       elevators (2) I remember my mother coming down the
489       hallway with her hands in her face (.) bawling her
          eyes out.
490  D1:  a:ww
491       (2)
492  P1:  an:d (1) you know I remember my father asking did he
493       go and she shook her head yes.
494  D1:  and you were only ten at the time?
495  P1:  nine or ten.
496  D1:  a:ww. (1) so after that > is when you started < (2)
497       having feelings of depression?
498       (3)
499  P1:  I can't say it a hundred percent (.) but it (.) might
          have played a cause into it.
```

In this process, D1 first connected the cause of depression and anxiety with significant life events

disclosed by P1. Two questions suggest that P1 made such connection: "was there something

that (.) cau:sed you to (.) be:come (.) mo:re anxious or depre:ssed" and "was there (.) a certain

e:vent (.) that (.) occurred in your life." As a result, P1 disclosed the loss of a family member

(line 476–478), followed by an expression of vulnerability (line 480). In addition, the empathic

responses were produced each time before P1's disclosure. In line 482, D1 provided an empathic response and explored the details of the relationship (line 482–483), followed by expressions of emotions (line 490 and 496).

In line 496–497, D1 went back to the original agenda that links life events to presenting diagnoses. The discourse of P1's perspectives changed moderately as a result of D1's attempt. When P1 first encountered the question, he indicated "I can't say for sure," followed by a disclosure of loss. In the second sequence when the question was provided again, P1 revised the statement, "I can't say it a hundred percent," with an acknowledgement of the impact of loss on his mental health issues, "but it (.) might have played a cause into it."

As the above three examples indicated, clients'/patients' life stories disclosed in this process often connected to earlier adverse life events and vulnerability. Trainees' empathic reflection during empathic opportunities had an important function especially in the context of initial sessions where the uncertainty of the relationship was present. As the sequence of the disclosure from the three examples indicated, this relational discourse encouraged clients/patients to continue narratives that were relevant to therapeutic discourses concerning psychosocial environment, family relationships, and behavioral issues.

Brief Utterances and Non-Lexical Conversational Sounds

In addition to being verbally active during the therapeutic process in relation to clients'/patients' disclosures, trainees used brief utterances and non-lexical conversational sounds such us "ok," "um-hm," or "yeah" as acknowledgments of the disclosure and continuers that demonstrate trainees' listening and giving up of the speaking floor to the patient/client. Two examples are used for illustration.

The first example is an interaction between C2 and P2, who disclosed the process of

breaking off his relationship with his fiancée:

```
(6.9)
746  C2:  so when did you officially split. like you said
747       February?
748  P2:  yeah. the end of February. beginning of March of last
749       year. (2) um (.) and yeah we were just sort of in this
750       really weird in between state for a long time a:h (.)
751       which was really bad. um (.) I mean it wasn't like –
752       it was fine. like we could be civil with each other
753  C2:  sure
754  P2:  but for a while after we broke up like she really
755       would have done anything for us to get back together
            and I was still very much not thinking that was
756       a great idea. and then that shifted somewhere in the
757       summer where she was like (.) well I guess I'm going
758       to move o:n and I don't know if that's what triggered
759       me to like start questioning everything or if I was
            just already questioning everything.
760  C2:  um hm
```

A brief utterance such as "um-hm" (line 760) and "sure" (line 753) appeared in the process of

P2's narration to show C2's acknowledgement and listening. In this process, such an utterance

shows little personal reaction, value judgment, or therapeutic intervention toward the disclosures

but serves as a simple acknowledgement that encourages a continuance of narration.

In D2 and P2's interaction where the history of homelessness was disclosed by P2, D2's

brief utterances occurred simultaneously with P2's narration:

```
(6.10)
627  D2:  how did you end up living [ on the street    ]
628  P2:                            [because one cause] I used –
629       be:fo:re I used to live (.) I used to live with a
630       fr:iend (.) ri:ght? (0.3) but then (.) I lost my j:ob
631  D2:  ok.
632  P2:  because of my anger issues I had.
633  D2:  when you were sixt:een
634  P2:  y:eah (.) so I had issues with that (.) and I aint
635       like(.) you know I was like (.) type of dude like (.)
636       I never follow the rules like my mom said come in at
            nine and I'd be
```

```
637        like pfft I'm coming in at twelve o'clock (.) stuff
638        like that you know what I mean?
639  D2:  yeah (.) gotcha
640  P2:  so - so (.) to make a long story short I got kicked
641        out (0.4) when I was sixteen (.) so I just stayed on my
642        own (.) ever since then I said FUCK the world.
643  D2:  ok.
644  P2:  and that's how I feel (.) even to the day (.)FUCK the
          WOR:LD
645  D2:  yeah.
646  P2:  even if I die today it's ok with me (.) does not
647        matter (.) you -you get where I'm going?
648  D2:  ((nods))
```

As the story of P2's homelessness at a younger age unfolds, P2 took the lead in the session and

D2 stepped back in a supportive and listening role. This was demonstrated by her brief responses

in line 639. Notice that as the interaction progressed, P2 presented his emotions with curse words

and stressed tones in line 642. D2 simply presented her acknowledgment of the intense emotion

with brief utterances such as "ok" (line 643) and "yeah" (line 645) and nodding (line 648). Such

neutral responses toward the adverse life events disclosed by the patient indicate premonitory of

a shift that may encourage further disclosures or transitions of topics (Beach & Dixson, 2001).

The above two examples show that brief utterance and non-lexical conversational sounds

during disclosure conveyed trainees' action of listening and acknowledgement. So far the chapter

has presented how disclosures occurred as a result of trainees' presentation of therapeutic

discourses such as preparation, repetition, empathic reflection, and brief utterance and non-

lexical conversational sounds. Interactions were shaped and reshaped through trainees and

clients'/patients' presenting discourses at the moment. This study also found a small number of

interactions that illustrated unusual dynamics outside the norm of the process of clinical sessions.

Three themes, managing discrepancy, disclosure in closing, as well as challenging interactions,

show trainees' encounters and negotiations of unusual circumstances in an initial context. This

study includes these themes because they are part of the research question. In addition, they

reveal a progression of the therapeutic process as well as relationships.

Managing Discrepancies

In the process of completing therapeutic tasks and building a relationship in an initial

session, trainees occasionally encountered discrepant information provided by patients/clients.

As such, managing discrepant information became necessary in the process of interactions. Two

examples illustrate this process. Note that both examples relate to the issue of an abusive

relationship between the patient/client and their partners.

The first example is the interaction demonstrated by C2 and P3 surrounding P3's

husband's mental health history. In this session, P3 brought up the issue of marital conflict, as

this was one of the main reasons that brought her in for counseling. C2 intended to conduct

history taking that included family members' mental health history. In this interaction, C2's tried

to clarify the information:

```
(6.11)
180  C2:  does he see a psychiatrist?
181  P3:  he sees a therapist (.) but she hasn't done him any
182       good at all. there's no change in him wha- whatsoever.
183       so I have no idea what he (.) what he tells this woman
184       because a therapist can only help you based on what
          you tell them.
```

Notice that when the question was provided (line 180), P3 neither confirmed nor denied the fact

that her husband had a psychiatrist. Instead, the answer was primarily about his counseling

history.

As the session progressed, P3 continued providing detailed descriptions of her husband's

behaviors. At this point, P3 indicated that he had taken multiple psychiatric medications. The

question of whether he had psychiatric visits emerged again in the interaction:

(6.12)
```
547  P3:  but I think this combination of these pills are making
548       him insane.
549  C2:  sure. that's a very real possibility. does he see a
550       psychiatri:st.
551  P3:  oh yeah (.) he was interviewed. now they're not
552       picking up anything because I don't know if he doesn't
553       tell them what – you know
```

C2 in the process presented a non-confrontational and yet persistent discourse when encountering P3's discrepant information. First, C2 validated P3's speculation about her husband's condition by responding "sure. that's a very real possibility." Then, she proceeded to ask the same question again (line 549–550). Notice that after C2's question the second time, P3 then confirmed that her husband had been seeing psychiatrists, possibly multiple professionals, as indicated by her use of pronoun, "they" (line 551). Furthermore, P3 added an additional note that "they're not picking up anything because I don't know if he doesn't tell them what," suggesting that the psychiatric history is inconsequential. It is unclear about P3's reasoning behind the discrepant information presented in the session. However, the delayed disclosure and her indications of her husband's habit of concealing information to practitioners suggest a sense of reluctance and uncertainty about the question, at least in the earlier stage of the counseling process. C2's non-confrontational approach seems to function as a non-threatening intervention in this circumstance.

Managing discrepant information can also be found in the session of D4P5. An example between the two used previously is reexamined in this section because the process of disclosure reflects the theme. In this example, the trainee's clarification and recollection of the discrepancy may elicit further revelation of the patient's' perspectives regarding the discrepancy, or perhaps, provide explanations of why discrepancy occurred in the first place. During the history taking in the beginning of the session, D4 inquired about P5's history of hospitalization:

(6.13)
```
168  D4:  and u:m (1) ever been in the hospital for any other
169       reason besides delivering babies?
170  P5:  no.
```

In this interaction, P5 denied having any history of hospitalization. However, this information

was clarified in a later process when the issue of child protection service was revealed:

(6.14)
```
204  D4:  did (.) CPS ever been involved.
205  P5:  they have. back in two thousand fourteen.
206  D4:  alright. so (.) recently.
207  P5:  um hm
208  D4:  why was that.
209  P5:  uh (0.8) just messy violence between me and my baby
          father.
210  D4:  Hhh. Alright (.) previous baby's father (.)
          not (_____)
211  P5:  not (____). that's what he said (.) he saved me seven
          months ago. ((laughs))
212  D4:  alri:ght (3) u:m  was (0.4) was he physically abusive
213       toward you?
214  P5:  um-hm put me in the hospital a couple of times and -
215  D4:  oh so you↑ have been in the hospital besides  -
216  P5:  oh↑ well it wasn't really bad. he's like - like
217       suffocated me -
```

The clarification and correction of the statement emerged between lines 204 to 215. First, in line

209, a contrast presentation and possible minimization of the severity of domestic violence was

reflected by P5 through the narration, "just messy violence between me and my baby father."

After clarification about the batterer (line 210), D4 proceeded to solicit details of the event (line

212–213). At this point, P5 disclosed the fact that she had been hospitalized "a couple of times"

due to the physical violence conducted by the ex-partner. D4's response "so you↑ have been in

the hospital" with a slightly rising tone implying surprise and an attempt to correct the discrepant

information.

After D4's clarification and intent of correcting the discrepant information, P5's

presentation of discrepant and contrasting discourses about the severity of the violence was

further revealed. After D4 concluded that P5 was indeed hospitalized a couple of times, P5 did

not deny or confirm it, but focused on defending the severity of the circumstance, "oh↑ well it

wasn't really bad." This may have provided a possible reason for why she denied her

hospitalization in the first place. In addition, the contrasting discourse regarding the severity of

the violence was presented through the juxtaposition of "it wasn't really bad" followed by "he's

like - like suffocated me –."

A potential challenging interaction in an initial clinical session is that while in the process

of completing therapeutic tasks and building a relationship, trainees may encounter discrepant

information provided by patients/clients. The above two examples show that trainees were

persistent in pursuing the correct information. In the second example, the clarification elicited

the patient's further responses that revealed personal discourses regarding the incident.

Disclosure in Closing

Another feature of disclosure found in this sample was disclosure of additional unsaid

feelings and thoughts at the end of the session during closing. Similar to the theme, "managing

discrepant information," trainees in this process encountered a series of decisions in the

procedure of closing, while attending to clients'/patients' request. Two examples are used to

illustrate this negotiation. The first example is between C1 and P1 near the end of the session

where P1 intended to discuss an earlier conversation about hiding:

```
(6.15)
964  C1:  is there anything else you need to say before we close
965       this off.
966  P1:  = no no no no no (.) you brought -you brought a good-
967       good  topic about hiding – am I hiding using that so I
968       don't  have to –
969       (0.5)
970  C1:  all I did is repeat what you said
971  P1:  I like (0.5) what you say. yeah see but see - but in
972       my mind I don't - I don't understand that question you
973       know you're you are (   ) you know how to do it just
```

```
974        like – it just like therapy (.) she know how to do it
975        just stay ( )like she was guided like – guide me ok.
976        and – and –and in a loving and caring way and like the
977        force – and that's what I get form u:m cause over here
           this is a force- force –
978  C1:   right.
979  P1:   there are some forces and I have no control over. I
980        have some force on me. I have no control over it I am
981        going with (blind) are my reality was (1) this is over
982        here- if I go gravitate toward you like you said (0.5)
983        recovery (.)like what they said even though I have to
984        go through I have go through (0.5) I am grateful then
           I don't have to be-
985  C1:   well here is something else. now remember this – we
986        don't know if over here is a whole lot better
987  P1:   right right right
988  C1:   but it would be a shame not experience to be able to
989        rule it out or embrace it
990  P1:   alright
991  C1:   so (.) Wednesday at one o'clock.
```

Initially, P1 repeated "no" five times to emphasize that he had nothing else to say (line 966) after

C1's question (line 964–965), but immediately brought up the issue of hiding discussed earlier

(line 967), with an indication of praise that C1 had "brought a good topic" (line 966–967). A

presentation of different perspectives is reflected through the use of pronoun, "you," and the

assignment of the ownership of the statement (line 971). For example, while C1 responded to

P1's thoughts regarding hiding as "all I did is repeat what you said," P1 negated the statement by

indicating "I like (0.5) what you say," followed by presentation of his perspective with the

opening "yeah see but see." Then, P1 brought up his former therapist and his therapeutic

experiences with an indication of his perspectives regarding having no control and power over

addiction.

Supporting that, P1's narration regarding the former therapist (line 974–976) in this

context implied the intent to request C1 to modify his therapeutic stance with regard to the issue

of hiding, guidance, and accountability. On the other hand, C1's negotiations revealed several

discourses. First, a brief intervention that neither confirmed nor denied P1's perspective was

presented with an open-ended conclusion. "we don't know if over here is a whole lot better"

suggests uncertainty about the therapeutic discourse, followed by a statement that suggested the

necessity of having different perspectives, "but it would be a shame not experience to be able to

rule it out or embrace it." With the brief intervention provided, C1 then concluded the session

with confirmation of the next visit (line 991).

A similar negotiation was found in D1 and P1's session during closing. The example

between D1 and P1 used previously is reexamined in this section because the process reflected

the theme. In this session, P1 intended to discuss an earlier conversation he had with another

therapist regarding self-harm risk:

```
(6.16)
720  D1:  ok. well thank you very much for sharing all of this
721        information (.) I think it's really going to help (.)
722        our(.) u:m (.) patient doctor relationship and I think
723        it will(.) um (.) just (.) -  it makes me understand
724        you a little more and that's (.) a good thing (.) ok
725        (1)  u:mm (.)anything else you like to share?
726        (2)
727  P1:  .hh one thing I've been think a lot is u:mm (2) when I
728        see my therapist I mention a few times h:ow (1) .hh I
729        just want to end it (.) or I (.) I just don't care
           anymore. .hhh
730  D1:  um hm
731        (2)
732  P1:  I (.) when I say that I don't I don't  mean - I don't
733        reference myself (.) like I just want to end my life
734        or anything? but I just want to be done with (.) you
735        know (.)whatever is causing my frustration (.) you
736        know (.)depression and (.) - she mentioned yesterday
737        how (.) .hh she noticed I'd been saying I don't care
738        anymore (.) quite often.
739  D1:  um hm
740  P1:  I don't know if she's wondering if (.) .hh you know
741        (.) if I'm going to do something unusual o:r (.) I
742        mean I'm not going to.
```

Recall that in the beginning of this session, D1 asked P1 about his experience with therapy. What P1 brought up here was new information. In this process, P1 intended to explain and clarify that he is not at-risk for committing suicide. In responding to this emerging topic at the end of the session, D1 conducted a brief assessment in order to evaluate the risk:

```
(6.17)
743  D1:  have you ever thought↑ about it?
744  P1:  (            )
745  D1:  ok.
746  P1:  no. .hh I mean (4) um (.) I (.) I sort of questioned
747       her (.) you know whe -  you know where does she think
748       I'm  at(3) I don't see her again until the twelve of
             March (.) so.
749       (3)
750  D1:  ok (2) ((nods)) can you get in to see her sooner↑ if
751       you feel you might need to?
752  P1:  .hh if I needed to I'm pretty sure she could .hhh
753  D1:  ok.
```

As D1 confirmed the risk was low (line 743–745), she shifted the direction from risk assessment to the communication between P1 and his therapist, as indicated by her question at the end (line 750–751).

The two examples illustrate another unique feature of disclosure, the disclosure of additional unsaid feelings and thoughts at the end of the session during closing. Trainees in this process encountered a series of decision-making and negotiations between closing the session while attending to the patient's/client's presenting concerns. It appears that trainees continued responding to those concerns, while re-introducing the agenda of closing as a reminder of the continuation of the therapeutic process in the future sessions.

Challenging Interactions

The third unique relational dynamic shared by both professions in this sample is challenging interactions. This phenomenon occurred in a particular context when health risks or risky health practices are identified. Under this circumstance, trainees provided direct therapeutic

interventions or standpoints that may not ally with clients'/patients' perspectives. However, this

strategy was used to help achieve therapeutic agendas that intended to eliminate presenting

issues or prevent potential complications associated with the issue. The negotiation between

providing direct therapeutic standpoints while managing relationships signifies the challenges.

Analysis shows that trainees presented relatively direct and overt therapeutic language in this

process. A total of four interactive examples are used to illustrate the theme.

The first challenging interaction is found in the session of C3P4 during assessment where

P4 revealed that he was still actively using drugs. The interaction started with C3's question of

P4's medication history, which brought up P4's disclosure of his substance use:

```
(6.18)
617  C3:   u:mm so any other current- u:m (.) medication like
618        herbs (.) vitamins anything like that?
619  P4:   no. no.
620  C3:   ok.
621  P4:   I smoke a little bit of pot here and there.
622  C3:   alright ((nods))
623        (4) ((C3 reads the document))
624  C3:   ((looks at P4)) is that something (.) you want to
625        change (.) while you're coming here? [or is that
             something
626        you're kind of ok with right now.]
627  P4:                                       [the wee:d (.)
             y:eah I
628        got – yeah I      gotta –       ] I gotta stop doing
629        it anyway. just for (.) you know – I –
630  C3:   um hm (.) so (.) so one of the goals (.) you want out
631        of coming here is kind of cut – [ cut] all of it?
632  P4:                                   [yeah]          yeah.
633        I mean the Soboxin thing I'd like to get off of them
634        (.) t:oo but for now I'm alright with that.
```

After P4's disclosure of his ongoing use of marijuana followed by a few seconds of silence (line

623), C3's overt, forthcoming therapeutic stance appeared in line 624–626. Accordingly, C3's

question in responding to P4's disclosure implies a therapeutic agenda that encourages P4 to hold

himself accountable for his recovery (line 624–626) and explored P4's personal goals in coming

to counseling (line 630–631). Notice in the middle of the question, a personal account was

produced where overlapped talk emerged that indicated P4's assurance of sobriety (line 627–

628). While P4 intended to continue the talk (line 629), C3 interjected another question that

summarized the therapeutic goal (line 630–631). The rapid, focused, immediate response

suggested the importance of the topic. This process re-introduced therapeutic agendas and

conveyed the importance of sobriety as well as P4's personal accountability for the treatment.

Another similar example is found in the interaction between D4 and P5 during

assessment. This example was used previously and is reexamined in this section because the

process of disclosure reflects the theme. After discovering that P5 was actively using substances

during pregnancy, D4 provided a direct intervention though the overt language of advice:

```
(6.19)
285  D4:  any weed use.
286  P5:  I smoke weed.
287  D4:  are you still smoking?
288  P5:  uh hm. I know my limit to stop before the
          baby((laughs))
289  D4:  are we quitting before (.) because otherwise CPS is
290        gonna be involved again.
291  P5:  yeah
```

Line 285 indicated D4's specific focus on checking whether P5 is still actively using, with the

question of the present tense "are you still smoking?" Notice that P5 neither denied nor

confirmed her use of marijuana (line 288). Without further solicitation of the details of P5's

answer, D4 provided immediate responses with preventive measures regarding the issue of CPS,

"are we quitting before (.) because otherwise CPS is gonna be involved again." In addition, "are

we quitting before" provided a therapeutic standpoint with regard to the decision of chemical

use.

Later in the session, the two continued the conversation about marijuana. After D4

explained why marijuana causes more depression, P5 then changed her reason for using from

"calming herself down" to her experience of receiving different advice from a previous doctor.

This process inevitably brought up D4's overt therapeutic stance:

```
(6.20)
371  P5:  that's what doctor (_____) (.) my old doctor - he gave
372       me permission to smoke until I was six months pregnant
373       and then he was like when I was six months (.) I need
374       you to(basically) so I stop.
375  D4:  yeah (.) !I'M↑ NOT THAT LENIENT! $I must say$
376  P5:  ((laughs))
377  D4:  cause I think we have other drugs too and the only
378       thing too - the only - u:m the only thing that really
379       scares me is the problem (.) the - the-  quality of
380       the weed that is actually coming into town. we've got
381       a couple of kids at (__) young kids that really got a
382       lot of dama:ge from weed that was thrown a spike into
383       i:t and other additives (.) who knows what and - and
384       that's I think where I get more nervous than anything
         else (.) we do not know what -
```

D4 in this process presented a similar path with C3 but with some variations. First, unlike C3, who presented his standpoint with a question, D4 provided a direct statement with noticeable volume and speech pattern (line 375). Secondly, while providing the explanation, D4's risk assessment focused on the health of the fetus (line 381–382). Thirdly, D4 shared her affective reactions in the process of negotiation by disclosing her emotions, the sense of being "scare[d]" and feeling "nervous" with regard to P5's behaviors (line 379 and 384).

It is clear that D4 and P5 had different standpoints on the discourse of marijuana and pregnancy. For P5, stress relief is the main concern. For D4, the prognosis of depression and the health of the fetus are the main reasons why P5 should not use. Notice that despite the different standpoints, the two jointly constructed the interactions surrounding the issues. When P5 talked about stress relief, D4 provided a counter narrative that explains why it causes more mental health issues. When P5 talked about her previous doctor's standpoint, D4 provided a counter narrative that indicates her position.

Recall from earlier sections that the main reason that P3 came to counseling with C2 was

her ongoing conflicting, abusive relationship with her husband, and her ambivalence about

seeing someone else while being married. As the session progressed, C2 identified potential risks

to P3's safety. A rather direct and overt therapeutic statement was provided in the middle of the

session:

```
(6.21)
422  C2:   I wouldn't normally say this on a first session (.)
423        but I'm going to (.) just because some of this stuff
424        that you've said to me about the police visits and him
425        being violent.pt He sounds like (1)he sounds like an
426        (.) abusive person. and it sounds like you're in -
427        regardless that it hasn't physically happened. There
428        hasn't been an actual physical injury yet (.) but it
429        sounds like he in some ways is a domestically violent
430        (.) person (.) to you. like (.)psychologically. I mean
431        (.) that must be really scary that he was threatening
432        you with various weapons your husband I mean. and so
433        (.)  you kind of said I'm a little bit worried about
434        this divorcing and how he's going to handle it. like I
435        said (.) I'm only saying this because I'm not sure if
436        you're going to continue to come here afterwards and I
437        know you just said you're in the process of figuring
438        out divorce stuff .hhh(.) my encouragement to you
439        would be to maybe make(1) like I don't know we could
440        do it in he:re or you know whatever, but talk about a
441        safe way to have that happen. because I guess my
442        concern, based on the the hhh. half hour we've spent
443        together would be that something - that could be like
444        a trigger to - to cause something to go further with
445        his kind of (0.5) threats. (4) like I said I'm sorry,
           I don't normally (.) drop heavy of a bomb in the first
           session.
446  P3:   nah
```

Note that before C2 introduced her direct standpoint, she provided a brief statement to point out

the unusualness of this conversation: "I wouldn't normally say this on a first session (.) but I'm

going to (.)" Then, she provided the reason for this unusual conversation: "just because some of

this stuff that you've said to me about the police visits and him being violent." This statement

contained several sources of perspectives. First, line 424–425 shows the facts. Line 425 indicates C2's personal standpoint. Line 426–433 indicates materials from P3. Using these three sources of rationales provides ground for C2 to introduce her intervention. Line 439 introduced a safety plan, followed by a repair to this challenging conversation. By telling P3 that she doesn't "normally (.) drop heavy of a bomb in the first session," C2 was buffering the intensity of the conversation, while at the same time raising P3's awareness of the issue.

As the above four examples indicated, challenging interactions often occurred when health risks or risky health practices were identified. The negotiation between providing direct therapeutic interventions while managing a relationship signifies the challenges. In this process, trainees provided direct therapeutic interventions or standpoints that may not align with clients'/patients' perspectives, but intended to prevent potential complications associated with the issue.

Summary of Processes of Disclosures and Unique Features of Interactions: Convergence

This section discusses how clients'/patients' disclosures occurred in the process of interaction, as well as the dynamic interaction between trainees and their clients/patients as a result of the progression of the relationship. Trainees encountered patients'/clients' disclosures of significant life events associated with the primary reason for their visit. In addition, more interpersonal and intense interactions between trainees and their patients/clients were produced.

This study found a total of seven identified convergent themes shared by both counseling and family medicine. The process of disclosure and the unique feature of interactions appeared in both clinical interactions including preparation, repetition, empathic reflection, brief utterances and non-lexical conversational sounds, managing discrepancies, disclosure in closing, and challenging interactions, with the first four themes describing how disclosures occurred as a

result of therapeutic discourses, and the remaining three themes describing how trainees negotiated unusual circumstances and interactions.

The next section will present the divergent themes with regard to the therapeutic relationships and discourses in an initial context.

Processes of Disclosures and Unique Features of Interactions: Divergence

As patients'/clients' disclosures can be very contextual and circumstantial, this condition reflects the divergence of practices in the two professions. This section will illustrate distinctive talk and interactions in each profession with regard to disclosures and unique interactions, such as the presentation of challenging communications and vulnerability. This study found three divergent practice, disclosures through treatment protocols and delayed affective responses, telling bad news, as well as disclosures through relational discourse and presentation of analytic standpoint. The first two themes, disclosures through treatment protocols and delayed affective responses as well as telling bad news, were found in doctor-patient interactions. The theme, "disclosures through relational discourse and an analytic presentation," was found in counselor-client interactions. Each theme is discussed in detail with examples.

Divergence: Doctors-in-Training

Disclosures through Treatment Protocols and Delayed Affective Responses

In the context of doctor-patient interactions, disclosures may occur as a result of the therapeutic process, such as questions and answers during assessment. The analysis showed that such disclosure reflected the following sequence: answering a question provided by trainees, hedging, and delayed affective responses. Three examples demonstrate this process of disclosure. The first example is the beginning of the session between D3 and P3. When the reason for the

visit was asked, P3 provided two reasons in different sequence, and the second concern turned

out to be the main reason for the visit:

(6.22)
```
40   D3:  ok good good good. so what brings you in today.
41   P3:  um (.) today I need a TB shot due to employment.
42   D3:  like a TB ppd test?
43   P3:  yep a ppd and um (0.4) pt I also have a
44        hemorrhoid(.) that appeared (.) the beginning of (0.4)
45        the - the month (0.4) has yet to go away and I don't
46        really know the whole cycle of hemorrhoids so
```

P3 provided the TB test as the reason of the visit when the question was asked (line 41). After

D3's confirmation (line 42), P3 disclosed the second concern, the hemorrhoid, which turned out

to be the main reason for her visit. Notice that P3's "um" and a 0.4 second of silence occurred

before this delayed disclosure, suggesting a possible hesitation. This demonstrates how

disclosure of concerns occurs in the sequence of treatment protocol and procedures. In this case,

the assessment inquiry led to P3's disclosure of her physical concerns.

In addition to general health concerns, disclosure of adverse childhood events and a

delayed reaction of vulnerability emerged during a BPS session in doctor-patient interactions. An

example between P2 and D2 used previously is reexamined in this section because the process of

disclosure reflects the theme. In the BPS session between P2 and D2, P2 disclosed his homeless

life in the question and answer process. Although there was lack of affective response at the

moment, the emotional vulnerability manifested itself in the process of storytelling:

(6.23)
```
617  D2:  [  ((looks at P2 and nods   ] ok. so from sixteen you
618       lived on the street for eight y:ears? (.) then where
619       did you live.
620  P2:  ((shakes his head)) in the streets
621  D2:  so always right up until you moved here two years ago.
622  P2:  ((nods))
623  D2:  that's a hard life.
624  P2:  and I lived it.
625       (0.5)
```

```
626  D2:  ok.
627  P2:  I slept in abandoned ca:rs (.) I slept in roofto:ps
628       (.) I slept in par:ks (.) I slept wherever I could
          slept.
629  D2:  how did you end up on the streets.
630       (0.3)
631  P2:  Hu:h
632  D2:  how did you end up living [ on the street    ]
633  P2:                            [because one cause] I used
634       be:fo:re I used to live (.) I used to live with a
          fr:iend
635       (.) ri:ght? (0.3) but then (.) I lost my j:ob
636  D2:  ok.
637  P2:  because of my anger issues I had.
638  D2:  when you were sixt:een
639  P2:  y:eah (.) so I had issues with that (.) and I aint
640       like (.) you know I was like (.) type of dude like (.)
641       I never follow the rules like my mom said come in at
642       nine and I'd be like pfft I'm coming in at twelve
643       o'clock (.) stuff like that you know what I mean?
644  D2:  yeah (.) gotcha
645  P2:  so - so (.) to make a long story short I got kicked
646       out (0.4) when I was sixteen (.) so I just stayed on
647       my own (.) ever since then I said FUCK the world.
648  D2:  ok.
649  P2:  and that's how I feel (.) even to the day (.)FUCK the
650       WOR:LD
651  D2:  yeah.
```

After an empathic response (line 623), D2 continued soliciting the reason for P2's homelessness from a young age (line 629). There were two pieces to the disclosure, the content and affective display in this process. First, the disclosure of the reason and stories regarding his homelessness (line 633–635). In this process, there is little indication of vulnerability (line 624 and 637) but a more mechanical question and answer pattern was shown (line 639–643). A more dynamic, relational disclosure occurred as the interaction progressed. As P2 indicated his anger issue as the reason for being kicked out at the age of 16, more emotional reactions were revealed in the process. The change of speech pattern can be found in line 647. For example, the tone rose with

stress on certain words, "that's how I feel (.) even to the day (.)FUCK the WOR:LD," followed

by the ownership of the emotion, "that's how I feel (.) even to the day (.)FUCK the WOR:LD."

Disclosure of adverse life events through question and answer, followed by delayed

affective responses, can be found in the interaction between D4 and P5 regarding the issue of

domestic violence. Again, this example used previously is reexamined in this section because the

process of disclosure reflects the theme:

```
(6.24)
204  D4:  did (.) CPS ever been involved.
205  P5:  they have. back in two thousand fourteen.
206  D4:  alright. so (.) recently.
207  P5:  um hm
208  D4:  why was that.
209  P5:  uh (0.8) just messy violence between me and my baby
          father.
210  D4:  Hhh. Alright (.) previous baby's father (.)
          not (_____)
211  P5:  not (____). that's what he said (.) he saved me seven
212       months ago. ((laughs))
213  D4:  alri:ght (3) u:m  was (0.4) was he physically abusive
214       toward you?
215  P5:  um-hm put me in the hospital a couple of times and –
216  D4:  oh so you↑ have been in the hospital besides  –
217  P5:  oh↑ well it wasn't really bad. he's like – like
218       suffocated me –
219  D4:  THAT'S REALLY BAD. honey – that's really bad.
220       (((nervous laughter)))
221  P5:  I had blood clot in my no:se (.) in my throat from
          him.
222  D4:  oh that's pretty ba:d
223  P5b: real bad (.) try terrible.
```

The sequence of question and answer, hedging, and delayed affective responses occurred in this

interaction. First, P5 answered the question provided by D4 as part of history taking (line 205).

When P5 disclosed further details (line 209 and 215), the two presented different perspectives on

the event (line 217–219). Hesitation and ambivalence were displayed. For example, P5 first

diffused the severity of the issue by saying "oh↑ well it wasn't really bad," followed by a

presentation of contrasting discourse on the same statement (line 218) and then an elaboration of

the details of violence (line 221). After D4 repeatedly expressed her therapeutic standpoint on

the issue of violence (line 219 and 222) with a higher volume the first time (line 219), P5

revealed more details that confirmed D4's standpoint (line 221). This process produced P5b's

reaction that reflects D4's perspective, as indicated by his comment (line 223).

A variation of the process of disclosure between counseling and family medicine was that

in some cases of doctor-patient interactions, disclosure occurred as a result of the therapeutic

process, such as questions and answers during assessment. In addition, there were hedging and

delayed affective responses from the disclosures.

Telling Bad News

Showing concern and telling bad news were part of the routine in doctor-patient

interactions. In some cases, showing concern and telling bad news co-occurred in a conversation.

This study found two examples that show doctors-in-training's negotiation in the processes of

telling bad news when a critical condition was identified in an initial encounter. Analysis shows

trainees engaged in reasoning and persuasion before telling bad news.

The first example is a regular doctor's visit with D3 and P4, who had a relatively critical

condition before he came in to the session. After a series of history taking and physical

examination, D3 sought consultations before providing therapeutic actions. In this interaction,

D3 came back to the examination room and indicated her concerns and treatment decisions for

P4:

```
(6.25)
264  D3:  ((opens the door)) L(____) my dear (.) u:m (.) ((shuts
265       the door)) because you had recent flu↑
266  P4:  uh huh
267  D3:  and because your lungs sound horrible
268  P4:  uh huh
269  D3:  I'm concern of pneumonia or a bacterial infection.
```

```
270        often times. young healthy people like yourself -  if
271        they get the flu and then pneumonia. it can be pretty
272        serious. I want to admit you to the hospital (.) here
273        at (_____) ok? I just want them to draw some blood.
274        give you some fluids. you haven't been eating well (.)
275        for a week. you have nausea. vomiting. I'm concerned
276        about you ok? I want to see if you need antibiotics
           (.) and we'll go from there ok?
```

The delayed presentation of the bad news was reflected through the organization of discourse in

the sequence of the action. First, D3 presented the rationales for the decision to admit P4 to an

inpatient unit by pairing up the health history (line 265) and the result of the current physical

exam (line 267) in the presentation. Then, a personal concern was displayed, followed by

providing medical knowledge regarding the flu to highlight the severity of the condition (line

269–271). The bad news of in-patient admission was provided at this point, followed by a brief

overview of what would happen in the in-patient unit (line 273–274). The interaction was

concluded through a recycling of P4's critical condition (line 274–275) and a display of concern

(line 275–276). The organization of discourse in the sequence of telling bad news is summarized

in the following pattern:

Rationale (presentation of critical condition) => Concern = Knowledge presentation =>

Telling bad news and associated future proceeding => Rationale (presentation of critical

condition) => Concern.

Notice that the sequence of Rationale (presentation of critical condition) => Concern was used

at the starting as well as the end point in this process of telling bad news.

Postponing the telling of bad news was also found in the interaction between D2 and P2

near the end of the session. In this process, D2 had sought supervision regarding P2's fluctuating

mood conditions that warranted an inpatient treatment. When coming back to the session, the

two engaged in the conversation regarding P2's family history, until P2 initiated the topic:

(6.26)
```
1543 D2:  is she - so she's not active anymore.
1544 P2:  huh?
1545 D2:  she's not acti:ve
1546 P2:  Yeah she's active (.) when they ca::ll (.) she's
          active
1547 D2:  ok.
1548 P2:  yes she is. she can leave today or tomorrow ((moves
1549      his body))
1550 D2:  ok (.) alright (0.6) OK (.) SO
1551      (0.6)
1552 P2:  Thiz (        ) thing.
1553 D2:  Yes (0.5) what do you think.
1554 P2:  what do you think.
1555 D2:  how do you fee:l if I say I think you need it.
1556 P2:  pt ((smacks the sofa with one hand)) but then how long
1557      you think I need it (.) that's my problem
1558 D2:  I th:in:k I need you to get started on medications.
1559 P2:  and I got to be in (____) [to start medications]
1560      ((smacks the sofa with one hand))
1561 D2:                           [and I think (____)  ]
          because I want someone to keep an eye on you. HERE'S
1562      THE OTHER THING. you don't have heat right now (.) and
1563      you don't have electric.
```

Line 1543–1549 shows a discussion related to P2's sister that was ended before the presentation of the bad news initially brought up by P2 (line 1552). The indication of P2's urge to bring up the bad news was shown through his body language (line 1548–1549) and a brief moment of silence (line 1551), and finally manifested through an abrupt, expressive tone and volume (line 1552).

A circuitous discourse of bad news telling was presented after P2's initiation (line 1552) and omission of presentation of personal standpoint (line 1554). P2 deflected the question back to D2 who revealed her standpoint with a question, "how do you fee:l if I say I think you need it." When P2 displayed overt resistance toward the hospital admission (line 1556), followed by his questions of the timeline (line 1557), D2 responded with a proposed future proceeding (line 1558), personal concern and rationale (line 1561) as supporting reasons for P2's admission to the

hospital. Thirdly, D2 added a perspective on living conditions (line 1562–1563) in order to persuade P2 to agree to the decision. A similar sequence of the process of delivering bad news is summarized in the following formula:

Telling bad news and associated future proceeding => Concern => Rationale (presentation of critical condition)

The above two examples indicated that telling bad news occurred when a critical condition was identified in an initial encounter. Doctors-in-training in such circumstances often needed to negotiate the processes and procedures of telling bad news. For example, the analysis indicated that trainees engaged in a recursive process among showing concerns, providing explanations, and reporting the bad news. In addition, reasoning and persuasion strategies were used in the process.

Divergence: Counselors-in-Training

Disclosures through Relational Discourse and Analytic Presentation

Disclosure in counseling sessions in this sample displayed a pattern that was different from medical sessions. That is, disclosure was formed through relational discourse provided by trainees. In addition, clients in counseling sessions often displayed a forthcoming and analytic standpoint in the process of problem presentation and disclosure of adverse events. Due to the context of the visits, disclosures in counseling sessions in this sample seem to show little hesitation. This study selected four examples to illustrate this theme.

The first example is the session of C2P3. Initially, when the question was provided by C2, P3 struggled to talk about the issue with her husband. Disclosure and immediate problem presentations occurred when validation was provided:

```
(6.27)
98   C2:  you can start wherever – wherever you feel comfortable
```

```
99           or wherever makes sense.
100          (2)
101  P3:  he's disabled. okay -
102  C2:  okay. what's his disability.
103  P3:  as far as I'm concerned he's not disabled (.) oka:y
104          (.) he's been trying to get disability for six to
105          seven years. and they keep turning him down. okay (.)
106          he had me in a situation that I hurt my back u:m (.)
107          two years ago. a:nd (1) because of it I was forced not
108          to go to work for a while. so it turned out to be like
109          longer than what I thought to be o:ff.
```

Different from the conversations between doctors-in-training and their patients discussed

previously, the disclosure in this interaction displays little question and answer format. It

occurred as result of C2's invitation. When the open-ended question and validation was provided

through C2's language, "you can start wherever—wherever you feel comfortable or wherever

makes sense," P3 started with the issue of her husband's application for disability benefits. After

C2's question that intended to solicit the type of disability (line 102), P3 provided extensive

narration regarding the problem of the application (line 104–105), the ongoing conflict in the

relationship (line 105–106), and financial issues (line 107–108). Notice that the disclosure was

presented as story-telling narrative with little affective display.

The client's disclosure of addictive behaviors and associated vulnerability can be found

in C3 and P4's interaction, where C3 provided a reflective statement in the beginning. In this

process, P4 actively engaged in the dialogue and presented his perspectives on relapse and

relational issues:

```
(6.28)
61  C3:  um hm (.) that seems like something when you look back
62          on it (.) it was kind of like (1) there-  there's a
63          little bit of you wish you did mo:re↑
64  P4:  yeah
65  C3:  but in a sense you really haven't - didn't have [the
66          opportunity] -
67  P4:                                          [   I
68          wish       ] y:eah (.) I wish I would have taken it
```

```
69          more seriously and got a handle on it at an (.)
            earlier age.
70   C3:    um hm ((writes))
71   P4:    except really a:h (.) I burned a lot of bridge:s (.)I
72          - I (.) you know (.) I've - I've burned a lot of good
73          jo:bs (.) I mean it's just really (.) family.
74   C3:    um hm
75   P4:    you name it I've destroyed it (.) pretty much.
76   C3:    um hm. so you through - through struggling with your
77          addiction (.) it has really impacted your
78          relationships with your family?
79   P4:    big time =
80   C3:    = your friends =
81   P4:    = big time.=
82   C3:    = yeah.=
83   P4:    = family (.) friends (.) u:m (.) mainly family.
84   C3:    um hm
85   P4:    jo:bs (.) I mean (0.3) you know even where I work now
86          they all know my pa:st and they all (.) you know
87          (.) they all(.) keep an eye on m:e and (.)
88          some of them are hesitant to even (.) work
89          around me because
90          they know (.) you know (.) my past.
```

This disclosure was accomplished via a sequence of reflective statements. First, after C3

provided a reflection regarding P4's motivation for sobriety (line 61–63), P4 expressed a sense

of regret (line 67–69) but quickly moved to an analytic position regarding the impact of

addiction on his social relationships (line 71–73). Second, after C3 reflected on how addiction

impacts P4's work and relational functions (line 76–78), the two engaged in a rapid, interactive

feature of talk and responses (line 79–83), followed by P4's disclosure of the impact of addiction

on his work. As the example indicates, this disclosure was interactively achieved with a

relatively low degree of hesitation and affect presentation, but a high degree of analytic process.

A similar pattern can be found in C3 and P5's session. With a prompt reflection from C3,

P5 quickly revealed his past behaviors with detailed descriptions:

```
(6.29)
83   C3:    = it doesn't matter what you've [learned or] what you
            know =
```

```
84   P5:                                    [pretty much] pretty
          much.
85        and it's like .hh (1) like every time it ha:ppens (.)
          then (0.5)
86        I like - I had - I always had to have like - one of my
87        friends my close friends. ones I grew up with. family
          and everything
88   C3:  um hm
89   P5:  none of them use. smoke (.) some pot (.) and drink. -
90   C3:  (  ) so -
91   P5:  I was us:ing (0.3) and then hiding it (.) from
          everybody (.) you know what I mean like (.) I would- I
92        would use it (.) and then I would li:e or whatever and
          you know(.) tried to hi:de it (.) for (.) four yea:rs
93        I used (.) and (.) you know not really many people
          knew my  - my grandparents -
```

P5's disclosure was interactively achieved through the process of talk with C3. First, C3

reflected his understanding of P5's perspectives on using drugs (line 83). Then, P5 responded by

mentioning the contrasting behaviors from his family and friends who did not use (line 89),

followed by a detailed narration of his behaviors associated with using (line 91–93). Notice that

similar to the above two examples, the narrative presented by P5 shows little hesitation and

affect presentations, but a more analytic discourse.

The disclosure that presented with a forthcoming and analytic style with little hesitation

and affective display can be found in the beginning stage of the interaction between C1 and P1,

where P1 disclosed his perspectives on the addictions related to abuse:

```
(6.30)
2    C1:  al:right well (0.5) u:m why don't we start. U:m (1) pt
3         maybe we just talk a little bit about what's going on
4         with you.
5    P1:  u:m (.) I'm trying to keep my thinking less thinking
6         (.) thinking.
7    C1:  ok.
8    P1:  that crazy way (.) you know that crazy way I think
9         because what I see more and more about what we talk
10        about you know the using was about distortion
11   C1:  ok.
12   P1:  and the thinking, it's all about distorted - distorted
```

```
13          view of life (.) of how life was presented to me
14          coming up through the abuse. now I see my thinking is
15          always geared toward like (.) illusion (.)
16          disillusion. not like - if I don't catch myself – like
17          when I - bam. I got to catch myself. no you're not all
18          that mani:pulation (.) all that trying to. all that
19          slick stuff (.) lay to the side. That stuff ain't got
            nothing to do with (.) reality.
```

As an open-ended question was provided in the beginning (line 2–4), P1 proceeded the session with problem presentations that were analytical and cerebral, such as the focus of thinking and distortion (line 12–13), followed by the disclosure of the abuse (line 14) and how the distortion was formed by the abuse history (line 14–19). Notice that the event of abuse was not presented in detail. In addition, little affect was displayed in this narrative even though P1 was forthcoming about opening up the conversation.

The above four examples show that a variation of disclosure in counseling sessions displays trainees' open invitation and reflective statements. Disclosure of adverse life events and vulnerability was formed through such relational discourse. Clients in this process presented a forthcoming and analytic standpoint during their disclosure.

Summary of Processes of Disclosures and Unique Features of Interactions: Divergence

Chapter six explored the third research question: how do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability? This sub-section discusses the divergent themes with regard to the process of disclosures and unique interactions as a result of dynamic interaction and the progression of relationships between the dyad. A total of three divergent themes were identified: disclosures through treatment protocols and delayed affective responses, telling bad news, and disclosures through relational discourse and analytic

presentation. The first two themes were found in doctor-patient interactions, and the last theme was found in counselor-client interactions.

Conclusion

Chapter four, five, and six reported the results of the data. Data analysis was based on three overarching research questions and a funneling approach: first, the formation of the conversations in an initial clinical encounters; second, the development of therapeutic relationship and discourses; and third, the presentation of disclosure, challenging communications, and vulnerability as a result of co-constructed therapeutic discourses and interactions. The identified themes from the data illustrate both convergent and divergent themes.

There were a total of 34 themes found in the data. In the first analytic chapter, the development of the conversations in initial clinical encounters, a total of five themes were found in convergence and six themes in divergence with regard to the formation of interaction in an initial clinical context. A total of four themes emerged in question two that demonstrated individual trainees' negotiation between professional norms and interactions present at the moment in order to achieve therapeutic tasks. In the second analytic chapter, a total of seven themes were found in convergence and two found in divergence that illustrated the development of therapeutic discourses and relationships. In the final analytic chapter that demonstrated unique talk features such as disclosures, presentation of challenging communications, and vulnerability, seven themes were found across sessions in counseling and family medicine, and three divergent themes were found in the data.

The results indicated that while professional practice is contextual and circumstantial, as reflected by a number of divergent themes in the first analytic chapter that focused on the development of the conversations in an initial clinical encounter, both professions in this study

share a number of strategies and talk features with regard to the development of therapeutic relationships and discourses, as well as the process of disclosures and presentation of unique interactions such as challenging communications and vulnerability as a result of co-constructed therapeutic discourse and interactions. The final chapter, which will be presented next, will provide synthesis of the findings, followed by the discussion of limitations and implications.

Chapter VII

Discussion

An initial clinical encounter involves a variety of institutional, interpersonal, and social interactions. In addition to routine tasks such as assessment, diagnoses, and treatment, relational dynamics such as the uncertainty of mutual trust between a clinician and a patient/client, the uncertainty of personal and therapeutic agendas, or unexpected physical and psychological circumstances make initial encounters unique from subsequent visits (Easter & Beach, 2004; Esogbue & Elder, 1979; Katon & Kleinman, 1981; Odell & Quinn, 1998). Some argued that these characteristics have caused initial sessions to have a tremendous bearing on future encounters and may shape subsequent therapeutic process (Budman et al., 1992). Accordingly, an initial session in both family medicine and counseling settings establishes a foundation for subsequent visits, thus establishing that a treatment alliance is imperative (Budman et al., 1992; Odell & Quinn, 1998; Rahman, 2000).

This study explored the processes of talk and interactions of initial sessions between doctors-in-training and counselors-in-training and their clients/patients in two professions, family medicine and counselor education. This study used naturally occurring, video-recorded data by examining how interactions were formed, how talks were achieved through sequential and co-constructed interactions, and how discursive relationships and subsequent actions and interactions such as disclosures, challenging communications, and vulnerability occurred as a result of formed initial relationships.

This chapter combines the salient themes of data analysis and literature review into the discussions. There will be four sections of synthesis, professional practice, formation of initial sessions, development of therapeutic relationship and discourses, as well as a process of

disclosure and unique feature of interactions. The discussions of the themes will be organized in order based on the three overarching research questions, as correspond to the three sub-analytic chapters. In addition, the limitations of the study, and discussion of the implications on practice, training, and research, will be provided at the end of the chapter.

Synthesis: Professional Practice

Convergence and Divergence of Professional Practices

As discussed in earlier chapters, the fields of counselor education and family medicine have unique emphases in their training and practice (Barrett et al., 2003; Doherty, Baird, & Becker, 1987; Engel, 1977; Myers & Sweeney, 2008); that is, counselor education primarily focuses on mental health/behavioral issues, while family medicine primarily focuses on the bio-physiological causes of pathology (Barrett et al., 2003; Doherty, Baird, & Becker, 1987; Engel, 1977; Myers & Sweeney, 2008). At the same time, the fields share several professionalism. First, both professions experience intensive and frequent encounters of psychosocial issues related to wellness, mental health, re-adjustment and emotional regulations (Arthur, Kowel, & Liu, 2012; Myers & Sweeney, 2008). Secondly, clinical activities, such as providing treatment and helping clients manage their health issues, emerge in both fields (Brown, 2004; Howgego et al., 2003; Mann, Gaylord, & Norton, 2004; Mead & Bower, 2002; Street et al., 2009; www.aafp.org; www.counseling.org). Thirdly, since both professions involve intense human interactions and communications in the work routines, a strong working alliance is required to achieve desired treatment outcomes (Buttny, 1996; Fuertes et al., 2007; Horvath & Symonds, 1991; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Kim, Kim, & Boren, 2008; Lelorain, Brédart, Dolbeault, & Sultan, 2012; Mead & Bower, 2002; Mead et al., 2002; Sexton & Whiston, 1994; Tryon, 1990). As can be seen, there are theoretical discussions related to the area of professional

practices and identities, but very little empirical research reflects the discussion, and no study explored the professional practices in the context of both family medicine and counseling.

A major insight gained from the data analysis is that trainees in both professions reflected the general view of distinctive practices, and, at the same time, revealed a number of shared qualities. With a total of 34 themes found in the data, five convergences and six divergences were found with regard to the formation of interaction in an initial clinical context. However, more convergent themes across the two clinical contexts emerged with regard to the development of therapeutic discourses and relationships, as well as the process of disclosures and unique talk features, such as challenging communications and vulnerability. For example, seven convergences and two divergences were found in terms of the development of therapeutic discourses and relationships in the contexts of counseling and family medicine; in the analysis of the process of disclosures and unique talk features, seven convergent themes and three divergent themes were identified in the data. Notice that the first analytic chapter, which reflects the formation of interactions in an initial encounter, has more divergences. However, trainees in the development of therapeutic relationships and discourses shared more common practices and interactions than what previous literature suggested.

This finding suggests that due to unique professional and institutional contexts, and the nature of the session, trainees and their patients/clients produced interactions according to the context. In this process, unique professional identities and practices occurred based on their respective training missions and the types of clients they serve. This may explain why the formation of the session has more divergences, because the distinctive practices may be more salient in the beginning context of the session. In addition, some themes, such as the presentation of prior knowledge of patients' health and health records, rapid intervention through preventive

measures and the report of treatment plans, as well as bad news delivery, reveal that doctor-patient interactions can be highly contextual because of the unique circumstances of patients' conditions. The counseling sessions in this sample did not appear to have clients who had critical conditions that needed trainees' immediate procedures and rapid responses.

As suggested earlier, a community of practice indicates one's acquiring professional identity through linguistic construction where a trainee learns, negotiates, and develops particular practices, language use, and worldview from a profession within which one is situated (Gordon & Luke, 2012; Luke & Gordon, 2012). Themes like opened-ended questions in opening statements, the use of paraphrase, summation, reflection, co-created therapeutic discourses, as well as a resilient approach in the counseling sessions in this sample, may result from an emphasis on training and professional norms. Arguably, these features show the institutional and larger themes of the community of practice. Additional diverse linguistic data from clinical samples are needed for future research regarding the features of professionalism and community of practices.

Individual Variations and Community of Choice

While community of practice characterizes professional identity and interactive patterns of a particular group, community of choice indicates members' divergence from group norms and practices (Van Herk, 2012, p. 23). Currently, very little empirical research was found focusing on community of choice in a professional context, and no study explores community of choice in the context of family medicine and counseling.

In this study, variations within groups exist among the trainees in both family medicine and counseling. Another interesting phenomenon found in this study was individual trainees' negotiation between professional norms and interactions at the present moment. This discussion

intends to link to this phenomenon to the earlier discussion concerning community of choice (Van Herk, 2012).

There were a total of four themes that demonstrate individual trainees' negotiation between professional norms and interactions present at the moment. Several features of community of choice emerged. For instance, prioritization was demonstrated by an individual trainee, C3, who appeared to put the institutional tasks related to filling out history taking questionnaires at the end of the session. In some ways, C3 diverged from the expectation of institutional protocols that have required tasks and routines. On the other hand, C3's personal choice seems to ally with the overarching counseling norm where a major emphasis of the training is to put attention on relational, here-and-now dynamics.

Some trainees presented practices that were atypical of professional norms. For example, a doctor-in-training, D2, utilized the strategy of transforming here-and-now to therapeutic agendas in her BPS session. This therapeutic discourse does not typically exist in routine doctor-patient interactions. Rather, it has been emphasized in the field of counseling and psychology (Corey, 2011; Young, 2013). In addition to the evidence of individual variation, this example supports the finding of this study where more convergences than divergences of practices exist in this sample.

Humor. A unique phenomenon found in this study concerning individual trainees' negotiation was the feature of humor in the context of initial clinical encounters. Humor is an interesting talk feature because it is highly contextual and idiosyncratic. Mismatch of humor styles and misinterpretation can create misunderstandings (Brône, 2008), which could be a risky strategy in an initial encounter because the uncertainty of the relationship and unfamiliarity of interpersonal styles is present. In addition, humor is not a typical curriculum in the majority of

counseling and physicians' training, as it is a theme that primarily exists in casual interactions (Norrick, 1993). Nevertheless, four individual trainees, D1, D4, C2 and C3, utilized humor to solicit answers and details of health history and convey therapeutic agenda and acceptance. The analysis shows that humor's therapeutic functions intersected with the therapeutic tasks happening at the moment of interaction. Conversational examples indicate that humor was used to convey understanding and acceptance of clients' symptoms and presenting behaviors in the context of an initial session. Humor not only helps relieve some potential anxiety regarding the relational dynamics at the moment of disclosure, but it also helps trainees and clients process difficult subjects and psychological experiences. Such gallows humor and gallows laugh may possibly help relieve anxiety and the intensity of the topic, as displaying symptoms and talk about problematic behaviors is an emotional and socially vulnerable experience (Watson, 2011).

The finding from this study supports previous findings regarding humor's therapeutic function in some ways. For example, in an analysis of a video-taped couple's therapy session, Buttny (2001) found that humor such as exaggerating presenting issues and creating playful themes shown by the therapist can buffer resistance and present contrasting interpretations in a couple's therapy. These themes are consistent with this current study's finding regarding the function of humor; in this case, humor provides an opportunity to reframe a therapeutic stance being advocated. A variation found in this study is that humor's therapeutic function was found in an initial encounter, whereas the example from Buttny's study was from a working stage of the therapeutic process. The data analyses indicated that humor was used for disarming resistance or to relieve anxiety is particularly salient in an initial encounter, as the dyad is in the process of building a relationship while completing therapeutic tasks.

There are two implications based on this finding. First, humor in this context reflected a certain level of established comfort between the trainees and their patients/clients, which functioned as a precursor to the occurrences of humor. Secondly, routine, professional practices contained personal style, trainees' identity, creativity, and idiosyncratic practices, which shaped the interactions present at the moment. More studies regarding the function of humor in an initial encounter will enrich theoretical frameworks on the therapeutic function of humor.

Synthesis: Formation of Initial Sessions

A number of salient themes concerning the formation of initial sessions found in this study provided additional perspectives on existing discussions. This section intends to integrate the findings and existing literature on the discussions of history taking, integration of assessment and the BPS approach, ordinary interactions, asymmetry, and co-created therapeutic discourses.

History Taking

This study found that history taking was part of the routine tasks and protocols in initial sessions across the two professions in this sample. Overall, a mechanical style of question and answer process during history taking was found in trainees across both professions. In addition, although history taking was a collaborative process, trainees in this study took a relatively leading positon in this therapeutic task. These findings have supported previous CA studies on clinical assessments and intake in doctor-patient relationships (Heritage & Clayman, 2010; Heritage & Maynard, 2006). For example, previous studies suggested an asymmetrical interaction manifested through doctors' leading of agenda setting, soliciting details, and going through routine checklists with less narrative process during intake (Heritage & Clayman, 2010; Heritage & Maynard, 2006). An additional finding in this study is that the mechanical style of question and answer process also exists in interactions between counselors-in-training and their

clients. This provides additional considerations with regard to training and supervision. Specifically, if the training goal is to help novice practitioners engage in narrative, person-centered process in their sessions, education and supervision need to include theoretical and practical support that help trainees negotiate fulfilling institutional tasks while at the same time engaging person-centered practice during the intake process.

Two additional themes found in this study, requesting details and recapitalization, are included under this section because they were found as part of the formation of the session and occurred in the process of history taking.

Requesting details. A common therapeutic strategy shared by trainees in both professions is the process of soliciting details of information as the interaction progressed. Soliciting details provided two therapeutic functions, the continuance of assessment when the presenting issues needed further attention and rapport building within initial sessions. This finding connects to previous studies on intake process in doctor-patient interactions, in particular the first function, the continuance of assessment. Heritage and Maynard (2006) indicated that soliciting details is a way of negotiating incompleteness during problem presentations (p. 113). This strategy helps practitioners communicate unknown issues and new concerns that arose as result of problem presentations. The finding from this study supports the discourse of negotiating incompleteness, as the data indicate that trainees requested detailed information from their patients/clients when identifying particular health issues that needed further attention.

On the other hand, this study found little information from previous literature that address the second function of requesting details found in this study, that is, requesting details as a process of rapport building during intake. From a relational standpoint, requesting details in the intake process may not directly aim at completing a specific therapeutic task, but the

conversations seem to have a relational function that maintained therapeutic interactions and helped the dyads achieve therapeutic tasks in the following interactions. Trainees in this sample appeared to utilize this strategy in an initial context.

Recapitulation. Another theme found in the formation of the initial session, the strategy of recapitulation, provides several insights to current and future studies related to its functions and roles. Recapitulation is the repetition and recurrence of words, phrases, and stories disclosed by speakers that emerge in the process of interaction previously or in the present time. This study found that recapitulation consists of trainees' recollection of story and events disclosed previously, repetition of the phrases and words that emerged at the moment of interaction, and the shared lexicon between the dyad to confirm therapeutic agendas. The three features of recapitulation appear to help trainees introduce therapeutic agendas and therapeutic interventions during initial sessions.

This study found that recapitulation supports previous discussions concerning the therapeutic function of repetition, specifically echoing and mirroring in psychotherapeutic conversations (Ferrara, 1994). According to Ferrara (1994), these two types of repetition that occur in psychotherapy reflect a speaker's acceptance and agreement with a particular statement. Ferrara argued that echoing and mirroring someone's statement indicates a stronger mutual understanding than brief utterances such as "yes," "yeah," or "exactly." In addition, a shared lexicon implies the client's echoing the therapist's interpretation of clients' experiences. An additional insight gained from this current study and not addressed in Ferrara's research is that within the context of the initial session, echoing and mirroring can help both in introducing interventions as well as in strengthening therapeutic alliances.

Integration of Assessment, History Taking, and the BPS Approach

As discussed earlier, an integrative, holistic approach that includes biopsychosocial health, support system, wellness and mental health is the dominant discourse in counseling and is gradually receiving attention in the field of family medicine. The idea of this integrative practice is that clinicians could be more effective in responding to the presenting issues if clinicians have more comprehensive knowledge about the person; thus, an integrative practice would lead to proper diagnoses and treatments (Barrett et al., 2003; Borrell-Carrió et al., 2004; Doherty et al., 1987; Mann et al., 2004; McKinlay et al., 1996; Stange et al., 2001). Although there are a number of studies in the literature that discuss the function of the BPS approach, this study found no study addressing talk and interaction with regard to the BPS approach.

This study found that history taking appeared in all samples, with the BPS approach emerging in three doctor-patient interactions and four counseling sessions. In addition, two regular doctor's visits appeared to have mental health issues emerge during the assessment concerning physical health. While treatment and diagnoses are often paired together in the training (www.cms.gov/ICD10; www.dsm5.org), this study found no session that presented determined diagnostic language. A couple of explanations are proposed. First, it may be due to the participants' training status, where determining a diagnosis requires collaboration and supervision. The second explanation is that the relationship among assessment, diagnosis, and treatment is a complex, recursive process. As presented in chapter four, several themes, such as requesting details, recapitulation, and unique conditions such as rapid intervention through preventive measure and report of treatment plan, indicated that trainees appeared to navigate between assessment and intervention during their first encounter, with an attempt to understand the presenting issues and the person. Interventions were often provided to elicit more

occurrences and the next sequence of assessment, as opposed to a prescription based on a determined diagnosis. This fluid process of providing interventions and assessment, while getting to know the person and the presented problems, seems to be consistent with much of the literature concerning person-centered practice, holistic approaches to health issues, and wellness (Barrett et al., 2003; Bell et al., 2002; Borrell-Carrió et al., 2004; Doherty et al., 1987; Stange et al., 2001).

Another salient theme with regard to assessment, history-taking, and the BPS approach is that the majority of trainees in this sample utilized existing institutional protocols and symptom checklists to conduct history taking as well as the BPS evaluation, with the exception of two counseling trainees and two doctors-in-training who conducted the BPS sessions using the narrative approach. In addition, one of the distinctive practices in family medicine, presentation of prior knowledge of patients' health and health records, shows that doctors-in-training obtained patients' health history through institutional sources such as colleagues, electronic health records, or charts.

In a discussion of person-centered, holistic approaches in the intake process, Timm (2015) argued that the narrative approach, which focuses on story-telling, working alliance, and lived experiences, not only provides more possibilities of knowing than typical pathogenic focuses such as symptom checklists and questionnaires, but it also facilitates therapeutic alliance and promotes changes in the context of an initial session. Timm's viewpoint is allied with an earlier discussion related to Guilfoyle's (2003) study on a dialogued-oriented, "not-knowing" form of therapeutic approach. Accordingly, a clinician's "not-knowing" assumption would produce co-constructed dialogues and promote a richer, deeper therapeutic process.

Note that while attending to narrative approach in initial sessions, as it reflects a person-centered, integrative approach to health care, it is important to consider contextual and institutional factors. For example, routine doctor's visits have a limited time range; in some cases, attending to immediate health concerns is priority, as reflected by the sessions of D3P4 and D5P7. Thus, obtaining targeted health information is necessary to conduct a focused, time-limited session. In addition, with the managed care's expectation of outcome-based measures and cost-effective conversational practices, it is important to consider the practicality and applicability of such an approach in regular doctor's appointments. Perhaps more discussions and research on structural factors, recourses, and the policy of managed care are necessary to integrate the narrative approach in clinical training and practices.

Another limitation of applying the narrative intake process in doctor's appointments is that while this approach has been found effective in a majority of counseling research related to childhood trauma, eating disorders, natural disasters and developmental issues (Timm, 2015), little research has been conducted on the narrative approach in relation to an initial regular doctor's appointment. Hence, more research attention regarding this approach in regular doctor's visits is required.

Ordinary Interactions and Their Therapeutic Functions

A salient theme found in the process of session formation is ordinary interactions. The discussion of casual conversations in institutional practices can be found in large amount of CA literature, including health communications (Heritage & Clayman, 2010; Heritage & Maynard, 2006). Accordingly, ordinary interactions and professional practice are not distinctive or separated social activities. Rather, ordinary talk and interaction is influenced by and embodies institutional characteristics, often in a predictable way (Heritage & Clayman, 2010; Heritage &

Maynard, 2006). For example, Heritage and Clayman (2010) indicated that interactions that occurred in institutions involve a focus, specialization, and specification of interactions that are relevant to the function of the situated institution. In this case, the range of interaction is theoretically restricted to the relevance of the clinical practice concerning health. While participants intend to "turn to business" in various social interactions in institutions, ordinary conversations inevitably emerge and often encompass a vast array of social rules and practices.

Some of the literature discussed functions of ordinary interactions in promoting effective communications and working alliances. For example, in Walsh's (2007) study of the role of small talk in two speech language pathologists' interactions with patients, the author indicated that small talk in clinical interviews appeared to facilitate a more informative discussion. The study concluded that small talk has a powerful effect in building therapeutic relationships and producing effective health communications.

The data of this sample support previous discussions with regard to the fluid, unstable, dynamic process between institutional interactions and ordinary interactions. A majority of trainees in this sample formed, shaped, and reshaped the clinical interactions through switches between casual conversations and institutional tasks, such as history taking and assessment in a single episode of interaction. The analysis indicated that casual conversations and associated questions seemed to assist trainees in getting to know the person holistically, which indirectly served the purpose of therapeutic tasks. That said, a variation regarding ordinary interactions found in this study is the function of "intermission." Specifically, trainees who produced ordinary interactions during the therapeutic tasks appeared to create an "intermission" or a "temporal break" from the ongoing mundane tasks and agendas.

With regard to working alliance and therapeutic relationships, Gelso and Carter (1994) suggested that a therapeutic relationship consists of a working alliance, transference configuration, and the real relationship. The authors argued that the real relationship, which shares qualities of ordinary interactions such as genuineness and realistic perceptions, functions as an indicator of the effective therapeutic relationship.

With the examples that display ordinary interactions in this sample, this study found that ordinary interaction is both relational and institutional in the context of the initial clinical encounter. It is relational and collegial because both trainees and their patients/clients contributed to the interactions in a natural occurrence without further questions and clarifications of intentions. For example, ordinary interactions that occurred in the midst of therapeutic tasks functioned as an "intermission" from the ongoing therapeutic agendas. In addition, casual conversations that occurred during clinical assessment assisted trainees in getting to know the person holistically, which has reflected the function of small talk in Walsh's (2007) study, as well as the real relationship suggested by Gelso and Carter (1994).

Some unique features of ordinary interactions found in this sample suggested that ordinary interactions reveal asymmetrical relationships between the clinicians and the patients/clients, which will be discussed in detail in the next section.

Asymmetry

Asymmetry has been studied in a considerable amount of CA research. It is perhaps one of the major focuses in studying doctor-patient interactions (Ainsworth-Vaughn, 1992; Maynard, 1991; ten Have, 1991). Asymmetry indicates that an asymmetrical relationship is co-created and co-constructed through the structure of question and answer, turn-taking, and topic shifting (Heritage & Clayman, 2010; Heritage & Maynard, 2006; Maynard, 1991; ten Have, 1991).

This study found four emerging phenomena associated with asymmetry, including the presentation of prior knowledge of patients' health and health records, knowledge presentation and education, report style and rapport style in formation of initial sessions, and atypical ordinary interactions. The two distinctive practices found in the formation of the session in doctor-patient interactions, the presentation of prior knowledge of patients' health and health records, as well as knowledge presentation and education, reflect asymmetry discussed in existing CA studies. In addition, these two features of practice reflect the report style of talk. Finally, this study found that asymmetry exists in counselor-client interactions, as evident in the process of ordinary interactions. Details of the four phenomena of asymmetry will be discussed in the sub-sections presented next.

The presentation of prior knowledge of patients' health and health records. The first asymmetry found in this study that connects to previous linguistic analysis on doctor-patient interactions is the doctors-in-training's presentation of prior knowledge of patients' health and health records. This theme connects to the two linguistic phenomena, presupposition and epistemic stance from previous literature (Heritage & Clayman, 2010). While both presupposition and epistemic stance demonstrate doctors' representation of their knowledge of patients' health records and history through their questions and inquiry, some minor variations exist (Heritage & Clayman, 2010). Presupposition indicates a question that shows the speaker's assumptions and knowledge of the hearer; epistemic stance shows a question that contains already gained knowledge about the respondent (Heritage & Clayman, 2010).

The findings of this study support previous discussions on doctors' presentation of authority, particularly the discourse of presupposition. Doctors-in-training used prior knowledge of the patients' health information in the process of history taking to accomplish three functions:

opening, supplemental information, and clarification. For example, the linguistic data suggested that doctors-in-training referenced existing information about the patients in the situated institution and incorporated that knowledge into the process of history taking. Referencing the patients' health history not only provided a source for an opening statement in an initial encounter between doctors-in-training and their patients, but it also functioned as a means to gain supplemental knowledge and assists doctors-in-training in identifying focuses of assessments in their subsequent interactions. In addition, information about patients may be gained from colleagues and medical records that contained the patients' health history and prior visits.

  Knowledge presentation and education. In addition to the presentation of prior knowledge of patients' health and health records, doctors-in-training appeared to produce another feature of asymmetry, knowledge presentation and education. Heritage and Clayman (2010) found that doctors convey authority and accountability in the process of diagnosis and interventions through three specific talk features: plain assertion, evidential formulation, and evidence formulating pattern. Plain assertion shows direct terms that names the apparent presenting problems and issues and is found to be the most common talk phenomenon in the process of diagnosis and intervention. The variation between evidential formulation and evidence formulating pattern is that the former shows doctors' indirect or inexplicit reference to the evidence. The latter provides explicit language that lays out reasoning being the judgment.

  The examples in this study show that doctors-in-training presented the evidence formulating pattern in conveying their medical knowledge, and little evidence shows the feature of plain assertion. This study speculates that this may be due to specific populations with low socioeconomic status and education that doctors-in-training encountered in this sample. In addition, it could be due to participants' training status, where the diagnostic process requires

further supervision and training before delivering a plain assertion about the patients' presenting issues. For example, trainees displayed instructional linguistic features to communicate interventions with little use of diagnostic terms under risk assessments and identification of health issues. The knowledge presentations included both the health knowledge and trainees' observations of patients' behaviors.

The style of knowledge presentation and education in this study is very similar to the report style of speech (Tannen, 1991). It is direct in terms of the content delivery of known and public knowledge to the listener. However, an affective presentation is implicit unless they are addressed. The next sub section will discuss such in detail.

Report style and rapport style in formation of initial sessions. The earlier chapters discussed the report style and rapport style in professional practices. Specifically, in the medical field, a relatively report-focused, formal, and dominant style of practice abounds (Mathews, 1983; Pace, Chaney, Mullins, & Olson, 1995; Roter, 2000), whereas a rapport-focused, relational, and accommodating style of practice has been emphasized in the field of counseling (Goodman et al., 2004; Reis & Brown, 1999; Rosen et al., 2012).

The divergent themes found in this sample reveal a style difference between doctors-in-training and counselors-in-training based on the evidence of interactions and characteristics of communications. As the analysis indicated, doctors-in-training tended to utilize institutional knowledge and discourses in approaching their sessions. The presentation of prior knowledge of patients' health and health records assumed a discourse of problem focus and invited expected answers (Maynard, 1991). Arguably, questions that contained information that presents the clinician's pre-existing knowledge about the person connotes selected agendas while telling patients about themselves (Bergmann, 1992; Maynard, 1991).

Counselors-in-training in this sample presented a relatively rapport-focused, relational, and accommodating style of practice, as reflected by the themes of opened-ended questions in opening statements and co-created therapeutic discourses, as well as paraphrases, summation, and reflection. The opened-ended questions in opening statements particularly connected to Maynard's (1991) discussion of the unmarked inquiry where open-ended questions and encouragement of narration signify the rapport style of talk.

Note that this style difference is not to say that report style only represents asymmetry and that rapport style is equal to a person-centered approach. As Maynard (1991) indicated, clinical conversations often constitute expertise and authority of knowledge regardless of the style of talk. For example, an unmarked question can indirectly invite expected results and represent authority. The next section will discuss how an ordinary interaction, which is typically seen as collegial and casual, connotes asymmetrical relationships between speakers.

Asymmetry: atypical ordinary interactions. This study found that some features of ordinary interactions, such as casual conversations related to hobbies and music, which usually exist in casual social interactions, were reproduced in several initial clinical sessions. An additional finding concerning asymmetry in this study is that asymmetry existed in ordinary interactions that occurred in both professional contexts in this study. That is, ordinary interactions do not merely reflect discourses between speakers and audiences, but they also reveal larger, systematic but often unspoken social rules and practices (Maynard, 1991; Wetherell et al., 2001). In addition to the relational and therapeutic function, ordinary interactions reflected asymmetrical relationships between trainees and patients/clients. As indicated in chapter four, several rules of ordinary interactions did not apply in the process of

trainees – patients/clients interactions. These include trainees' initiations of the topic as opposed to mutual initiatives. Moreover, a uni-direction of information sharing was found in the sample.

This study suggests that ordinary interaction was both relational and asymmetrical in the context of initial clinical encounters. It was relational and collegial because both trainees and their patients/clients contributed to the interactions without further questions and clarifications of intentions. It was asymmetrical because the rule of mutuality in ordinary interactions did not apply in the interactions found in the sample.

Co-Created Therapeutic Discourses

A unique divergent utterance found in the counseling sessions in this study is counselors-in-trainings' use of paraphrase, summation, and reflection of their observation at a here-and-now moment to convey their therapeutic intention. This finding supports several previous studies on jointly constructed therapeutic discourses in psychotherapeutic processes (Buttny, 1996; Ferrara, 1994).

First, in two therapeutic communications using perspective display series (PDS) where therapists' utterance indicate understanding and acknowledgement of clients' discourses, Buttny (1996) found that therapists' initiatives of inquiry with the subsequent acknowledgement of clients' perspectives brought up clients' further self-reflection and adjoining therapists' perspectives. The theme of paraphrase, summation, and reflection found in this study is very similar to the process of PDS, as it requires attention to detailed materials produced or occurring in a here-and-now moment. In addition, more affective components of language appeared in this type of conversation. While telling clients about themselves from therapists' point of view connotes an asymmetrical, expertise position, the PDS strategy presented in Buttny's (1996)

study indicates that such interaction is a rhetorical, back-and-forth dialogue between clients and therapists rather than an asymmetry between experts and laymen.

Paraphrase, summation, and reflection also connect to another study concerning aligned speech as a joint production of therapeutic discourses (Ferrara, 1994). Accordingly, joint productions are interlocked utterances that are produced firstly by one speaker's initiation of a discourse and the second speaker's continuance or synchronization of the discourse displayed through integrated syntax and semantics. A number of counseling interactions, including C2P3, C2P3, C3P4, and C3P5 in this study have displayed the phenomenon where both the trainee and the client synchronized with the semantic content from previously initiated sentences, or both co-author a therapeutic statement, so to speak (Ferrara, 1994). Ferrara argued that joint productions show a deeper sense of empathy and spontaneity between the speakers, or signal that speakers intend to create empathy.

Synthesis: Development of Therapeutic Relationships and Discourses

A number of salient themes concerning the development of therapeutic relationships and discourses have provided additional perspectives on existing discussions. This section intends to integrate the findings and existing literature on the discussions of relational discourses, validation, personal standpoint and self-disclosure, repair, and praise.

Interactions and Relational Discourses

As discussed earlier, interactions, which include the verbal and nonverbal communication between speakers, mirror social relations, context, and discourses (Wetherell, Taylor, & Yates, 2001). A therapeutic interaction is produced through exchanges of speakers' positions, and is not a fixed-state phenomenon (Buttny, 1996). Both Street et al.'s (1992) and Barkham and Shapiro's (1986) studies argued that a therapeutic interaction is complex, relational, and circumstantial.

Like the function of ordinary interactions discussed above, empathy, like ordinary interactions, is often interactively achieved through therapeutic processes. Thus, the study of empathic discourses and working alliances in clinical encounters is best investigated in the actual process of interactions.

Trainees in this sample revealed a number of convergent practices concerning developing therapeutic relationships. Relational utterances and interactions, for example, indicated utterances on relationship building and speech features that revealed co-constructed relational discourses between trainees and their patients/clients. This theme contains three features. First, therapeutic discourses were developed through trainees' explicit language regarding rapport building. Secondly, a relational dynamic was revealed through jointly constructed speech features such as the use of a collective pronoun and overlapped speech. Thirdly, the example of overlapped speech displayed in the sessions of D3P4, C4P4, and C4P5 implied a shared energy and mutual understanding in agreement and understanding. According to Tannen (1994), overlapped speech, in which speakers talk at the same time, is an indication of a "high-involvement style" (p. 63). This is different from violation of speech turn such as interruption, as discussed in chapter six in the theme of challenging interactions.

An additional relational discourse found in this study that has received little discussion previously is the discourse of neutrality. Neutrality shows trainees inhabiting a non-judgmental, non-reactive standpoint, displayed through brief utterances such as "ok" or a reflective statement that does not indicate any value judgment. In addition, neutrality is found when clients/patients display behaviors that are not considered socially desirable.

Previous literature has focused on therapeutic relationships used in experiments, retrospective surveys, interviews, and observations (Fuertes et al., 2007; Graugaard, Holgersen,

& Finset, 2004; Horvath & Symonds, 1991; Howgego et al., 2003; Kivlighan & Shaughnessy, 1995; Saltzman et al., 1976; Sexton & Whiston, 1994; Tryon, 1990). The author of this study argues that these methods provide limited information because the data was a retrospective account rather than present materials. Some methods such as measurement of perception is often open for individual interpretation. For example, the perception of empathic occurrences were judged differently between clinicians and clients in Barkham and Shapiro's (1986) study. Moreover, Street et al. (2009) indicated that the circumstantial factors influence the interactions between physicians and clients. If interactions are jointly achieved through complex personal, institutional, and circumstantial factors, it is difficult to conclude whether an interaction results from a specific factor, unless it is clearly presented in the data (Maynard, 1991; Schegloff, 1991). The insight into as well as the presentation of therapeutic processes in this study can provide further considerations for future practice and training related to therapeutic relationships and working alliances. The focus of interaction provides rich information regarding how relational utterances and co-construed therapeutic discourses occur.

Validation

Another relational discourse, validation, showed trainees' initiations of acknowledgement of patients'/clients' perspectives and potential affects. Validation was used in building therapeutic relationships on a global level. In a local context, it encouraged patients'/clients' further disclosures in subsequent interactions. This study found that validation occurred during patients'/clients' disclosure of significant life events and those events tended to be emotionally charged and unpleasant.

In two counseling examples displayed by the sessions of C3P5 and C2P3, validations provided by trainees connect to the concept of perspective display series (PDS) where therapists'

utterances indicated understanding and acknowledgement of clients' discourses (Buttny, 1996).

In addition, validation in this study supports Voutilainen et al.'s (2010) study of counseling

conversation with regard to recognition and interpretation of emotions, along with exploring

personal experiences. Voutilainen et al.'s (2010) study indicated that when the expression of

emotions or potential opportunities of empathic discourses are present, validation and expansion

of narration occur. Voutilainen et al. (2010) indicated that acknowledgement of emotions

functions as a priori condition for subsequent interpretations of emotions. Moreover,

interpretations often overlap with recognition. For example, when the client disclosed emotional

disturbance, the therapist provided a question that elaborates the phenomenon of a particular

emotion. An interesting phenomenon found in this study concerning acknowledgment of

emotions is that it was provided during the disclosure of undesirable behaviors and stories.

Disclosures of such require a degree of comfort, trust, and emotional readiness. Disclosures of

undesirable behaviors and stories occurred in this study in the context of initial sessions where

uncertainty of relationships was present, indicating a formation of trust and a degree of

emotional safety.

Although the majority of studies that discussed empathic utterances were found in the

counseling context, this study found that validations occurred in doctor-patient interactions in the

sample as well. In addition, Street et al.'s (2009) article discussed in an earlier chapter focused

on seven principles of professional practices in medicine. The four proposed principles,

enhanced therapeutic alliances, increased social support, patient agency and empowerment, and

better management of emotions, are relevant to the theme of validation in this sample. For

example, the two BPS sessions conducted by D1 and D2 showed a number of acknowledgments

of emotions associated with events disclosed by the patients, even though patients did not overtly

expressed vulnerability in the process. This adds additional evidence that therapeutic relationships, including doctor-patient interactions, are dynamic, contextual, and relational rather than exclusively linear, static, instructional relationships. Validation could convey the intention of care and encourage further disclosures and as a result, strengthen therapeutic alliances and health outcomes.

Personal Standpoint, Self-Disclosure, and its Relational Function

While an initial session often involves varied technical tasks and the sequencing of scientific operations including assessment, diagnosis, and treatment, interactions can be shaped, reshaped, and jointly achieved through the presentation of discourses between speakers. This study found that displays of trainees' personal reactions included circuitous questions that intended to manage personal reactions, present affects, and convey therapeutic stances, as well as non-verbal behaviors that displayed affirmations. In addition to conveying personal standpoints regarding clients'/patients' presenting issues, the analysis shows that trainees' display of a personal standpoint can be used as a strategy that communicates empathy and helps re-direct therapeutic agendas.

Another discourse found in the analysis concerning the display of a personal standpoint is trainees' self-disclosure. Self-disclosure in this sample occurred in the process of greeting, history-taking, therapeutic interventions, and closing. In addition, the function of self-disclosure included providing compliments, conveying alignment and sameness, and sharing identity. The presentation of sameness, in particular, tended to occur after the client/patient revealed some personal information. In some cases, trainees' speech patterns changed during self-disclosure. The analysis identified self-disclosure did not directly accomplish any therapeutic task; as such, it may have been intended to convey a sense of connection with the clients/patients.

This study found that the display of a personal standpoint and self-discourse connect to the concept of self-narrative (Wetherell, Taylor, & Yates, 2004). Accordingly, self-narrative is a public discourse and a form of social accountability. Self-narrative can be implemented in sequences of interactions and relationship building in order to sustain, enhance, or impede various forms of action. Self-narratives may include but are not limited to the following social purposes: self-identification, justification, and solidification.

Although the data did not explicitly indicate trainees' intent while displaying personal reactions toward the patients'/clients' presenting issues, this study speculates that displayed personal reactions were used to help trainees reconcile possible internal conflicts toward the presenting issues, as well as to communicate trainees' sense of connection to their patients/clients in a covert form.

In addition, the researcher argues that trainees' intent to convey a sense of connection with the clients/patients through disclosing personal information relates to the notion of sameness in a therapeutic context. The phenomenon of sameness in connection to therapeutic relationships has been discussed in Buser et al.'s (2011), as well as Luke's and Goodrich's (2015) research regarding LGBTQ counseling. Buser et al.'s (2011) study discussed the intersectionality of sexual/gender identity and spirituality. Participants in the study revealed a sense of connection and acceptance with regard to client–counselor similarity on salient aspects of identities. In LGBTQ counseling, clients perceived the counselors' sameness as a protective factor in alliances and therapeutic outcomes. This is particularly true in LGBT youth counseling where social support, counseling interventions, and advocacy are salient aspects of practices (Luke & Goodrich, 2015).

The researcher argues that although self-disclosure is not a commonly encouraged practice in the training of psychotherapy as discussed by a number of studies, self-disclosure may distract attention from the therapeutic agendas and the clients (Peterson, 2002; Stricker & Fisher, 1990). Self-disclosure that intends to convey a sense of connection with the client/patient relates to the concept of real relationships discussed earlier (Gelso & Carter, 1994), which could potentially be beneficial if trainees engage in personal reflection and supervision with regard to the purpose of using such a strategy.

Repair

In an initial clinical session, intervention is necessary if severe symptoms are detected. This process may inevitably create potential tension and anxiety for patients/clients. It may also breach an established rapport. This study found that trainees used repair as a strategy to relieve tension and negotiate therapeutic direction in such a circumstance. When tension was displayed during an interaction, repair helped reestablish the relationship and therapeutic agenda.

The repair utterances found in this study connect to previous studies on the discourse of repair in conversations. For example, Colman and Healey (2011) studied the linguistic patterns of repair in task-oriented dialogues. The result indicated that repair occurred more frequently in task-oriented dialogues than in ordinary interactions. In addition, repair was substantially affected by speakers' task roles. The author concluded that repair is an integrated, cross-turn and cross-person system that maintains the mutual-intelligibility of dialogue.

The repair in this study occurred in a context of task-oriented dialogues. In addition, the cross-turn, cross-person repairing process occurred in one of the examples (see chapter five and the transcription of C2P2 for details). However, it appears that the relational aspect of repair was more salient at the moment of interaction before the trainees shifted the focus on the completion

of the therapeutic tasks. In the two examples of repair, this study found that trainees displayed stepping back and joining in the process repair. Stepping back shows the trainee's avoidance of presenting a direct therapeutic proposal. Joining indicates trainees' sharing the patient's/client's perspectives with regard to the resistance of the proposed interventions. For example, when sensing emotional tension and agitation arisen from the patient and the client, both D2 and C2 "stepped back" by discounting the original proposal. Moreover, both joined the patient's and the client's perspective through revising the proposal (C2) and explaining the therapeutic intent without mentioning the proposal (D2). Future studies could focus on the function and process of repair from a relational perspective.

Praise in Clinical Interactions

A unique divergent practice found in doctor-patient interactions is the use of praise. Data analysis showed that praise was used to reinforce a positive relational dynamic, strengthen the therapeutic discourse by promoting certain health behaviors, install hope, and to recount therapeutic goals. In addition, praise appeared at specific moments when patients reported desirable health outcomes and practices.

The theme of praise from this study connects to a previous study on a computer-mediated supervisory conversation in a counseling context. Accordingly, praise appeared to function as affirming supervisees' behaviors (Luke & Gordon, 2012) while at the same time mitigating the subsequent feedback regarding changes (Gordon & Luke, 2012). For example, supervisors' use of exclamations and labeling specific behaviors were found to reinforce supervisees' behaviors concerning assessment, interventions, and professional behaviors (Luke & Gordon, 2012). In some cases, praise was a strategy to affirm supervises' positive behaviors and, at the same time, to provide feedback (Gordon & Luke, 2012).

Praise that emerged in this sample has shown trainees' labeling and affirming desirable behaviors. Although no exclamation was found in the process of praise, the change of speech patterns such as rising and stressed tones were found in the sample. A variation found from the data and that is not consistent with the previous study is the juxtaposition of feedback giving and intent to challenge current behaviors during praise. This function does not appear in the data.

Looking at praise from a relational perspective, one can see that praise in the context of clinical relationships and supervisory relationships occurred under an asymmetrical relationship, as the speakers who provided praise in both contexts have assumed authority to the receiver. Praise in this sample existed primarily in doctor-patient interactions and little evidence was found in counseling-client interactions. This could be explained by the emphasis on the collegial and relational approach in the field of counseling. Additional linguistic data from clinical samples are needed for future research regarding the therapeutic as well as relational functions of praise.

Synthesis: Processes of Disclosures and Unique Features of Interactions

As discussed earlier in the literature review, a formed therapeutic relationship may open up the possibility of further disclosures (Tay, 2011) and emotional vulnerability (Tryon, 1990). In addition, the negotiation of discourses and expression of expectations may emerge in a therapeutic encounter (Angus & Korman, 2002; Like & Zyzanski, 1986; Maynard, 1991; Sutcliffe, Lewton, & Rosen et al., 2004). In this process, individual and institutional factors, as well as interactions created moment by moment, inevitably shape how one speaks, acts, and reacts (Jones & Beach, 1995).

Currently, few studies focus on in-depth discussions of the process of disclosures in initial clinical contexts. This study found a total of seven convergent themes regarding the

process of disclosures and unique features of interactions. Several themes including preparation, repetition, empathic reflection, and brief utterance and non-lexical conversational sounds were linguistic features that described how disclosures occurred as a result of interactions. Two variations of the strategies, disclosure through treatment protocol and delayed affective responses as well as disclosure through relational discourse and presentation of analytic standpoint, were found in doctors-in-training and counselors-in-training, respectively.

A number of salient themes concerning the process of disclosure and unique features of interactions have provided additional perspectives on existing discussions. This section intends to integrate the findings and existing literature on the discussions of empathic utterances, disclosures, utterances of vulnerability, trauma, and adversity, as well as challenging interactions.

Empathic Utterances

Repetition. As discussed in an earlier section, this study found that recapitulation appeared in the beginning of the sessions for getting into the therapeutic agenda or re-introducing therapeutic interventions in an initial context. In the middle stage of an initial session, trainees' repetition of stories and events said by patients/clients previously was found to be used for opening up further disclosures in therapeutic processes. The linguistic features of repetition found in this study include recollection of stories and events as well as repetition of the phrases and words said by patients/clients.

The repetition found in this study supports Ferrara's (1994) study on psychotherapeutic language discussed earlier. While echoing signifies a sequential repetition including clients repeating therapists' words, mirroring indicates a partial repetition by the therapist of a client's statement. Specifically, mirroring shows that therapists selected key portions of clients' utterance

and repeated these portions in the process of conversation. Mirroring is an indirect request for elaboration; it also conveys therapists' intent to listen. In this study, repetition was used by trainees to mirror salient aspects of clients'/patients' stories disclosed in the preceding discourse. Analysis showed that patients/clients produced further disclosures as result of this indirect invitation of elaboration. Such invitation, along with an established relationship between the dyad, constructed deeper and richer narratives.

Empathic reflections. Another relational discourse found in initial sessions in both family medicine and counseling was trainees' reflections during empathic opportunities. Linguistic features of empathic reflection included reflection of nonverbal behaviors presented at the moment of disclosure, and reflection of affects and potential distress associated with the events.

The empathic reflection found in this study is close to a previous study on the sequence of empathic reflection between a therapist and a client. Tikkanen et al. (2013) used dialogical sequence analysis to examine how changes occurred through the therapist's reflective and empathic dialogues in a psychotherapeutic session. Linguistic features of the sequence included recognition of a recurring inter and intra dynamics that the client had experienced.

Data analysis shows that clients'/patients' life stories disclosed in this process often connected to earlier adverse life events and vulnerability. Trainees' empathic reflections in this study reflect Tikkanen et al.'s (2013) findings on therapeutic recognition of intrapersonal and inter-personal discourses. Trainees' empathic reflection during empathic opportunities had an important function especially in the context of initial sessions where the uncertainty of the relationship was present. This relational discourse encouraged clients/patients to continue their

narratives that were relevant to therapeutic discourses and also strengthened the working alliance.

Brief utterances and acknowledgement. This study found that brief utterance and non-lexical conversational sounds such us "ok," "um-hm," or "yeah" appeared in the process of disclosures. This acknowledgment has connected to previous study on doctors' utterance during patients' problem presentations (Heritage & Clayman, 2010). Accordingly, there are two types of acknowledgment, continuers and shift-implicative.

Acknowledgments like "mm hm" and "uh huh" are continuers (Heritage & Clayman, 2010, p.113). Continuers indicate that the previous speaker has arrived at the unit of the boundary of the talk. "mm hm" and "uh huh" create an opportunity for turn-taking and encourage the previous speaker to continue. The second type of brief acknowledgment such as "Okay" and "right" are shift–implicative (Heritage & Clayman, 2010, p.113). Shift-implicative acknowledgements are frequently used during problem presentations. Shift-implicative also indicate that the previous speaker has arrived at the unit of the boundary of the talk but imply a preparedness to shift to a new topic or a new primary speaker. Unlike continuers which encourage more narrations from the previous speaker, shift–implicative imply a completion of the talk by the previous speaker. Accordingly, problem presentation, which includes disclosures, is essentially a linguistic activity co-constructed by the speakers because brief acknowledgements as well as speakers' responses to such acknowledgements constantly appear in the process of disclosures (Heritage & Clayman, 2010).

The analysis of the data shows that brief utterance and non-lexical conversational sounds during disclosure produced continuances of narrations from the patient/client, but the differentiation regarding the function of continuers and shift–implicative is not salient, as the

data shows that patients/clients continued their narrations after both types of acknowledgements were provided without shifting the turn or producing a new topic. More studies and data are needed to explore types and functions of brief acknowledgements in the context of initial sessions.

Disclosures and Session Depth

Two studies regarding the initial session's depth and breadth provide some further insights and discussions regarding the analysis of disclosure in this study. First, in Tryon's (1990) correlational study focusing on the initial session's depth and smoothness in predicting the subsequent treatment continuance in a university counseling center, the analysis indicated that clients' continuance of therapy after the initial encounter was significantly associated with the depth of the conversational processes, and other factors such as greater satisfaction, disturbance of the presenting issues, and motivation.

In addition, trauma and adverse life events are prevalent among patients/clients in primary care settings. For example, survey research was conducted by a NIH study to explore the occurrence of trauma and PTSD within 14 primary care settings (Bruce et al., 2001). In a total 504 primary care patients that were screened for anxiety, 83% (n=418) reported experiencing at least one traumatic incident in their life; 44% (n=185) met the DSM criteria for PTSD. Accordingly, clinicians in the primary care setting are likely to meet clients who present physical symptoms while having traumatic history. Bruce et al. (2001) argued that identifying trauma and related screening is necessary in primary care. Assessment and knowledge of trauma-informed care can effectively achieve a more accurate diagnosis and effective intervention for clients.

Both Tryon's (1990) and Bruce et al.'s (2001) studies connect to the themes such as disclosure, emotionally charged and challenging topics as result of therapeutic interactions found

in this study. For example, the strategy of repetition, which was shared by both professions, indicated how a new therapeutic discourse was introduced through trainees' use of patients'/clients' language before interjecting new words or meaning or introducing agendas. In addition, the use of non-lexical conversational sounds such as "ok" and "uh-hm", though presented as minimal responses, function as "demonstrations of continued coordinated hearership,' according to Schegloff (as cited in Woods, 1989, p.143). Thirdly, notice that some therapeutic themes such as the BPS approach in history taking, requesting details in assessment, preparation, and managing discrepancies that associated with disclosures of additional personal stories occurred in regular doctor's appointments. This confirms Bruce et al.'s (2001) study that indicated a high occurrence of disclosure of adverse life events in primary care settings.

In addition to the training and development of therapeutic skills, an insight gained from this discussion is how trainees conceptualize and navigate a therapeutic process. Conventional practices during initial sessions often put emphases on assessment, diagnosis, and rapport building; conceptual and process skills that attend to disclosures of adverse life events and trauma receive modest attention in training (Black, 2006; Hodas, 2006; Ko et al., 2008; Levers, 2012). In some cases, overly emphasizing the relational aspects of practice or solely operating according to this approach without advancing therapeutic directions or providing necessary interventions is referred to as problematic "nice counselor syndrome" (Chung et al., 2008, p. 314) where changes and "rocking the boat" are minimized in therapeutic processes. Tryon's (1990) study in combination with the finding in this sample suggest that maintaining therapeutic relationships and conducting in-depth discussions, insight building, and immediacy are not mutually exclusive in the context of the initial session. In fact, it could result in a person's further engagement of insights, health practice, and wellness. As Jacques Lacan described the

identification of the therapeutic desire, "the ending of a session cannot but be experienced by the subject as a punctuation of his progress" (As cited in Fink, 2011, p. 47).

Utterances of Vulnerability, Adversity, and Trauma

Narratives of vulnerability are one of the most unique qualities of narrative medicine because clinical interactions tightly connect to illness and narration (Bochner, 2009). A couple of studies have focused on vulnerability and disclosure in a therapeutic context. For example, Horowitz et al. (1993) provided an in-depth analysis of clients' utterances regarding disclosure of adverse life experiences. Accordingly, emotionality and defensive control were present in the conjunction of disclosure. The defensiveness and over-control of emotions function as a counter-action in order to control vulnerability presented at the moment of the interactions. Horowitz et al. (1993) concluded that these are signs of unresolved emotional states because processing significant life events simultaneously activates memories and associated affects.

In addition, participants in Farber et al.'s (2004) study reported that fear of therapists' reactions and sense of shame, embarrassment, and feeling vulnerable were key factors that may hinder further disclosures. However, the perceived quality of the relationship was a mediator of the decision to engage in this complex psychological and emotional process, as well as in facilitating subsequent disclosures. Farber et al. (2004) concluded that the impact of the interpersonal process served as a foundation and protection for the psychological effects (sometimes negative) of disclosures.

This study found that in some cases of doctor-patient interactions, disclosures occurred as a result of therapeutic processes such as questions and answers during assessment. In addition, patients/clients appeared to show hedging and delay affective responses during their disclosures. Disclosures in counseling sessions tended to occur through relational discourse provided by

trainees. For example, analysis indicates that disclosures in counseling was interactively achieved through trainees' initial reflections, open-ended questions, and clients' further disclosures. In addition, clients' disclosures in counseling sessions often displayed an analytic standpoint with little affect and hesitation shown in the process of problem presentation and disclosure of adverse events.

Several insights are gained from the data analysis and the previous discussions. First, understanding therapeutic process related to trauma and adverse life events needs to attend to patients' and clients' utterances in the process of disclosure. The data analysis in this study reflected Horowitz et al.'s (1993) finding regarding how affective and emotional reactions may be delayed and controlled in the process of disclosure. This provides valuable insights to training and practices regarding approaches to disclosures and how the therapeutic relationship helps further mediate and process the language of pain.

In addition to patients'/clients' utterances, the author argues that it is necessary to attend to clinicians' utterances and interactions with regard to how one approaches the language of pain, and how relational discourses are shaped and reformed as a result of patients'/clients' display of vulnerability. The analysis suggested that disclosures in an initial encounter could occur both in the process of assessment and as a result of built relationships. Future research regarding disclosures that includes both initial encounters as well as subsequent visits will provide a more comprehensive picture of how the language of pain is formed and transformed as a result of therapeutic interactions.

Challenging Interactions

Challenging interactions and dispute is perhaps one of the most uncomfortable relational dynamics in clinical encounters. Challenging interactions were found in both counseling and

family medicine in this study. A variation of challenging encounter found in this sample that appeared only in doctor-patient interaction is telling bad news. Challenging interactions tended to occur when health risks or risky health practices were identified. Analysis showed that trainees provided direct therapeutic interventions or standpoints that may not ally with clients'/patients' perspectives. However, this strategy was used to help achieve therapeutic agendas that intend to eliminate presenting issues or prevent potential complications associated with the issue. The negotiation between providing direct therapeutic standpoints while managing the relationship signifies the challenges. Analysis indicates that the linguistic features of challenging interactions include trainees' direct and overt therapeutic language.

Discussions of challenging interactions or uncomfortable therapeutic interventions appear in some CA literature. For example, Sanders (2012) analyzed a discord occurring between a patient who demanded a specific prescription and the physician's uncomfortable decision that conformed to the request. The discord was illustrated through a sequence of interactions and a position of conflict that occurred in the expert-layman relationship, that is, a doctor's difficulty in presenting professional judgment and medical agendas in front of a patient, despite the presence of medical expertise and authority. The challenging interactions appeared in this study indicate variations of speech features, that is, trainees' relatively direct utterances in presenting therapeutic interventions and expertise. This could be explained by the presence of health risks or risky health practices that could produce potential complications.

Several studies addressed insights with regard to training and practices relate to this unique feature of interaction. First, Guilfoyle's (2003) "not-knowing" stance discussed earlier in this chapter also connects to the context of challenging interactions. Specifically, while a narrative approach, a "not-knowing" stance appears to encourage further dialogues and develop

working alliance in a clinical context. Guilfoyle (2003) indicated that a "not knowing" position may produce an anxiety-provoking scenario if a patient/client is in need of immediate interventions in a potentially dangerous or risky situation. In this case, a direct utterance is necessary and could be therapeutic.

With regard to challenging conversations where discord occurs between clinicians and patients/clients, Reis and Brown (1999) indicated that premature termination could be minimized and subsequent interventions may be implemented if different perspectives between therapists and clients were acknowledged and recognized during interactions. Similarly, a previous study regarding challenging encounters, caring behaviors, and patients' perceptions of clinicians' caring behaviors indicated that the person-centered discourse and conveyance of caring were subject to interpretation; however, taking patients' perspectives and reflecting on patients' responses facilitated further communications in discussing stressful topics (Quirk et al., 2008). In other words, including the others' perspectives in difficult conversations can alleviate tensions, avoidance, and unexpressed grievance (Tikkanen et al., 2013; Voutilainen et al., 2010).

The above studies provided some implications for training and practices regarding approaching stressful interactions in clinical settings. First, taking patients' perspectives and reflecting on patients' responses connects to the concept of perspective display series (PDS) discussed in the section of validation where therapists' utterances indicate understanding and acknowledgement of clients' discourses (Buttny, 1996). It appears that the two principles are very similar and both apply to the discourse of vulnerability. In validation process, patients/clients disclosed undesirable behaviors and life circumstances to the trainee in an initial encounter where vulnerability was present. In challenging situations such as display of discord

and receiving bad news, patients/clients may present as confrontational but, arguably, experiencing a degree of vulnerability at the moment.

The data reflects challenging encounters discussed in the literature. That is, acknowledgment is necessary when different perspectives emerged during interactions; in addition, direct interventions, which may not be desirable for patients/clients, are necessary if a risk is identified. It is imperative that trainees are prepared for both conceptual skills and interactions with regard to such encounters.

Telling bad news. A unique phenomenon found in doctor-patient interactions is telling bad news when a critical condition was identified in an initial encounter. Different from the analysis of challenging interactions where trainees in both professions seem to produce forthcoming, overt, direct linguistic features, interactions in telling bad news indicated a more circuitous sequence of talk among showing concerns, providing explanations, and reporting the bad news. In addition, reasoning and persuasion strategy were used in bad news delivery. The organization of discourse in the sequence of telling bad news is summarized in the following formula:

Rationale (presentation of critical condition) => Concern = Knowledge presentation =>

Telling bad news and associated future proceeding => Rationale => Concern.

In some cases, the sequence of Rationale => Concern was used in the starting as well as the end point of bad news delivery.

Heritage and Maynard (2006) studied how doctors delivered bad news to patients. Speech features indicated the discourses of hesitation and neutrality. For example, analysis showed that doctors often provided a perspective display invitation in order to initiate a prerequisite of the news delivery. The perspective display invitation led the recipient to present a viewpoint before

the doctor announces the news. In addition, confirmation and validation of the recipient's perspectives were used to bring the doctor's subsequent affirmations of the diagnosis. While bad news delivery often evoked distress, few speech features that present affect and emotion were found in the process of news delivery.

Beach et al. (2005) analyzed video recorded sessions regarding how doctors, family members, and patients responded to conversations related to cancer screening, treatment, and diagnoses. Accordingly, delivering bad news was displayed through discord and disconnected dialogues between doctors and patients such as minimum responses and avoidances. Several features of interactions reflecting emotions associated with avoidance (fear, anxiety, etc.) were experienced by doctors and patients in the process of conversation. For example, doctors presented selective responses and glossing over difficult topics. Some examples display avoidance to referencing cancer diagnoses and focusing on tasks and instrumental conversations as opposed to emotional concerns. In addition, joint fear responses can be found in patients' repeating indirect references of raised cancer-like symptoms.

Note that the analysis of bad news delivery in this study was in a context that is different from the above two studies. For example, telling bad news in this study occurred when a critical condition was identified in an initial encounter. Trainees in this sample did not deliver a diagnosis. Rather, they proposed interventions that were not aligned with the patient's wishes. Secondly, little evidence of invitation and subsequent affirmation was found. Nonetheless, the recurrent themes such as showing rationales, concerns, and knowledge presentations support the theme of hesitation and neutrality in the above two studies (Beach et al., 2005; Heritage & Maynard, 2006).

It seems that trainees' circuitous, instrumental conversations in the delivery of bad news implied a degree of hedging and avoidance, as this was not found in challenging interactions and the process of validation. Heritage and Maynard (2006) indicated that such hedging and avoidance of affect during bad new delivery may result from the value of affective neutrality in medicine. Heritage and Maynard recommended that acknowledgement of patients' distress and emotional reactions should occur before the discussions of treatment in order to facilitate treatment alliances. This suggests that in addition to attending to conceptual skills and interventions, training and supervision should also include an approach to personalization, a dimension that attends to supervisees' personal experiences and reactions toward therapeutic processes (Bernard & Goodyear, 2008). In addition, debriefing and defusing after stressful events is necessary to prevent burnout and secondary traumatic stress (Arthur, Kowel, & Liu, 2012).

Limitations

This study explores the process of talk and the interactions of initial sessions between trainees and their patients/clients in family medicine and counselor education. As with all research considerations and cautions when considering the findings, the discussion of limitations will be based on three components: sampling, research design, and analysis.

Sampling

There are several limitations with regard to sampling. First, due to the rigorous inclusion criteria, this study encountered challenges in recruiting diverse volunteer institutions and trainees. Concerns to participate this study often related to institutions' limitation of recording, concerns of confidentiality, concerns associated with protection of health information, and concerns related to potential complication on the therapeutic dynamic due to additional request

of research participation in the context of initial session. Some other individual constraints include trainees' reluctance of being taped and examined from their initial sessions, scheduling issues, trainees' full caseloads and pending status of receiving new patients/clients at the time of the field placement.

The above circumstances bring up the second limitation with regard to sampling. Although this study included the recruitment of participants from four institutions, some data from an institution were limited to sessions conducted by one trainee. Data drawn from a more diverse pool of trainees from the same institution increases generalizability and provides a more comprehensive picture with regard to patterns of talk features in a situated context.

Due to the rigorous inclusion criteria, it is reasonable to say that trainees who volunteered for this study could have had a certain level of comfort and confidence with regard to conducting initial sessions prior to the research participation. While the primary goal of this study is to descriptively assess characteristics of talk and interactions of health communications in initial sessions conducted by novice practitioners, the generalizability of the result from the pool of participants in this study to trainees in the profession overall is limited.

Research Design

This study found three limitations concerning research design. First, CA studies use naturally occurring, video-recorded data in investigating the detailed processes of interactions. Some provided visual analyses (Beach et al., 2005). The majority of transcriptions and data analysis in this study were limited to audio data only, due to participants' consent.

Secondly, studying the phenomenon of talk and interaction in an initial clinical session in family medicine and counseling should include not only different institutions, but also the level of professional status. The analysis and interpretation of results regarding the phenomena of

interactions in initial clinical encounters were limited to participants' training status and cannot be generalized to initial sessions in a broader sense. As indicated earlier, trainees in both professions engaged training and clinical supervisions on clinical skills, case conceptualizations, diagnoses, as well as personal awareness during their field practices (www.acgme.org; www.cacrep.org; Arthur & Bernard, 2012; Bernard & Goodyear, 2009). The sessions conducted by trainees in this sample were products of participants' training status and their ongoing supervision in therapeutic skills, practices, and professional development. Consequently, this training structure shapes how talk and interactions were formed. Future research that includes diverse levels of participants' experience will add additional knowledge to the field.

Thirdly, this study recognizes the constraint with regard to the formation of the BPS session in the context of family medicine. As mentioned earlier, a full bio-psycho-social evaluation (BPS) in family medicine is a unique feature of institutional practice differentiated from general routine visits. It is a one-time only, in-depth assessment, and time can range from 45 to 60 minutes due to the nature of in-depth discussion. In a BPS session, residents and patients engage an in-depth assessment and communication related to patients' life history, family backgrounds, social adjustment, and wellness; typically, such in-depth conversation cannot be done in a routine, short visit due to the constraint of time. Thus, a BPS appointment in the context of family medicine is often a result of a previous routine visit where the doctor-in-training identifies some behavioral health issues or recognizes the presenting health concerns that might connect to the patient's psychosocial environment. This means that doctors-in-training may have a prior encounter with the patient such as a brief phone conversation or a previous regular doctor's appointment before the session takes place. This previous encounter may have shaped participants' comfort level in approaching the session and presentations of talk and

interactions in the BPS session. This may be the case for the two BPS sessions collected in a family medicine setting in this sample.

This study includes such data from family medicine because a BPS session is an extension of the initial doctor's visit. In addition, the unique nature of the interactions in a BPS session contributes various interesting themes that reveal a shared feature of practice between family medicine and counseling. That said, it also raises some issues with regard to the consistency of the initial encounter.

Fourthly, past research suggested that the interactions, interventions, and relationships that have occurred in initial sessions have an impact on or connection to the following therapeutic alliance and subsequent treatment (Buttny & Jensen, 1995; DeGood, 1983; Greenberg & Stone, 1992; Kokotovic & Tracey, 1990; Odell & Quinn, 1998; Saltzman et al., 1976; Whitlock et al., 2004; Zisook et al., 1978). Although some themes are typical for initial clinical encounters such as history taking, open-ended questions in opening statements, rapid interventions, disclosure through questions and answers, the majority of themes found in this study can occur throughout the entire course of therapy. The analysis of how the interactions occurred in the first encounter connects and shapes subsequent interactions and will provide additional insights into studying the impact of initial sessions. This study found a limitation to drawing a definite conclusion about the impact of initial sessions on subsequent visits unless such data are available. Future research concerning process and the impact of initial sessions should consider including subsequent session data.

Analysis

Although this study had engaged repeated reviews of data in order to ensure the accuracy of the analysis, as well as sought consultations of experts in the field during data analysis, the

coding process was primarily conducted by the author. Along with this awareness, this study recognizes that the primary coder's positionality may have contributed to how the communications and interactions were examined and studied. The positionality of the primary coder include the training and practices of psychiatric nursing as well as mental health counseling. This cross-professional background that contains medicine and counseling has provided the primary coder a cross-institutional lens during the process of data analysis. At the same time, it could have narrowed the scope and angle of analytic dimensions. Future studies should include using a diverse coder structure, along with additional qualitative methods such as data triangulation, auditing, and member checking in order to increase the trustworthiness and credibility of the analysis.

Consistent with previous studies of doctor-patient interactions (Beach et al., 2005) and therapist-client interaction (Buttny, 1996), the steps of analysis in this study included analyzing the overarching talk phenomena (global themes) and the process of talk and interactions (local themes). Global themes include general talk and interactions based on themes, patterns, and lexicon usage. Local themes include detailed interactions and conversations that captured the significance of talk and acts between trainees and patients/clients, signs and marks of relationships, therapeutic relationships, and subsequent interactions. Previous studies on talk and interactions have focused on social cultural variables such as race and gender factors associated with certain speech patterns (Tannen, 1991, 1994; Van Hark, 2012) and reproductions of macro-level structures of domination in professional-client interactions (Waitzkin, 1979). This study did not include these identity characteristics in the analysis. Future studies may consider including these elements in the analysis of talk and interaction in the context of health care.

Implications

Clinical Practices

This study proposes three implications for future practice. First, as the data and analysis indicated, assessment and history taking are typical routines in initial sessions across doctors and counselors-in-training. Using symptom checklists and questionnaires in history taking is a prevalent practice in initial assessments. That said, this assessment process may have limited the function of the holistic approach to the person and, as a result, limited information sharing. At the same time, this study recognizes focused assessment is necessary in cases of time-limited appointments or presenting issues that need immediate, rapid responses. This study suggests two levels of integrative approach. First, the initial assessment process needs to include the BPS aspects of the presenting issues. These include aspects of health practices, family function, support systems, and psychosocial and behavioral health (Borrell-Carrió et al., 2004). Previous studies suggested that a BPS approach uses systematic perspectives to explore a person's symptoms and illness while at the same time valuing subjective experiences and explanations of disease and health conditions. The three overarching principles, the mind-body integration, the holistic approach of individual conditions in treatment and interventions, and third, the person-centered practice offer a potential solution for reducing the cost of unnecessary prescriptions, poor treatment outcomes, and health care disparities (Maizes et al., 2009).

The second level of integration is the emphasis of person-centered care and relational approach that attend to various psycho-social factors such as health practices, beliefs, cultures, and contexts (Cheston, 2000; Corey, 2012; Katon & Kleinman, 1981; Kokotovic & Tracey, 1990; Maizes et al., 2009; McKinlay et al., 1996; Stange et al., 2001). This integration requires a diverse method of inquiry, which brings up the second level of integration. The initial assessment

needs to include both standardized methods such as symptom checklists, tests, examinations, and diagnostic protocols, as well as a narrative method that allows sociological, discursive, phenomenological data to emerge in the process of trouble telling.

In addition, the formation of therapeutic relationships in an initial encounter not only includes a preliminary formation of comfort level such as trust, acceptance, and safety building, but the complex therapeutic process in initial encounters requires clinicians to navigate among ethical practices, therapeutic directions, and necessary interventions while attending to therapeutic relationships. Analysis of talk-in-interaction provides key access for practitioners to explore a fundamental source of therapeutic process, specifically, how practitioners and patients/clients manage, structure, and develop various moments of interactions and relationships through language. In addition to the performance of assessment and intervention, language is crucial in the process of forming a relationship which is recognized as a crucial predictor of therapeutic outcomes in mental health care (Kress et al., 2005; Erikson & Kress, 2006). Examining talk and interactions that occurred in a therapeutic process helps practitioners from both professions gain awareness, build both conceptual and practical skills, and more importantly, attend to both the macro and micro levels of linguistic strategies that promote a working alliance. Thirdly, while assessment may be the main focus of an initial encounter, the analytic themes and results from this study suggest that initial sessions are a microcosm of the entire therapeutic course where assessments, disclosures, the impact of the therapeutic relationship on changes, interventions, and closure simultaneously occur in a single episode of encounter. The discussion of the process of disclosure and unique feature of interactions suggests that initial sessions that attended to patients'/clients' disclosures, in-depth conversations on

salient subjects, and therapeutic relationships have significance regarding changes and subsequent therapeutic interactions.

Training and Supervision

While previous studies have investigated the effect of relationship building and skill performances in clinical interactions (Anderson & Sharpe, 1991; Beck, Daughtridge, & Sloane, 2002; Elder, Ayala, & Harris, 1999; Fielding, 1995; Negri, Brown, Hernández, Rosenbaum, & Roter, 1995; Roter et al., 1995; Satterfield & Hughes, 2007), very few focus on the crucial training period of trainees who are in the field practicing as novice practitioners. This exploratory, descriptive study based on naturally occurring sessions conducted by trainees intends to provide additional insights related to working alliances, which have been emphasized in both family medicine and counseling (Angus & McLeod, 2004; Guilfoyle, 2003; Like & Zyzanski, 1986; Maizes, Rakel, & Niemiec, 2009; Mead & Bower, 2000; Mead et al., 2002; Sexton & Whiston, 1994; Quill & Brody, 1996). The emerging themes identified from linguistic data and the process of interactions will help both medical education and counselor education to improve current training and pedagogy regarding assessment, diagnosis, and skills that aim at forming therapeutic relationships. For example, doctors-in-training can benefit from learning counseling skills and strategies. Counselors-in-training can benefit from learning behavioral health practices and collaborative care in a medical context. Further, the focus on the detail of talk and conduct informs clinical supervisors in effectively assisting trainees in achieving the client-centered model of practice. It also helps establish supervisory protocols for clinical supervisors who can effectively assist trainees in their practices.

In addition, the focus on the details of talk and the process of interactions informs clinical supervisors in effectively assisting trainees in developing their conceptual skills, interventions,

and personalization (Bernard & Goodyear, 2008). For example, some idiosyncratic practices such as humor, self- disclosures, praise, managing discrepancies and personal reactions need to further attend to therapeutic intentions, personal style, identity, and creativity.

Data that demonstrate interactions provide a genuine picture for such further inquiries. Clinical supervision that focuses on direct observational data will assist clinical supervisors in effectively providing a trainee-focused supervision. In a broader educational context, both medical education and counselor education will enhance their training and pedagogy by including recorded data and direct observations; this may include but is not limited to assessment, interventions, and effective skills that form therapeutic relationships.

Given the findings, this study suggests that training topics related to initial sessions could include the themes that are found in this study but are under-discussed in the current literature. These themes include the function of ordinary interaction, recapitulation, and repair. Moreover, some unique features found in this study including managing discrepancy, managing personal reactions, disclosure in closing, telling bad news, and challenging interactions are salient issues in the context of an initial session. Therefore, they should be given both supervisory and educational attentions in both fields.

As discussed above, self-disclosure is not a commonly encouraged practice in the training of psychotherapy because a number of studies argue that self-disclosure may distract attention from the therapeutic agendas and clients (Peterson, 2002; Stricker & Fisher, 1990). That said, self-disclosure that intends to convey a sense of connection with the client/patient relates to the concept of real relationships and sameness discussed earlier (Buser et al., 2011; Gelso & Carter, 1994; Luke & Goodrich, 2015). Creating a sense of connection through self-disclosure could potentially be beneficial if trainees engage critical reflection and supervision with regard to the

purpose of using such a strategy. As can be seen, self-disclosure is an idiosyncratic practice, and it requires a supervisory process that helps trainees to gain the conceptual skills and insights, and more importantly, self-reflection and awareness related to this strategy.

As the data and the results indicated, a number of convergent practices, particularly on therapeutic relationships and the unique features of interactions were found between family medicine and counseling. These include relational utterances and interactions, neutrality, validation, self-disclosure, managing personal reactions, repair, repetition, empathic reflection, brief utterance, managing discrepancy, disclosure in closing, and challenging interactions. This finding is consistent with this study's assumption that both professions involve frequent encounters with mental health issues and treatment (www.acgme.org; www.cacrep.org), as well as the ongoing supervision of therapeutic practices (Arthur & Bernard, 2012; Bernard & Goodyear, 2009). In addition, a common feature of emphasis across both mental and behavioral health service fields are accreditation standards and training programs (www.acgme.org; www.cacrep.org). Given the observations, this study suggests that a more cross-disciplinary, collaborative approach to professional practices, professionalism, and professional identity will provide additional insights and diversity for training and education in both professions.

Research

This study analyzes talk and interaction within initial sessions in health care systems. With the consideration of all aspects of reach process, design, and outcome, this study proposes the following implications for future research that intends to focus on the related subjects. First, past research suggests that the interactions, interventions, and relationships that have occurred in initial sessions have an impact on or connection to the following therapeutic alliance and subsequent treatment (Buttny & Jensen, 1995; DeGood, 1983; Greenberg & Stone, 1992;

Kokotovic & Tracey, 1990; Odell & Quinn, 1998; Saltzman et al., 1976; Whitlock et al., 2004; Zisook et al., 1978). Yet, initial sessions as a phenomenon have been understudied and overlooked by researchers in related fields. This study believes that studying the talk and interactions in initial sessions needs more attention because of the impact of an initial encounter on subsequent therapeutic processes. In order to see how the interactions that occurred in the first encounter connect and shape subsequent interactions, future research concerning the process and impact of initial sessions should consider including subsequent sessions' data.

This study also suggests that future studies regarding training and supervision on the holistic approach and person-centered practice in the fields of family medicine and counseling should utilize the existing training data such as taped sessions as a source to develop theoretical constructs and models that attend to the training focuses such as the effect of relationship building and skill performances in regular institutional interactions (Anderson & Sharpe, 1991; Beck, Daughtridge, & Sloane, 2002; Elder, Ayala, & Harris, 1999; Fielding, 1995; Negri, Brown, Hernández, Rosenbaum, & Roter, 1995).

While recording a clinical session on a regular basis is unusual in both professional contexts, it is a common practice in a number of training settings in counseling and family medicine. This study utilized these evaluative contexts from the training protocols of both professions in designing sampling selections, recruitments, and data collection. The design of utilizing existing training structures as a convenient sample can be included as an analytic element in future studies that focus on trainees' professional developments in the timeline when the data is collected. For example, including more types of data, such as the visual elements of a session and trainees' self-evaluations of the sessions, could provide a more comprehensive picture of how a strategy is developed and used in a particular interaction.

As discussed previously, language is a primary tool in mental health care and behavioral science settings (Anderson & Goolishian, 1988; Buttny, 1996; Voutilainen et al., 2010). In addition, language is crucial in the process of forming a relationship which is recognized as a significant predictor of therapeutic outcomes in mental health care (Kress et al., 2005; Erikson & Kress, 2006). Since little is known about how the therapist and client engage in conversation and use talk to develop, maintain, or repair the therapeutic relationship, as well as what linguistic features display empathy, this study believes that to assess therapeutic processes, the person-centered approach, treatment effectiveness, and therapeutic outcomes, future studies will need to include direct observation of naturally occurring interactions between clinicians and patients/clients in health-related communications because analysis of talk and interactions will provide direct logical inferences and scientific procedures to assess speech and interactions in communicating health-related concerns.

Furthermore, CA as both the methodological and analytical tool examines talk phenomena on both a process level (a so-called "thematic level") (Heritage & Maynard, 2006) and a microanalytic level. While a process level of analysis explores a broader, overall theme of interaction, a microanalysis of talk focuses on the forms and function of specific language use, co-construction, and co–creation of therapeutic discourses. With the combination of two levels of analysis, CA provides a systematic and comprehensive analytic frame for studying interactions. This study suggests that future research should include this multilevel analysis in studying talk and interaction; this innovative method will also enrich methodological repertoires on future studies related to health communications.

The limitations found in this study have provided the following implications for future research designs. Future studies need to consider including diverse pools of data across different

institutions and practitioners; this will provide a more accurate and compressive picture of talk occurring in institutions. In addition, this study narrows the focus on novice practitioners. However, to gain a more comprehensive picture of talk and interactions in initial clinical encounters, future studies should consider including data from practitioners of diverse professional status.

The BPS approach occurred in both family medicine and counseling in this sample. This study recognizes that the unique nature of the interactions in a BPS session in family medicine contributes various interesting themes; at the same time, it also raises issues with regard to the consistency of an initial context. With this awareness, this study proposes that future research that studies BPS sessions in family medicine should include both the previous initial visit as well as the BPS session. This will provide a comprehensive picture of therapeutic interactions.

With regard to data analysis, this study proposes that including diverse coders along with additional qualitative methodologies will increase the rigor of the analysis. In addition, future research could include analysis focusing on social cultural variables such as speakers' identities and how these shape interactions and relationships in a communication.

Conclusion

The foundation of this study is to explore how talk and interactions manifest within initial sessions taking place in both family medicine and counseling settings. Through the analysis of how conversations are initiated and how talk and interactions are produced and co-constructed, the primary goal of this study is to descriptively assess characteristics of talk and interactions in health communications in initial sessions conducted by novice practitioners.

The fields of counselor education and family medicine have unique emphases for professionalism (Barrett et al., 2003; Doherty, Baird, & Becker, 1987; Engel, 1977; Myers &

Sweeney, 2008); at the same time, they share common features of practices, particularly in relation to client-centered practice and a focus on behavioral and mental health (Fuertes et al., 2007; Horvath & Symonds, 1991; Howgego et al., 2003; Lelorain et al., 2012; Mead & Bower, 2002; Mead et al., 2002; Sexton & Whiston, 1994; Tryon, 1990). Because both fields require trainees to engage in ongoing practical training and supervision, novice practitioners in both fields frequently encounter client/patient visits and often directly interact and communicate with clients in their routine practices.

This study used conversation analysis to look at talk-in-interaction in initial sessions conducted by novice practitioners in family medicine and counseling, using naturally occurring audio and video-recorded data examining the three overarching questions: How are the conversations between trainees and clients developed and maintained in their initial encounters? How are therapeutic relationships and therapeutic discourses developed in initial sessions? and How do co-constructed, sequential interactions at the moment produce subsequent actions and interactions such as disclosures, presentation of challenging communications, and vulnerability? Both convergent and divergent practices were included in analytic procedures.

The results indicated that while professional practice was contextual and circumstantial, as reflected by a number of divergent themes in the first analytic chapter that focused on the development of conversations in initial sessions, both professions in this study have shared a number of strategies and talk features with regard to the development of therapeutic relationships, the process of disclosures, and presentation of unique interactions as a result of co-constructed therapeutic discourses and interactions.

Conversation analysis provides a comprehensive analytic frame for studying talk and interactions. In addition, the emphasis on using the naturally occurring, recorded data of

interactions provides authentic materials for the review of clinical practices, training, and supervision. Future studies regarding clinical encounters, working alliances, and therapeutic discourses that include analyses of talk and interactions will provide additional insights and enrich methodological repertoires from current studies related to best practice, effective therapeutic alliance, and effective health communications.

Appendix I: IRB Approval Letter

SYRACUSE UNIVERSITY
Institutional Review Board
MEMORANDUM

TO:	Melissa Luke
DATE:	January 22, 2015
SUBJECT:	**Expedited Protocol Review - Approval of Human Participants**
IRB #:	14-295
TITLE:	*An Analysis of Talk and Interactions in Initial Sessions in the Context of Counseling and Family Medicine*

The above referenced protocol was reviewed by the Syracuse University Institutional Review Board for the Protection of Human Subjects (IRB) and has been given **expedited approval.** The protocol has been determined to be of no more than minimal risk and has been evaluated for the following:
1. the rights and welfare of the individual(s) under investigation;
2. appropriate methods to secure informed consent; and
3. risks and potential benefits of the investigation.

The approval period is **January 21, 2015** through **January 20, 2016**. A continuing review of this protocol must be conducted before the end of this approval period. Although you will receive a request for a continuing renewal approximately 60 days before that date, it is your responsibility to submit the information in sufficient time to allow for review before the approval period ends.

Enclosed are the IRB approved date stamped consent and/or assent document/s related to this study that expire on **January 20, 2016**. **The IRB approved date stamped copy must be duplicated and used when enrolling new participants during the approval period** (may not be applicable for electronic consent or research projects conducted solely for data analysis)**.** Federal regulations require that each participant indicate their willingness to participate through the informed consent process and be provided with a copy of the consent form. Regulations also require that you keep a copy of this document for a minimum of three years after your study is closed.

Any changes to the protocol during the approval period cannot be initiated **prior** to IRB review and approval, except when such changes are essential to eliminate apparent immediate harm to the participants. In this instance, changes must be reported to the IRB within five days. Protocol changes must be submitted on an amendment request form available on the IRB web site. Any unanticipated problems involving risks to subjects or others must be reported to the IRB within 10 working days of occurrence.

Thank you for your cooperation in our shared efforts to assure that the rights and welfare of people participating in research are protected.

Jeffrey Stanton, Ph.D.
IRB Chair

DEPT: Counseling and Human Services – 805 S. Crouse Avenue   **STUDENT:** Yihhsing Liu

Appendix II: Informed consent for **residents**

WRITTEN INFORMED CONSENT

SYRACUSE UNIVERSITY

COUNSELING AND HUMAN SERVICES

School of Education

805 S. Crouse Ave., Lower Level / Syracuse, New York 13244
315-443-2266

An Analysis of Talk and Interactions in Initial Sessions in the Context of Counseling and Family Medicine

My name is Yihhsing Liu, and I am a doctoral candidate in the department of Counseling and Human Services at Syracuse University. I am inviting you to participate in my dissertation research. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask any questions about the research project. I will be happy to explain anything in greater detail if you wish.

I am interested in exploring communication and interaction between the attending physician and patient in the first doctor's appointment in the context of family medicine. You will be asked to indicate whether you agree to be audio and/or videotaped during your sessions with your adult patients whom you will see the first time. Participation in this research will not take longer than the scheduled appointment with your patient.

I will use the recording files for the following purposes:

- Transcription

- Analysis of communication and interactions

- Consultation

- Publication of the research

The analytic process will involve transcribing the recorded files from audio format to text. In addition, after I conduct a preliminary analysis, I will consult with my dissertation advisor and committee members regarding my study. In addition, I will publish the study after I complete my dissertation. The publication will include written publication and conference presentation. The recording data and transcriptions will be retained during the time of the study, and they will then be destroyed when the study is complete.

All information regarding you and your tapes will be kept *confidential*. All the recording data will only be used for research purposes. Only myself, my advisor, two committee members, and the transcriptionist will have access to the tape. The revelation of identifiable information will be minimized throughout the research process.

First, to ensure the confidentiality of all private information discussed, all the recordings will be stored on a password protected computer and they will be coded and stripped of any identifying information prior to transcription. All research data will be de-identified and will remain unidentifiable even after transcription. Presentation of results will be clusters of examples of interactions without any identifiable information.

The benefit of this research is that you will be helping us to better understand communication and social interactions in initial sessions in the context of family medicine. If you want to increase opportunities for developing your awareness, case conceptualization and skill, transcriptions of your session will be available upon your request.

The risks to you for participating in this study may be concerns related to the evaluation of your practices and concerns related to the confidentiality of your personal information. These risks will be minimized by my effort to protect your confidentiality. First, your participation is confidential. I will not disclose your decision of participation to anyone, including your instructor, faculty member, supervisor, and patient. Your participation does not relate to any of your course and clinical evaluation. Your participation is only for helping me to complete my dissertation project. In addition, I will not share your tapes to your instructors or supervisors without your permission. I will abide by procedures and protocols regarding all the protection of privacy and confidentiality regarding your sessions.

If you do not wish to participate in this study, you have the right to refuse to participate without penalty. If you decide to participate and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

We have not set aside money to pay for related injuries. Signing this form does not waive any legal rights.

If you have any questions, concerns or complaints about the research, contact me by phone at 412-296-0145, or email me at maomiliu@gmail.com. You can also contact Dr. Melissa Luke by e-mail at mmluke@syr.edu or by phone at 315-443-5265. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator or if you cannot reach the investigator, you may contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered. I have received a copy of this consent form. I am 18 years of age or older.

_____   I agree to participate in this research

_____   I do not agree to participate in this research

In addition,

___ I agree to be audio recorded

___ I do not agree to be audio recorded

___ I agree to be video recorded

___ I do not agree to be video recorded

_____   _____

Signature of participant   Date

_____

Printed name of participant

_____   _____

Signature of researcher   Date

_____

Printed name of researcher

Appendix III: Informed consent for **counselors-in-training**

WRITTEN INFORMED CONSENT

SYRACUSE UNIVERSITY

COUNSELING AND HUMAN SERVICES
School of Education
805 S. Crouse Ave., Lower Level / Syracuse, New York 13244
315-443-2266

An Analysis of Talk and Interactions in Initial Sessions in the Context of Counseling and Family Medicine

My name is Yihhsing Liu, and I am a doctoral candidate in the department of Counseling and Human Services at Syracuse University. I am inviting you to participate my dissertation research. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask questions about the research if you have any. I will be happy to explain anything in detail if you wish.

I am interested in exploring communication and interaction between the attending counselor and client in the first counseling appointment in the context of mental health counseling. You will be asked to indicate whether you agree to be audio and/or videotaped during your sessions with your counselor whom you will see the first time. Participation in this research will not take longer than the scheduled appointment with your counselor.

I will use the recording files for the following purposes:

- Transcription

- Analysis of communication and interactions

- Consultation

- Publication of the research

The analytic process will involve transcribing the recorded files from audio format to text. In addition, after I conduct a preliminary analysis, I will consult with my dissertation advisor and committee members regarding my study. In addition, I will publish the study after I complete my dissertation. The publication will include written publication and conference presentation. The recording data and transcriptions will be retained during the time of the study, and they will then be destroyed when the study is complete.

All information regarding you and your tapes will be kept *confidential*. All the recording data will only be used for research purposes. Only myself, my advisor, two committee members, and the transcriptionist will have access to the tape. The revelation of identifiable information will be minimized throughout the research process.

First, to ensure the confidentiality of all private information discussed, all the recordings will be stored on a password protected computer and they will be coded and stripped of any identifying information prior to transcription. All research data will be de-identified and will remain unidentifiable even after transcription. Presentation of results will be clusters of examples of interactions without any identifiable information.

The benefit of this research is that you will be helping us to better understand communication and social interactions in initial sessions in the context of family medicine. If you want to increase opportunities for developing your awareness, case conceptualization and skill, transcriptions of your session will be available upon your request.

The risks to you for participating in this study may be concerns related to the evaluation of your practices and concerns related to the confidentiality of your personal information. These risks will be minimized by my effort to protect your confidentiality. First, your participation is confidential. I will not disclose your decision of participation to anyone, including your instructor, faculty member, supervisor, and client. Your participation does not relate to any of your course and clinical evaluation. Your participation is only for helping me to complete my dissertation project. In addition, I will not share your tapes to your instructors or supervisors without your permission. I will abide by procedures and protocols regarding all the protection of privacy and confidentiality regarding your sessions.

If you do not want to take part, you have the right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

We have not set aside money to pay for related injuries. Signing this form does not waive any legal rights.

If you have any questions, concerns or complaints about the research, contact me by phone at 412-296-0145, or email me at maomiliu@gmail.com. You can also contact Dr. Melissa Luke by e-mail at mmluke@syr.edu or by phone at 315-443-5265. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator or if you cannot reach the investigator, you may contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered. I have received a copy of this consent form. I am 18 years of age or older.

_____ I agree to participate in this research

_____ I do not agree to participate in this research

In addition,

___ I agree to be audio recorded

___ I do not agree to be audio recorded

___ I agree to be video recorded

___ I do not agree to be video recorded

_____   _____

Signature of participant   Date

_____

Printed name of participant

_____   _____

Signature of researcher   Date

_____

Printed name of researcher

Appendix IV: Informed consent for **patients**

WRITTEN INFORMED CONSENT

SYRACUSE UNIVERSITY

COUNSELING AND HUMAN SERVICES

School of Education

805 S. Crouse Ave., Lower Level / Syracuse, New York 13244

315-443-2266

An Analysis of Talk and Interactions in Initial Sessions in the Context of Counseling and Family Medicine

My name is Yihhsing Liu, and I am a doctoral candidate in the department of Counseling and Human Services at Syracuse University. I am inviting you to participate my dissertation research. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask questions about the research if you have any. I will be happy to explain anything in detail if you wish.

I am interested in exploring communication and interaction between the attending physician and patient in the first doctor's appointment in the context of family medicine. You will be asked to indicate whether you agree to be audio and/or videotaped during your sessions with your doctor whom you will see the first time. Participation in this research will not take longer than the scheduled appointment with your doctor.

I will use the recording files for the following purposes:

- Transcription

- Analysis of communication and interactions

- Consultation

- Publication of the research

The analytic process will involve transcribing the recording files from audio format to textual information. In addition, after I conduct a preliminary analysis, I will consult with my dissertation advisor and committee members regarding my study. In addition, I will publish the study after I complete my dissertation. The publication will include written publication and conference presentation. The recording data and transcriptions will be retained during the time of the study, and they will then be destroyed when the study is complete.

All information regarding you and your tapes will be kept *confidential*. All the recording data will only be used for research purposes. Only myself, my advisor, two committee members, and the transcriptionist have access to the tape. The revelation of identifiable information will be minimized throughout the research process.

First, to ensure the confidentiality of all private information discussed, all the recordings will be stored on a password protected computer and they will be coded and stripped of any identifying information prior to transcription. All research data will be de-identified and will remain unidentifiable even after transcription. Presentation of results will be clusters of examples of interactions without any identifiable information.

In addition, individually identifiable health information under the federal privacy law is considered to be any information from your medical record, or obtained from this study, that can be associated with you, and relates to your past, present, or future physical or mental health or condition. This is referred to as protected health information. If you agree to participate in this research, your health information will be shared with me, my dissertation advisor, two committee members, and the transcriptionist. For you to be in this research we need your permission to collect and share this information. Federal law protects your right to privacy concerning this information. Your protected health information will be kept confidential. Your identity will not be revealed in any publication or presentation of the results of this research. When you sign this consent form at the end, it means that you have read this section and authorize the use and/or sharing of your protected health information as explained above.

The benefit of this research is that you will be helping us to better understand communication and therapeutic interactions in initial sessions in the context of family medicine. The result will be helpful in the training and supervision of doctors' communicative skills in a medical context.

The risks to you of participating in this study are concerns related to your treatment process as result of participating this study, as well as concerns related to confidentiality of your personal and health information. These risks will be minimized by my effort to protect your confidentiality. First, your participation is confidential. I will not disclose your decision of participation to anyone, including your doctor. Your decision of participation does not relate to any of your treatment plan or decisions made by you and your doctor, and it will not affect any treatment process regarding your visits. Your participation is only for helping me complete my dissertation project. In addition, I will abide by procedures and protocols regarding all the protection of privacy and confidentiality regarding your sessions.

If you do not want to take part, you have the right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty. Furthermore, you always have the right to withdraw your permission (revoke authorization) for us to use and share your health information, by putting your request in writing to the investigator in charge of the study. This means that no further private health information will be collected and used by this research.

We have not set aside money to pay for related injuries. Signing this form does not waive any legal rights

If you have any questions, concerns or complaints about the research, contact me by phone at 412-296-0145, or email me at maomiliu@gmail.com. You can also contact Dr. Melissa Luke by e-mail at mmluke@syr.edu or by phone at 315-443-5265. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator or if you cannot reach the investigator, you may contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered. I have received a copy of this consent form. I am 18 years of age or older.

_____   I agree to participate in this research

_____   I do not agree to participate in this research

In addition,

___ I agree to be audio recorded

___ I do not agree to be audio recorded

___ I agree to be video recorded

___ I do not agree to be video recorded

_____   _____
Signature of participant   Date

_____
Printed name of participant

_____   _____
Signature of researcher   Date

_____
Printed name of researcher

Appendix V: Informed consent for **clients**

WRITTEN INFORMED CONSENT

SYRACUSE UNIVERSITY

COUNSELING AND HUMAN SERVICES

School of Education

805 S. Crouse Ave., Lower Level / Syracuse, New York 13244

315-443-2266

An Analysis of Talk and Interactions in Initial Sessions in the Context of Counseling and Family Medicine

My name is Yihhsing Liu, and I am a doctoral candidate at in the department of Counseling and Human Services at Syracuse University. I am inviting you to participate my dissertation research. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask questions about the research if you have any. I will be happy to explain anything in detail if you wish.

I am interested in exploring communication and interaction between the attending counselor and client in the first counseling appointment in the context of mental health counseling. You will be asked to indicate whether you agree to be audio and/or videotaped during your sessions with your counselor whom you will see the first time. Participation in this research will not take longer than the scheduled appointment with your counselor.

I will use the recording files for the following purposes:

- Transcription

- Analysis of communication and interactions

- Consultation

- Publication of the research

The analytic process will involve transcribing the recording files from audio format to textual information. In addition, after I conduct a preliminary analysis, I will consult with my dissertation advisor and committee members regarding my study. In addition, I will publish the study after I complete my dissertation. The publication will include written publication and conference presentation. The recording data and transcriptions will be retained during the time of the study, and they will then be destroyed when the study is complete.

All information regarding you and your tapes will be kept *confidential*. All the recording data will only be used for research purposes. Only myself, my advisor, two committee members, and the transcriptionist have access to the tape. The revelation of identifiable information will be minimized throughout the research process.

First, to ensure the confidentiality of all private information discussed, all the recordings will be stored on a password protected computer and they will be coded and stripped of any identifying information prior to transcription. All research data will be de-identified and will remain unidentifiable even after transcription. Presentation of results will be clusters of examples of interactions without any identifiable information.

In addition, individually identifiable health information under the federal privacy law is considered to be any information from your medical record, or obtained from this study, that can be associated with you, and relates to your past, present, or future physical or mental health or condition. This is referred to as protected health information. If you agree to participate in this research, your health information will be shared with me, my dissertation advisor, two committee members, and the transcriptionist. For you to be in this research we need your permission to collect and share this information. Federal law protects your right to privacy concerning this information. Your protected health information will be kept confidential. Your identity will not be revealed in any publication or presentation of the results of this research. When you sign this consent form at the end, it means that you have read this section and authorize the use and/or sharing of your protected health information as explained above.

The benefit of this research is that you will be helping us to better understand communication and therapeutic interactions in initial sessions in the context of mental health counseling. The result will be helpful in the training and supervision of counselors' communicative skills in a counseling context.

The risks to you of participating in this study are concerns related to your treatment process as result of participating this study, as well as concerns related to confidentiality of your personal and health information. These risks will be minimized by my effort to protect your confidentiality. First, your participation is confidential. I will not disclose your decision of participation to anyone, including your counselor. Your decision of participation does not relate to any of your treatment plan or decisions made by you and your counselor, and it will not affect any counseling process regarding your visits. Your participation is only for helping me complete my dissertation project. In addition, I will abide by procedures and protocols regarding all the protection of privacy and confidentiality regarding your sessions.

If you do not want to take part, you have the right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty. Furthermore, you always have the right to withdraw your permission (revoke authorization) for us to use and share your health information, by putting your request in writing to the investigator in charge of the study. This means that no further private health information will be collected and used by this research.

We have not set aside money to pay for related injuries. Signing this form does not waive any legal rights.

If you have any questions, concerns or complaints about the research, contact me by phone at 412-296-0145, or email me at maomiliu@gmail.com. You can also contact Dr. Melissa Luke by e-mail at mmluke@syr.edu or by phone at 315-443-5265. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator or if you cannot reach the investigator, you may contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered. I have received a copy of this consent form. I am 18 years of age or older.

_____ I agree to participate in this research

_____ I do not agree to participate in this research

In addition,

___ I agree to be audio recorded

___ I do not agree to be audio recorded

___ I agree to be video recorded

___ I do not agree to be video recorded

_____ _____

Signature of participant   Date

_____

Printed name of participant

_____ _____

Signature of researcher   Date

_____

Printed name of researcher

Appendix VI: The Jeffersonian Transcription System

The Jeffersonian transcription system is a primary transcription tool widely used in CA research (Atkinson & Heritage, 1984; Buttny, 2004; Sacks, Schegloff, & Jefferson, 1974), which look at micro analytic process of communications. Overall, the system is divided into three structures: temporal and sequential relationships, aspects of speech delivery, and other markings. This appendix provides a brief description of commonly used transcription symbols and their meaning.

1. Symbols present temporal and sequential relationships:

[ ]   Brackets present overlapping talk between speakers.

=   Equal sign presents a continence of utterance with no pause or silence, which can occur

        in one person's speech or conversations between two speakers

(number) A number in parentheses indicates the time of silence during communication.

(.)   A dot in parentheses indicates a since less than 0.2 second.

2. Symbols present aspects of speech delivery:

.   A period represents a falling or final intonation.

?   A question mark represents a rising tone

,   A comma represents a continuing intonation

:   Colons represent stretching of the sound.

➤   A hyphen after a word indicates a cut-off or interruption.

_   An underlying sign presents a stress or emphasis of particular words or phrases

A   An uppercased word represents a loud talk

↓   An up arrow indicates a sharp rise of pitch

↑   A down arrow indicates a falling pitch

>   <   Compressed and rush talk

<   >   A slowed down speech style

h   Letter h indicates an aspiration such as inhalation or laughter

.hh   Letter h with a dot represents inhalation

$ A dollar sign represents a smile voice

3. Symbols present other markings:

(( ))   A double parenthesis describes non-verbatim events occur during talks. For example, a

        cough or a telephone ring during conversation.

(words) Words within a single parenthesis indicates uncertain part of the transcription

( )   An empty parenthesis indicates inaudible speech

Appendix VII: Glossary

A number of theoretical constructs relate to talk-in-interactions of health communications and provide insights and guidance for this study. Conceptual frameworks and related empirical studies require lengthy discussion across disciplines. As such, they are provided in the Chapter Two: The Literature Review. In this section, the definition of terms will focus on key elements of the research questions and their meaning in this study.

Initial Session

This study focuses on health conversations in initial encounters between trainees and patients/clients in both family medicine and counselor education. Previous studies define initial sessions as the first encounter between clinicians and clients (Budman, et al., 1992; DeGood, 1983; Esogbue & Elder, 1979; Odell & Quinn, 1998; Rahman, 2000; Saltzman, et al., 1976; Whitlock et al., 2004; Zisook et al., 1978). Depending on treatment settings and institutional protocols, residents in family medicine conduct brief, routine visits for both physical and mental health concerns in a regular basis. A counseling initial session may range from 30 minutes to 50 minutes.

Apart from routine visits which range from 15 to 20 minutes, a full bio-psycho-social (BPS) evaluation in family medicine is a unique feature of institutional practice differentiated from routine visits. Some family medicine programs have implemented the BPS into curriculum (M. Arthur, personal communication, September 15, 2014). In a full bio-psycho-social evaluation, residents and patients engage in-depth assessment and communication related to patients' life history, family backgrounds, social adjustment, and wellness (Barrett et al., 2003; Borrell-Carrió et al., 2004; Doherty, et al., 1987; Future of Family Medicine Project Leadership Committee, 2004; McKinlay, Potter, & Feldman, 1996; Stange, Miller, & McWhinney, 2001). A

full bio-psycho-social evaluation is a one-time only assessment and time can range from 45 to 60

minutes due to the nature of in-depth discussion (M. Arthur, personal communication, September

15, 2014). Thus, initial sessions in this study includes three types of visits:

➢ Initial counseling session: time ranges from 30 to 50 minutes.

➢ Initial routine visit in family medicine: time ranges from 15-20 minutes.

➢ A full bio-psycho-social evaluation in family medicine: approximate time ranges from 45
   minutes to 60 minutes.

Medical Visit

A medical visit in this study refers to types of visits that relate to a variety of health

concerns which require further attentions and clinical interventions from medical professions.

There are varieties of medical interviews conducted by different types of medical professions. In

addition, health concerns presented in medical visits may include both physical and

psychological issues (Heritage & Clayman, 2010; Heritage & Maynard, 2006). This study refers

to a medical visit as appointments between patients and physicians or physicians-in-training with

focus of physical health issues. This will occur with the family medicine portion of the study.

Counseling

Counseling contains a broad range of services from K- 12 school settings, higher

education, to community mental health agencies and hospitals (www.cacrep.org). Because the

service foundations are situated in wide range of settings, counseling is also an encompassing

term (Fong, 1990). In 2013, American Counseling Association defines counseling as "a

professional relationship that empowers diverse individuals, families, and groups to accomplish

mental health, wellness, education, and career goals" (www.counseling.org). In other words,

counseling provides services and support concerning variety of emotional, developmental, social,

vocational, and educational issues. In this study, counseling refers to institutional practices related to promote higher level of psychological functioning such as helping clients engage psychotherapeutic activities, psycho-social adjustment, rehabilitation, and wellness. As mentioned above, both counselor education and family medicine frequently encounter clients/patients who present issues or concerns that may directly or indirectly relate to mental health or psycho-social issues. Counseling will mostly occur in sessions conducted by counselors-in-trainings but will also appear in sessions conducted by physicians-in-trainings.

Behavioral Health

Behavioral health training is a unique curriculum particular in family medicine for both educational and practical senses (Brown, 2004; Pace et al., 1995; Verhaak, 1986, 1988; Zuvekas, 2005). Behavioral health in family medicine is an integrative approach to medical issues presented by patients. Physicians in family medicine conduct clinical practices with a holistic approach that intends to understand patients' psycho-social environment, family functioning, and physician-patient relationships. This integrative approach overlaps with counseling practice. For example, curriculum of behavioral science in family medicine contain human development, communication skills, family systems, psychological diagnoses, common psychiatric issues, treatment, and diagnoses, and doctor-patient relationships (Longlett & Kruse, 1992). In this study, behavioral health and behavioral science may be used interchangeably; both refer to integrative practices in family medicine.

Doctor-Patient Interaction

Current CA research related to doctor-patient interactions refers to physicians' and patients' communications and related activities during medical visits (Heritage & Clayman, 2010). In addition, it is used with physician-patient interaction interchangeably (Heritage &

Maynard, 2006). This study refers to doctor-patient interactions as verbal and nonverbal activities between doctors or doctors-in-trainings and their patients during medical visits.

Counselor-Client Interaction

CA research that focuses on conversations regarding mental health, relational or emotional issues primary existed in contexts of psychiatric visits (Bergman, 1989), marriage and family therapy (Buttny, 1996), or individual psychotherapy (Voutilainen, Perakyla, & Ruusuvuori, 2010). Many CA studies refer to therapists as a mental health profession who conducted a counseling or psychotherapeutic session with clients who seek help for emotional or relational issues. This study will refer to counselor-client interactions as both verbal interactions and nonverbal behaviors between clients and psychotherapists, counselors, or counselors-in-training.

Co-Construction

Since discourse is relational and contextual, co-construction refers to discourses and meanings that are jointly created through complex and dynamic social interactions (Wetherell et al., 2001). In a conversational context, co-construction occurs primarily through language and interactions (Maynard, 1991). This study will use the term "co-construction," "jointly construct," or "co-create" referring to meaning, relationship, or moments of interactions that are mutually produced between clinicians and patients/clients.

Microanalysis

Different from thematic analysis which focuses on broader themes and phenomena, microanalysis captures details, ordinary, taken-for-granted and yet under examined evidence of interactions (Heritage & Maynard, 2006; ten Have, 1990). In conversation analysis, microanalysis refers to coding and analytic procedures that focus on contextual, detailed,

sequential, and perhaps unremarkable interactions. Microanalysis will be used in this study to examine detailed interactional occurrences between both trainees and their clients.

Trainees

Trainees of health care professions can range across different academic and educational status. Trainees, also called as "novice practitioners" in this study, refers to pre-graduate and pre-licensed interns and residents who are engaging in field practices in family medicine or counseling as part of requirements for degrees and board certification.

There are different stages of field practices in both training communities. For example, in CACREP accredited counselor education programs, field placement is divided into two parts: practicum and internship. Practicum is a prerequisite of internship for both master's and doctoral level of counselors in training (www.cacrep.org). In family medicine, doctors-in-training start three years of residency after four years of course work and exams. Residents conduct routine visits, which start during the first year of residency, and typically encounter behavioral health trainings and practices throughout the program. In this study, trainees include the following status:

- Doctoral level of counselors-in-training in practicum in accredited counselor education programs

- Both master's level and doctoral level of counselors-in-training in internship in accredited counselor education programs

- Doctors-in-training in family medicine: year one to year three.

The study will use trainees in referring to the above statuses for subsequent design, including data collection and data analysis. Specific status of clinical placement (i.e. practicum

or internship) and year of training (i.e. year one to year three) will be specified accordingly in the reporting of data.

Residents

The term "resident" in the field of medicine refers to a post-graduate physician who has obtained a Doctor of Medicine (M.D) and enters a residency program for both completing the practical training as an intern while providing medical services as a doctor. Typically the resident training ranges from three to seven years before the application of board certification. This study will use the term "doctor-in-training" to refer to the resident participant.

Novice Practitioner

The term "novice practitioner" may be applied to practitioners in the beginning stage of professional practices (Ajjawi & Higgs, 2007; Candlin & Candlin, 2002). Such stage can be varied according to professional standards or individual characteristics. This study will use "trainees" and "novice practitioners" interchangeably, referring to pre-graduate and pre-licensed counselors-in-training and family medicine residents who are engaging in their field practices.

Accreditation

This study will focus on novice practitioners who are trainees in accredited counseling and family medicine programs. Training programs that seek accreditations are required to meet the educational standards proposed by the accredited organizations. Thus, this educational structure provides a naturally occurring training data regarding recorded clinical sessions conducted by trainees. There are two main organizations provide accreditations for counselor education and family medicine.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is an accreditation organization that develops, promotes, and evaluates counseling

training standards and program developments. The CACREP requires both the master's level and the doctoral level trainees complete a total 100 hours of practicum and 600 hours of internship after the required course credits have been fulfilled. Audio and/or video tapes of clinical sessions are required for the purpose of supervision during field placements (www.cacrep.org).

Similar to the CACREP, the Accreditation Council for Graduate Medical Education (ACGME) is an organization that provides accreditations of approximately 9500 residency programs. The ACGME evaluates educational programs and standards based on criteria of each specialty. Although the ACGME does not stipulate the hours of training, they do indicate that family medicine physicians get training in and attend to both diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, sensitivity to gender, race, age, and cultural differences in patients, family violence, abuse, and factors influencing patient compliance. In addition to routine skill and knowledge-based trainings related to diagnosis and treatment of medical issues, behavioral health components, including skills in building doctor-patient relationships, mental health assessments, and psycho-social evaluation related to health and wellness, are required as part of residents' routine training (www.acgme.org).

Appendix VIII: References

Agnew, R. M., Harper, H., Shapiro, D. A., & Barkham, M. (1994). Resolving a challenge to the

therapeutic relationship: A single-case study. *British Journal of Medical*

Psychology, 67(2), 155-170.

Ainsworth-Vaughn, N. (1992). Topic transitions in physician-patient interviews: Power, gender,

and discourse change. *Language in Society, 21*(03), 409-426.

Ajjawi, R., & Higgs, J. (2007). Using hermeneutic phenomenology to investigate how

experienced practitioners learn to communicate clinical reasoning. *Qualitative*

Report, 12(4), 612-638.

Alegria, M., Nakash, O., Lapatin, S., Oddo, V., Gao, S., Lin, J., & Normand, S. L. (2008). How

missing information in diagnosis can lead to disparities in the clinical encounter. *Journal*

of Public Health Management and Practice : JPHMP, 14 Suppl, S26-35.

doi:10.1097/01.PHH.0000338384.82436.0d [doi]

Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary

and evolving ideas about the implications for clinical theory. *Family Process,27*(4), 371-

393.

Anderson, L. A., & Sharpe, P. A. (1991). Improving patient and provider communication: A

synthesis and review of communication interventions. *Patient Education and*

Counseling, 17(2), 99-134.

Angus, L. E., & McLeod, J. (2004). Toward an integrative framework for understanding the role

of narrative in the psychotherapy process. *The Handbook of Narrative and*

Psychotherapy: Practice, Theory, and Research, , 367-374.

Arbuthnott, A., & Sharpe, D. (2009). The effect of physician–patient collaboration on patient adherence in non-psychiatric medicine. *Patient Education and Counseling, 77*(1), 60-67.

Arthur, M. E., & Bernard, J. M. (2012). Application of the discrimination model of supervision for residency education. *Annals of Behavioral Science and Medical Education, 18*(1), 32-37.

Arthur, M., Kowel, C. D., & Liu, Y. (2012). Peer-defusing: Hospital-wide wellness initiative for medical professionals' compassion fatigue prevention and stress reduction. Paper presented at the 33rd Forum for Behavioral Science in Family Medicine: "Promoting Well-being and Reflection among Medical Professionals," Chicago, IL

Aspland, H., Llewelyn, S., Hardy, G. E., Barkham, M., & Stiles, W. (2008). Alliance ruptures and rupture resolution in cognitive–behavior therapy: A preliminary task analysis. *Psychotherapy Research, 18*(6), 699-710.

Atkinson, J. M., & Heritage, J. (1984). *Structures of social action* Cambridge University Press.

Barkham, M., & Shapiro, D. A. (1986). Counselor verbal response modes and experienced empathy. *Journal of Counseling Psychology, 33*(1), 3.

Barrett, B., Marchand, L., Scheder, J., Plane, M. B., Maberry, R., Appelbaum, D., . . . Rabago, D. (2003). Themes of holism, empowerment, access, and legitimacy define complementary, alternative, and integrative medicine in relation to conventional biomedicine. *The Journal of Alternative & Complementary Medicine, 9*(6), 937-947.

Beach, W. A., & Dixson, C. N. (2001). Revealing moments: Formulating understandings of adverse experiences in a health appraisal interview. *Social Science & Medicine, 52*(1), 25-44.

Beach, W. A., Easter, D. W., Good, J. S., & Pigeron, E. (2005). Disclosing and responding to cancer "fears" during oncology interviews. *Social Science & Medicine, 60*(4), 893-910.

Beck, R. S., Daughtridge, R., & Sloane, P. D. (2002). Physician-patient communication in the primary care office: A systematic review. *The Journal of the American Board of Family Practice, 15*(1), 25-38.

Bell, I. R., Caspi, O., Schwartz, G. E., Grant, K. L., Gaudet, T. W., Rychener, D., . . . Weil, A. (2002). Integrative medicine and systemic outcomes research: Issues in the emergence of a new model for primary health care. *Archives of Internal Medicine, 162*(2), 133-140.

Bensing, J., Schreurs, K., & Rijk, A. D. (1996). The role of the general practitioner's affective behaviour in medical encounters. *Psychology and Health, 11*(6), 825-838.

Bergmann, J. R. (1992). Veiled morality: Notes on discretion in psychiatry. *Talk at Work: Interaction in Institutional Settings,* , 137-162.

Bernard, I.8: Goodyear, RK (2009). *Fundamentals of Clinical Supervision (4th Ed.). Boston: Allyn, 8*

Besnier, N. (1990). Language and affect. *Annual Review of Anthropology,* , 419-451.

Black, T. G. (2006). Teaching trauma without traumatizing: Principles of trauma treatment in the training of graduate counselors. *Traumatology, 12*(4), 266.

Blake, S. C., McMorris, K., Jacobson, K. L., Gazmararian, J. A., & Kripalani, S. (2010). A qualitative evaluation of a health literacy intervention to improve medication adherence for underserved pharmacy patients.*Journal of Health Care for the Poor and Underserved, 21*(2), 559-567.

Bochner, A. P. (2009). Vulnerable medicine. *Journal of Applied Communication Research, 37*(2), 159-166.

Boden, D., & Zimmerman, D. H. (1991). *Talk and social structure: Studies in ethnomethodology and conversation analysis* Polity Press Cambridge.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. *The Working Alliance: Theory, Research, and Practice,* , 13-37.

Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The bio-psychopsycho-social model 25 years later: Principles, practice, and scientific inquiry. *The Annals of Family Medicine, 2*(6), 576-582.

Bradley, C. P. (1992). Factors which influence the decision whether or not to prescribe: The dilemma facing general practitioners. *The British Journal of General Practice, 42*(364), 454.

Breen, R., & Thornhill, J. T. (1998). Noncompliance with medication for psychiatric disorders. *CNS Drugs, 9*(6), 457-471.

Brink-Muinen, A. V. D., & Caris-Verhallen, W. (2003). Doctors' responses to patients' concerns: Testing the use of sequential analysis. *Epidemiologia e Psichiatria Sociale, 12*(02), 92-97.

Brône, G. (2008). Hyper-and misunderstanding in interactional humor. *Journal of Pragmatics, 40*(12), 2027-2061.

Brown, R. J. (2004). Psychological mechanisms of medically unexplained symptoms: An integrative conceptual model. *Psychological Bulletin, 130*(5), 793.

Bruce, S. E., Weisberg, R. B., Dolan, R. T., Machan, J. T., Kessler, R. C., Manchester, G., . . . Keller, M. B. (2001). Trauma and posttraumatic stress disorder in primary care patients. *Primary Care Companion to the Journal of Clinical Psychiatry, 3*(5), 211.

Budman, S. H., Hoyt, M. F., & Friedman, S. (1992). *The first session in brief therapy.* Guilford Press.

Buser, J. K., Goodrich, K. M., Luke, M., & Buser, T. J. (2011). A narratology of lesbian, gay, bisexual, and transgender clients' experiences addressing religious and spiritual issues in counseling. *Journal of LGBT Issues in Counseling, 5*(3-4), 282-303.

Buttny, R. (2004). *Talking problems: Studies of discursive construction* SUNY Press.

Buttny, R. (2001). Therapeutic humor in retelling the clients' tellings. *Text-the Hague then Amsterdam then Berlin-, 21*(3), 303-326.

Buttny, R. (1996). Clients' and therapist's joint construction of the clients' problems. *Research on Language and Social Interaction, 29*(2), 125-153.

Buttny, R., & Jensen, A. D. (1995). Telling problems in an initial family therapy session: The hierarchical organization of problem-talk. *The Talk of the Clinic: Explorations in the Analysis of Medical and Therapeutic Discourse,* , 19-48.

Candlin, C. N., & Candlin, S. (2002). Discourse, expertise, and the management of risk in health care settings. *Research on Language and Social Interaction,*

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 271.

Castro, C. M., Wilson, C., Wang, F., & Schillinger, D. (2007). Babel babble: Physicians' use of unclarified medical jargon with patients. *American Journal of Health Behavior, 31*(Supplement 1), S85-S95.

Cheston, S. E. (2000). A new paradigm for teaching counseling theory and practice. *Counselor Education and Supervision, 39*(4), 254-269.

Chomsky, N. (1959). A note on phrase structure grammars. *Information and Control, 2*(4), 393-395.

Chung, R. C., Bemak, F., Ortiz, D. P., & Sandoval-Perez, P. A. (2008). Promoting the mental health of immigrants: A multicultural/social justice perspective. *Journal of Counseling and Development: JCD, 86*(3), 310.

Chung, C., & Pennebaker, J. W. (2007). The psychological functions of function words. *Social Communication,* , 343-359.

Colman, M., & Healey, P. G. (2011). The distribution of repair in dialogue. *Proceedings of the 33rd Annual Meeting of the Cognitive Science Society,* 1563-1568.

Corey, G. (2011). *Theory and practice of group counseling* Cengage Learning.

Corey, G. (2012). *Theory and practice of counseling and psychotherapy* Cengage Learning.

De Negri, B., Brown, L. D. P., Hernández, O., Rosenbaum, J., & Roter, D. (1997). Improving interpersonal communication between health care providers and clients. *Bethesda US,* , 3-59.

DeGood, D. E. (1983). Reducing medical patients' reluctance to participate in psychological therapies: The initial session. *Professional Psychology: Research and Practice, 14*(5), 570.

Deuster, L., Christopher, S., Donovan, J., & Farrell, M. (2008). A method to quantify residents' jargon use during counseling of standardized patients about cancer screening. *Journal of General Internal Medicine,23*(12), 1947-1952.

Doherty, W. J., Baird, M. A., & Becker, L. A. (1987). Family medicine and the bio-psychopsycho-social model: The road toward integration. *Marriage & Family Review, 10*(3-4), 51-69.

Drew, P., & Heritage, J. (1992). Talk at work: Interaction in institutional settings.

Easter, D. W., & Beach, W. (2004). Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions. *Current Surgery, 61*(3), 313-318.

Elder, J. P., Ayala, G. X., & Harris, S. (1999). Theories and intervention approaches to health-behavior change in primary care. *American Journal of Preventive Medicine, 17*(4), 275-284.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136.

Eriksen, K., & Kress, V. E. (2006). The DSM and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling, 28*(3), 202-217.

Esogbue, A. O., & Elder, R. C. (1979). Fuzzy sets and the modelling of physician decision processes, part I: The initial interview-information gathering session. *Fuzzy Sets and Systems, 2*(4), 279-291.

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients' perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology, 51*(3), 340.

Ferrara, K. (1994). *Therapeutic ways with words.* New York: Oxford University Press.

Fielding, R. (1995). *Clinical communication skills.* Hong Kong University Press.

Fink, B. (2011). *Fundamentals of psychoanalytic technique: A Lacanian approach for practitioners.* WW Norton & Company.

Fong, M. L. (1990). Mental health counseling: The essence of professional counseling. *Counselor Education and Supervision, 30*(2), 106-113.

Fuertes, J. N., Mislowack, A., Bennett, J., Paul, L., Gilbert, T. C., Fontan, G., & Boylan, L. S. (2007). The physician–patient working alliance. *Patient Education and Counseling, 66*(1), 29-36.

Future of Family Medicine Project Leadership Committee. (2004). The future of family medicine: A collaborative project of the family medicine community. *The Annals of Family Medicine, 2*(suppl 1), S3-S32.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*(3), 296.

Gladding, S., Wedding, D., & Corsini, R. (2005). *Counseling theories: Essential concepts and applications* Pearson.

Goffman, E. (1978). Response cries. *Language,* , 787-815.

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents feminist and multicultural principles in action. *The Counseling Psychologist, 32*(6), 793-836.

Goodwin, C. (1994). Professional vision. *American Anthropologist, 96*(3), 606-633.

Gordon, C., & Luke, M. (2012). Discursive negotiation of face via email: Professional identity development in school counseling supervision. *Linguistics and Education, 23*(1), 112-122.

Graugaard, P. K. r., Holgersen, K., & Finset, A. (2004). Communicating with alexithymic and non-alexithymic patients: An experimental study of the effect of psycho-social communication and empathy on patient satisfaction. *Psychotherapy and Psychosomatics, 73*(2), 92-100.

Greenberg, M. A., & Stone, A. A. (1992). Emotional disclosure about traumas and its relation to health: Effects of previous disclosure and trauma severity. *Journal of Personality and Social Psychology, 63*(1), 75.

Greenfield, S., Kaplan, S. H., Ware Jr, J. E., Yano, E. M., & Frank, H. J. (1988). Patients' participation in medical care. *Journal of General Internal Medicine, 3*(5), 448-457.

Griffith, S. (1990). A review of the factors associated with patient compliance and the taking of prescribed medicines. *The British Journal of General Practice, 40*(332), 114.

Guilfoyle, M. (2003). Dialogue and power: A critical analysis of power in dialogical therapy. *Family Process, 42*(3), 331-343.

Hackney, H., & Cormier, L. S. (1996). The professional counselor: A process guide to helping.

Halse, C., & Honey, A. (2005). Unraveling ethics: Illuminating the moral dilemmas of research ethics. *Signs, 30*(4), 2141-2162.

Hays, D. G., & Singh, A. A. (2011). *Qualitative inquiry in clinical and educational settings.* Guilford Press.

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development, 89*(3), 288-295.

Hemminki, E. (1975). Review of literature on the factors affecting drug prescribing. *Social Science & Medicine (1967), 9*(2), 111-115.

Hepburn, A. (2004). Crying: Notes on description, transcription, and interaction. *Research on Language and Social Interaction, 37*(3), 251-290.

Heritage, J. (2001) 'Goffman, Garfinkel and conversation analysis' in M. Wetherell, S. Taylor, and S. J. Yates (editors). Discourse Theory and Practice: A Reader. UK: Sage.

Heritage, J., & Clayman, S. (2010). *Talk in action: Interactions, identities, and institutions* John Wiley & Sons.

Heritage, J., & Maynard, D. W. (2006). *Communication in medical care: Interaction between primary care physicians and patients* Cambridge University Press.

Hodas, G. R. (2006). Responding to childhood trauma: The promise and practice of trauma informed care. *Pennsylvania Office of Mental Health and Substance Abuse Services,* , 1-77.

Hoffman, R. M. (2010). Editorial: Trustworthiness, credibility, and soundness: A vision for research in the journal of mental health counseling. *Journal of Mental Health Counseling, 32*(4), 283-287.

Holmes, J., & Meyerhoff, M. (1999). The community of practice: Theories and methodologies in language and gender research. *Language in Society, 28*(02), 173-183.

Horowitz, M. J., Stinson, C., Curtis, D., Ewert, M., Redington, D., Singer, J., . . . Hartley, D. (1993). Topics and signs: Defensive control of emotional expression. *Journal of Consulting and Clinical Psychology, 61*(3), 421.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139.

Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry, 37*(2), 169-183.

Jefferson, G. (1993). Caveat speaker: Preliminary notes on recipient topic-shift implicature. *Research on Language and Social Interaction, 26*(1), 1-30.

Jones, C. M., & Beach, W. A. (1995). Therapists' techniques for responding to unsolicited contributions by family members. *The Talk of the Clinic: Explorations in the Analysis of Medical and Therapeutic Discourse,* , 49-70.

Katon, W., & Kleinman, A. (1981). Doctor-patient negotiation and other social science strategies in patient care. *The Relevance of Social Science for Medicine,* , 253-279.

Kim, S. C., Kim, S., & Boren, D. (2008). The quality of therapeutic alliance between patient and provider predicts general satisfaction. *Military Medicine, 173*(1), 85-90.

Kinderman, P., & Lobban, F. (2000). Evolving formulations: Sharing complex information with clients. *Behavioural and Cognitive Psychotherapy, 28*(03), 307-310.

Kivlighan, D. M., & Shaughnessy, P. (1995). Analysis of the development of the working alliance using hierarchical linear modeling. *Journal of Counseling Psychology, 42*(3), 338.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., . . . Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*(4), 396.

Koch-Weser, S., Rudd, R. E., & DeJong, W. (2010). Quantifying word use to study health literacy in doctor–patient communication. *Journal of Health Communication, 15*(6), 590-602.

Kokotovic, A. M., & Tracey, T. J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology, 37*(1), 16.

Kress, V. E. W., Eriksen, K. P., Rayle, A. D., & Ford, S. J. (2005). The DSM-IV-TR and culture: Considerations for counselors. *Journal of Counseling & Development, 83*(1), 97-104.

Kripalani, S., Jacobson, T. A., Mugalla, I. C., Cawthon, C. R., Niesner, K. J., & Vaccarino, V. (2010). Health literacy and the quality of physician-patient communication during hospitalization. *Journal of Hospital Medicine, 5*(5), 269-275.

Kuno, S., & Kaburaki, E. (1977). Empathy and syntax. *Linguistic Inquiry, ,* 627-672.

Langer, N. (1999). Culturally competent professionals in therapeutic alliances enhance patient compliance. *Journal of Health Care for the Poor and Underserved, 10*(1), 19-26.

Leahy, M. M. (2004). Therapy talk: Analyzing therapeutic discourse. *Language, Speech & Hearing Services in Schools, 35*(1)

Lelorain, S., Brédart, A., Dolbeault, S., & Sultan, S. (2012). A systematic review of the associations between empathy measures and patient outcomes in cancer care. *Psycho-oncology, 21*(12), 1255-1264.

Levers, L. L. (2012). *Trauma counseling: Theories and interventions* Springer Publishing Company.

Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, P. C., & Graham, I. D. (2009). Evolution of wenger's concept of community of practice. *Implementation Science, 4*(1), 11.

Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, P. C., & Graham, I. D. (2009). Use of communities of practice in business and health care sectors: A systematic review. *Implement Sci, 4*(27), 16.

Like, R., & Zyzanski, S. J. (1986). Patient requests in family practice: A focal point for clinical negotiations. *Family Practice, 3*(4), 216-228.

Longlett, S., & Kruse, J. (1992). Behavioral science education in family medicine: A survey of behavioral science educators and family physicians. *Family Medicine, 24*(1), 28-35.

Luke, M., & Goodrich, K. M. (2015). Working with family, friends, and allies of LGBT youth. *Journal for Social Action in Counseling and Psychology, 7*(1), 63.

Luke, M., & Gordon, C. (2012). Supervisors' use of reinforcement, reframing, and advice to re-author the supervisory narrative through E-mail supervision. *The Clinical Supervisor, 31*(2), 159-177.

Lutfey, K. (2005). On practices of 'good doctoring': Reconsidering the relationship between provider roles and patient adherence. *Sociology of Health & Illness, 27*(4), 421-447.

Luttrell, W. (2000). " Good enough" methods for ethnographic research. *Harvard Educational Review, 70*(4), 499-523.

Maizes, V., Rakel, D., & Niemiec, C. (2009). Integrative medicine and patient-centered care. *Explore: The Journal of Science and Healing, 5*(5), 277-289.

Mann, D., Gaylord, S., & Norton, S. (2004). Moving toward integrative care: Rationales, models, and steps for conventional-care providers. *Complementary Health Practice Review, 9*(3), 155-172.

Matarazzo, J. D., & Wiens, A. N. (1977). Speech behavior as an objective correlate of empathy and outcome in interview and psychotherapy research A review with implications for behavior modification. *Behavior Modification, 1*(4), 453-480.

Maynard, D. W. (1991). Interaction and asymmetry in clinical discourse. *American Journal of Sociology, 97*(2), 448.

McCabe, S. E., Cranford, J. A., & West, B. T. (2008). Trends in prescription drug abuse and dependence, co-occurrence with other substance use disorders, and treatment utilization: Results from two national surveys. *Addictive Behaviors, 33*(10), 1297-1305.

McCarthy, D. M., Waite, K. R., Curtis, L. M., Engel, K. G., Baker, D. W., & Wolf, M. S. (2012). What did the doctor say? health literacy and recall of medical instructions. *Medical Care, 50*(4), 277-282.

McDonald, H. P., Garg, A. X., & Haynes, R. B. (2002). Interventions to enhance patient adherence to medication prescriptions: Scientific review. *Jama, 288*(22), 2868-2879.

McKinlay, J. B., Potter, D. A., & Feldman, H. A. (1996). Non-medical influences on medical decision-making. *Social Science & Medicine, 42*(5), 769-776.

Mead, N., & Bower, P. (2002). Patient-centred consultations and outcomes in primary care: A review of the literature. *Patient Education and Counseling, 48*(1), 51-61.

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087-1110.

Mead, N., Bower, P., & Hann, M. (2002). The impact of general practitioners' patient-centredness on patients' post-consultation satisfaction and enablement. *Social Science & Medicine, 55*(2), 283-299.

Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy, 11*(02), 147-172.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. Journal of Counseling & Development, 86(4), 482-493.

Noble, L. M. (1998). Doctor–patient communication and adherence to treatment. *Adherence to Treatment in Medical Conditions,* , 51-82.

Norrick, N. R. (1993). *Conversational joking: Humor in everyday talk* Indiana Univ Pr.

Odell, M., & Quinn, W. H. (1998). Therapist and client behaviors in the first interview: Effecgts on session impact and treatment duration. *Journal of Marital and Family Therapy, 24*(3), 369-388.

Oring, E. (1994). Neal R. norrick, conversational joking: Humor in everyday talk. bloomington: Indiana university press, 1993. pp, x, 175. hb $29.95. *Language in Society, 23*(03), 448-452.

Owen, J. (2008). The nature of confirmatory strategies in the initial assessment process. *Journal of Mental Health Counseling, 30*(4), 362-374.

Pace, T. M., Chaney, J. M., Mullins, L. L., & Olson, R. A. (1995). Psychological consultation with primary care physicians: Obstacles and opportunities in the medical setting. *Professional Psychology: Research and Practice, 26*(2), 123.

Parboosingh, J. T. (2002). Physician communities of practice: Where learning and practice are inseparable. *Journal of Continuing Education in the Health Professions, 22*(4), 230-236.

Peterson, Z. D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training, 39*(1), 21.

Peyrot, M. (1987). Circumspection in psychotherapy: Structures and strategies of counselor-client interaction. *Semiotica, 65*(3-4), 249-268.

Pillai, A. K. (2010). Use of empathy by healthcare professionals learning motivational interviewing: A qualitative analysis.

Prest, L. A., & Robinson, W. D. (2006). Systemic assessment and treatment of depression and anxiety in families: The BPSS model in practice. *Journal of Systemic Therapies, 25*(3), 4-24.

Quill, T. E., & Brody, H. (1996). Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice. *Annals of Internal Medicine, 125*(9), 763-769.

Quirk, M., Mazor, K., Haley, H., Philbin, M., Fischer, M., Sullivan, K., & Hatem, D. (2008). How patients perceive a doctor's caring attitude. *Patient Education and Counseling, 72*(3), 359-366.

Rahman, A. (2000). Initial assessment of communication skills of intern doctors in history-taking. *Medical Teacher, 22*(2), 184-188.

Reis, B. F., & Brown, L. G. (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy: Theory, Research, Practice, Training, 36*(2), 123.

Reisfield, G. M., & Wilson, G. R. (2004). Use of metaphor in the discourse on cancer. *Journal of Clinical Oncology, 22*(19), 4024-4027.

Retzinger, S. M. (1998). 'Shame in the therapeutic relationship' in P. Gilbert, and B. Andrews (editors). Shame: Interpersonal Behavior, Psychopathology, and Culture. USA: Oxford University Press.

Riessman, C. K. (2008). *Narrative methods for the human sciences.* Sage.

Rosen, D. C., Miller, A. B., Nakash, O., Halperin, L., & Alegría, M. (2012). Interpersonal complementarity in the mental health intake: A mixed-methods study. *Journal of Counseling Psychology, 59*(2), 185.

Roter, D. (2000). The enduring and evolving nature of the patient–physician relationship. *Patient Education and Counseling, 39*(1), 5-15.

Roter, D. L., Hall, J. A., Kern, D. E., Barker, L. R., Cole, K. A., & Roca, R. P. (1995). Improving physicians' interviewing skills and reducing patients' emotional distress: A randomized clinical trial. *Archives of Internal Medicine, 155*(17), 1877.

Ruusuvuori, J. (2007). Managing affect: Integration of empathy and problem-solving in health care encounters. *Discourse Studies, 9*(5), 597-622.

Ruusuvuori, J. (2001). Looking means listening: Coordinating displays of engagement in doctor–patient interaction. *Social Science & Medicine, 52*(7), 1093-1108.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language, *, 696-735.

Saltzman, C., Luctgert, M., Roth, C., Creaser, J., & Howard, L. (1976). Formation of a therapeutic relationship: Experiences during the initial phase of psychotherapy as predictors of treatment duration and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 546.

Sanders, R. E. (2012). The representation of self through the dialogic properties of talk and conduct. *Language & Dialogue, 2*(1)

Satterfield, J. M., & Hughes, E. (2007). Emotion skills training for medical students: A systematic review. *Medical Education, 41*(10), 935-941.

Schegloff, E.A. (1993). Reflection on Quantification in the study of conversation. Research on Language and Social Interaction, 26(1), 99-128.

Schegloff, E. A. (1991) 'Reflections on Talk and Social Structure'. In D. Boden and D. Zimmerman (eds.) Talk and Social Structure, (pp. 44-70). Cambridge: Polity.

Schroeder, R., Morrison, E., Cavanaugh, C., West, M., & Montgomery, J. (1998). Improving communication among health professionals through education: A pilot study. *The Journal of Health Administration Education, 17*(3), 175-198.

Schwartzberg, J. G., Cowett, A., VanGeest, J., & Wolf, M. S. (2007). Communication techniques for patients with low health literacy: A survey of physicians, nurses, and pharmacists. *American Journal of Health Behavior, 31*(Supplement 1), S96-S104.

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship an empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*(1), 6-78.

Shaw, A., Ibrahim, S., Reid, F., Ussher, M., & Rowlands, G. (2009). Patients' perspectives of the doctor–patient relationship and information giving across a range of literacy levels. *Patient Education and Counseling, 75*(1), 114-120.

Şimşek, Ö. F. (2013). The relationship between language use and depression: Illuminating the importance of self-reflection, self-rumination, and the need for absolute truth. *The Journal of General Psychology,140*(1), 29-44.

Şimşek, Ö. F., & Çerçi, M. (2013). Relationship of the gap between experience and language with mental health in adolescence: The importance of emotion regulation. *The Journal of Psychology, 147*(3), 293-309.

Şimşek, Ö. F., & Kuzucu, Y. (2012). The gap that makes us desperate: Paths from language to mental health. *International Journal of Psychology, 47*(6), 467-477.

Sleath, B., Svarstad, B., & Roter, D. (1997). Physician vs patient initiation of psychotropic prescribing in primary care settings: A content analysis of audiotapes. *Social Science & Medicine, 44*(4), 541-548.

Sommerfeld, E., Orbach, I., Zim, S., & Mikulincer, M. (2008). An in-session exploration of ruptures in working alliance and their associations with clients' core conflictual relationship themes, alliance-related discourse, and clients' postsession evaluations. *Psychotherapy Research, 18*(4), 377-388.

Stange, K. C., Miller, W. L., & McWhinney, I. (2001). Developing the knowledge base of family practice. *Family Medicine-Kansas City-, 33*(4), 286-297.

Street Jr, R. L., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling, 74*(3), 295-301.

Street, R. L. (1992). Communicative styles and adaptations in physician-parent consultations. *Social Science & Medicine, 34*(10), 1155-1163.

Stricker, G., & Fisher, M. (1990). *Self-disclosure in the therapeutic relationship* Springer.

Strong, T., Zeman, D., & Foskett, A. (2006). Introducing new discourses into counseling interactions: A microanalytic and retrospective examination. *Journal of Constructivist Psychology, 19*(1), 67-89.

Sutcliffe, K. M., Lewton, E., & Rosenthal, M. M. (2004). Communication failures: An insidious contributor to medical mishaps. *Academic Medicine, 79*(2), 186-194.

Tagliaventi, M. R., & Mattarelli, E. (2006). The role of networks of practice, value sharing, and operational proximity in knowledge flows between professional groups. *Human Relations, 59*(3), 291-319.

Tannen, D. (1994). *Gender and discourse* Oxford University Press.

Tannen, D. (1991). You just don't understand: Women and men in conversation Virago London.

Tay, D. (2011). Discourse markers as metaphor signalling devices in psychotherapeutic talk. *Language & Communication, 31*(4), 310-317.

ten Have, P. (1990). Methodological issues in conversation Analysis 1. *Bulletin De Méthodologie Sociologique, 27*(1), 23-51.

ten Have, P. (1991) 'Talk and Institution: A Reconsideration of the "Asymmetry" of Doctor-Patient Interaction' in D. Boden and D. Zimmerman (editors) Talk and Social Structure: Studies in Ethnomethodological Conversation Analysis. Polity Press: Cambridge.

Tikkanen, S., Stiles, W. B., & Leiman, M. (2013). Achieving an empathic stance: Dialogical sequence analysis of a change episode. *Psychotherapy Research, 23*(2), 178-189.

Timm, M. (2015). Deconstructing pathology: A narrative view of the intake process. *Journal of Constructivist Psychology,* (ahead-of-print), 1-13.

Treichler, P. A., Frankel, R. M., Kramarae, C., Zoppi, K., & Beckman, H. B. (1987). Problems and problems: Power relationships in a medical encounter. *Language, Communication, & Education,* , 62-88.

Trostle, J. A. (1988). Medical compliance as an ideology. *Social Science & Medicine, 27*(12), 1299-1308.

Tryon, G. S. (1990). Session depth and smoothness in relation to the concept of engagement in counseling. *Journal of Counseling Psychology, 37*(3), 248.

Van Dulmen, A. (2002). Different perspectives of doctor and patient in communication. *International Congress Series, , 1241* 243-248.

Van Herk, G. (2012). *What is sociolinguistics* John Wiley & Sons.

Verhaak, P. F. (1988). Detection of psychologic complaints by general practitioners. *Medical Care,* , 1009-1020.

Verhaak, P. F. (1986). Variations in the diagnosis of psycho-social disorders: A general practice observation study. *Social Science & Medicine, 23*(6), 595-604.

von Wagner, C., Steptoe, A., Wolf, M. S., & Wardle, J. (2009). Health literacy and health actions: A review and a framework from health psychology. *Health Education & Behavior, 36*(5), 860-877.

Voutilainen, L., Peräkylä, A., & Ruusuvuori, J. (2010). Recognition and interpretation: Responding to emotional experience in psychotherapy. *Research on Language and Social Interaction, 43*(1), 85-107.

Waitzkin, H. (1979). Medicine, superstructure and micropolitics. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, *13*, 601-609.

Walsh, I. P. (2007). Small talk is" big talk" in clinical discourse: Appreciating the value of conversation in SLP clinical interactions. *Topics in Language Disorders, 27*(1), 24-36.

Watson, K. (2011). Gallows humor in medicine. *Hastings Center Report, 41*(5), 37-45.

Wenger, E. (2009). Communities of practice. *Communities, 22*, 57.

Wenger, E. (2004). Knowledge management as a doughnut: Shaping your knowledge strategy through communities of practice. *Ivey Business Journal, 68*(3), 1-8.

Wenger, E. (2000). Communities of practice and social learning systems. *Organization, 7*(2), 225-246.

Wenger, E. (1998). Communities of practice: Learning, meaning, and identity.

Wenger, E. (1998). Communities of practice: Learning as a social system. *Systems Thinker, 9*(5), 2-3.

Wetherell, M., Taylor, S., & Yates, S. J. (2001). *Discourse theory and practice: A reader.* UK: Sage.

Whitlock, E. P., Polen, M. R., Green, C. A., Orleans, T., & Klein, J. (2004). Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the US preventive services task force. *Annals of Internal Medicine, 140*(7), 557-568.

Woods, N. (1988). Talking shop: Sex and status as determinants of floor apportionment in a work setting. *Women in their Speech Communities.London: Longman,* , 141-157.

Wynia, M. K., & Osborn, C. Y. (2010). Health literacy and communication quality in health care organizations. *Journal of Health Communication, 15*(S2), 102-115.

Wynn, R. (2005). The achievement of empathy in provider-patient interaction. *Contexts-Historical, Social, Linguistic: Studies in Celebration of Toril Swan,* , 345.

Wynn, R. (2005). Empathy in general practice consultations: A qualitative analysis. *Epidemiologia e Psichiatria Sociale, 14*(03), 163-169.

Wynn, R., & Wynn, M. (2006). Empathy as an interactionally achieved phenomenon in psychotherapy: Characteristics of some conversational resources. *Journal of Pragmatics, 38*(9), 1385-1397.

Yates, S. J. (2001) 'Social interaction' in M. Wetherell, S. Taylor, and S. J. Yates (editors). Discourse Theory and Practice: A Reader. UK: Sage.

Young, M. (2001). Learning the art of helping. *Upper Saddle River, NJ: Merrill Prentice Hall,*

Young, M. E. (2013). *Learning the art of helping: Building blocks and techniques* Pearson Upper Saddle River, NJ.

Zisook, S., Hammond, R., Jaffe, K., & Gammon, E. (1978). Outpatient requests, initial sessions and attrition. *The International Journal of Psychiatry in Medicine, 9*(3), 339-350.

Zola, I. K. (1981). Structural constraints in the doctor-patient relationship: The case of non-compliance. *The Relevance of Social Science for Medicine,* , 241-252.

Zuvekas, S. H. (2005). Prescription drugs and the changing patterns of treatment for mental disorders, 1996–2001. *Health Affairs, 24*(1), 195-205.

YIHHSING LIU

Duquesne University
Department of Counseling, Psychology, and Special Education, 109 Canevin Hall
600 Forbes Avenue, Pittsburgh, PA 15282
liuy1239@duq.edu; 412-396-4026

EDUCATION

Syracuse University   Syracuse, NY
    Ph.D in Counseling and Counselor Education   2016

    Dissertation: *"An Analysis of Talk and Interactions in Initial Sessions in the Context of Counseling and Family Medicine"* [with Melissa Luke, PhD (Dissertation Chair), Melissa Arthur, PhD (Dissertation Committee), and Jeff Good, PhD (Dissertation Committee)]

Duquesne University   Pittsburgh, PA
    M.S.Ed in Community Mental Health Counseling   2011
    Thesis: Liu, Y. (2011). *Post-traumatic growth: Serving humanity by promoting transformation.* (Master's thesis). Duquesne University, Pittsburgh, PA.

    B.A. in Psychology with minor in Women and Gender Study (Summa Cum Laude) 2008

Chang Gung Institute of Technology   Taoyuan, Taiwan
    Associated Degree in Nursing. Specialty: Psychiatric-Mental Health Nursing   1999

PROFESSIONAL EXPERIENCE

Clinical Assistant Professor   July 2016- Present
Department of Counseling, Psychology & Special Education, Duquesne University

Clinical Instructor   2015- July 2016
Department of Counseling, Psychology & Special Education, Duquesne University

Adjunct Instructor   Fall 2014
Department of Counseling, Indiana University of Pennsylvania

Adjunct Instructor   2013-2014
Assistant Coordinator of school counseling and student affair counseling   2012-2014
Clinical Supervisor (clinical mental health counseling and school counseling)   2012-2013
Teaching Assistant   2011-2013
Department of Counseling and Human Services, Syracuse University

CLINICAL EXPERIENCE

Intern Psychotherapist – Vera House	Syracuse, NY	2013 – 2014
Intern Psychotherapist – Saint Joseph Hospital Family Medicine	Syracuse, NY	2011 – 2014
Counseling Intern – Pittsburgh Action Against Rape (PAAR)	Pittsburgh, PA	2010 – 2011
Counseling Intern – Gateway Rehabilitation Center	Pittsburgh, PA	2010
Interpreter - Welcome Center for Immigrants & Internationals	Pittsburgh, PA	2008 – 2009
Registered Nurse – Taipei City Psychiatric Center (Adult Unit)	Taipei, Taiwan	2002-2004
Severe Acute Respiratory Syndrome (SARS) Prophylaxis Task force	Taipei, Taiwan	2003
Registered Nurse – Taipei City Psychiatric Center (Child/adolescent Unit)	Taipei, Taiwan	1999 – 2002

CONFERENCE PRESENTATION

International
- **Liu, Y.** (2013, June). *Trauma Focused Supervision: A Qualitative Inquiry of Novice Counselor's Experiences*. Paper presented at the 9th International Conference on Clinical Supervision, Long Island, New York.
- **Liu, Y.** (2012, July). *Posttraumatic growth: Serving humanity by promoting transformation.* Paper presented at the 30th International Congress of Psychology (ICP), Cape Town, South Africa.

National
- Bernard, J, M., **Liu, Y**., & Miller, A. (2013). *Training Clinical Supervisors to Conceptualize Across Dimensions.* Paper presented at the 2013 Association for Counselor Education and Supervision Conference, Denver, CO.
- Arthur, M., Kowel, C. D., & **Liu, Y.** (2012). *Peer-defusing: Hospital-wide wellness initiative for medical professionals' compassion fatigue prevention and stress reduction*. Paper presented at the 33rd Forum for Behavioral Science in Family Medicine: "Promoting Well-being and Reflection among Medical Professionals," Chicago, IL

Regional
- **Liu, Y**. (2014). *Conversation Analysis: An Emerging Methodology in Counseling Profession.* Paper presented at the 46th annual meeting of the Pennsylvania Counseling Association conference, State College, PA.
- **Liu, Y**. (2014). *Internationalization of the Counseling Profession: Challenges, Opportunities, and Implications.* Paper presented at the 2014 North Atlantic Regional Association for Counselor Education and Supervision (NARACES), Providence, RI.
- **Liu, Y**., & Luke, M. (2014). *Integration of Discrimination Model and Trauma Recovery Model in Clinical Supervision.* Paper presented at the 2014 North Atlantic Regional Association for Counselor Education and Supervision (NARACES), Providence, RI.

- **Liu, Y.**, Vatter, B., Auld, L., & Tinsley, T. M. (2010). *Developing multicultural competence through travel: Counselor education students' cross cultural immersion in Africa.* Paper presented at the 42nd annual meeting of the Pennsylvania Counseling Association conference, State College, PA.
- **Liu, Y.** (2010, September). *Spatiality, gender, and ethnicity: A reflection on preschoolers' use of space in classroom.* Poster session presented at the 2010 North Atlantic Regional Association For Counselor Education and Supervision (NARACES), New Brunswick, NJ.
- **Liu, Y** (2007, March). *Sociocultural relativism of the creative process.* First Annual Duquesne University Regional Undergraduate Psychology Conference, Pittsburgh, PA.

Local
- 2002: Taipei City Psychiatric Center Periodical Case Conference: *Major Depression*
- 2001: Taipei City Psychiatric Center Periodical Case Conference: *Epilepsy & Bipolar Disorder*
- 1999: Taipei City Psychiatric Center Periodical Case Conference: *Multiple Sclerosis*

HONORS & AWARDS

- Award of University Fellowship   2011-2015
  The Graduate School Program, Syracuse University
- School of Education Research and Creative Grant Competition   2014
  Syracuse University: received $1000 award for a qualitative research project:
  Conversation Analysis of Initial Sessions of Trainees in Counseling and Family Medicine.
- Recipient of the 2014 Outstanding Teaching Assistant Award   2014
  The Graduate School Program, Syracuse University
- Teaching Mentor for the 2014 Graduate School, Teaching Assistant Program   2014
  The Graduate School Program, Syracuse University
- Teaching Mentor for the 2013 Graduate School, Teaching Assistant Program   2013
  The Graduate School Program, Syracuse University
- Association for Adult Development and Aging (AADA) Graduate Student Research Grant 2012
  American Counseling Association (ACA): received $500 award for a qualitative research project:
  Posttraumatic Growth: A Qualitative Inquiry of Transformation and Negotiation among Volunteers
- School of Education Research and Creative Grant Competition   2012
  Syracuse University: received $750 award for a qualitative research project: *Crisis Management: A Qualitative Inquiry of Peer Defusing Following Critical Incidents in a Hospital Setting.* [With Melissa Arthur, PhD and Christopher Kowal, PhD]
- NARACES Outstanding Graduate Student Award   2010
  North Atlantic Regional Association for Counselor Education and Supervision (NARACES)
- NARACES Scholarship   2010
  North Atlantic Regional Association for Counselor Education and Supervision (NARACES)
- Selected as a Finalist in International Student Panel: *Mental Health Counseling Around the World* American Counseling Association Conference & Exposition, Pittsburgh, PA   2010

CREDENTIALS

- Certificate in University Teaching(CUT)
  Future Professoriate Program: Syracuse University
- National Certified Counselor (NCC) in the United States of America
- Registered Professional Nurse (RPN) in Taiwan, R.O.C
- Registered Nurse (RN) in Taiwan, R.O.C
- Certification of Psychotherapy: Series on Psychodynamic Psychotherapy
  Taiwan Institute of Psychotherapy
- Certification of Marriage and Family Therapy in Satir Model
  Shiuh-Li Liuh Memorial Foundation (in cooperation with Satir Professional Development
  Institute of Manitoba, Canada)
- Certification of Structural Family Therapy
  Shiuh-Li Liuh Memorial Foundation

PROFESSIONAL AFFILIATIONS

American Mental Health Counselors Association	2015 – Present
Pennsylvania Counseling Association	2014 – Present
International Psychotherapy Institute	2014 – Present
American Counseling Association	2013 – Present
American Psychoanalytic Association	2013 – Present
Association for Counselor Education and Supervision	2013 – Present
North Atlantic Region Association for Counselor Education and Supervision	2010- Present
Taiwan Psychiatric Mental Health Nursing Association	1999-2004
Taipei City Nursing Association	1999-2004
Taiwan Dance Therapy Association	2002-2003