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Program

	Thursday October 4th
10.00 – 10.30	Registration & coffee and tea
10.30 – 10.35	Welcome
10.35 – 12.00	**Keynote lecture 1,** Anssi Peräkylä
12.00 – 13.30	Lunch *(including AWIA meeting)*
13.30 – 15.00	**Keynote lecture 2,** Anssi Peräkylä
15.00 – 15.15	Coffee and tea
15.15 – 16.05	**Presentations – session 1** *Either/ or questions in general practice triage telephone conversations: should we send an ambulance or not?,* T. van Charldorp et al. *Openings of face-to-face versus video-mediated medical consultations,* W. Stommel et al.
16.05 – 17.15	**Data session**
18.30 – ...	Conference dinner, in restaurant De Hemel

	Friday October 5th
09.00 – 10.15	**Presentations – session 2** *Teachers instigating, fostering and closing moments of actual discussion between students,* A. Willemsen et al. *Building collections from complex concepts: Identifying reflection sequences in collaborative group meetings of GP residents,* M. Veen *Tutors' sharing of own experiences during collaborative reflection in GP training,* M. van Braak et al.
10.15 – 10.45	Coffee and tea
10.45 – 12.25	**Presentations – session 3** *How treatment conditions shape therapist formulations,* L. Knol et al. *"The foot in the door": negotiating rights to speak,* L. van Burgsteden & H. te Molder *'Talking with families about redirection of care in the NICU, PICU and ICU',* A. Akkermans et al. *Towards a shared understanding of the pain: patient-practitioner interaction in chronic pain rehabilitation,* B. Stinesen & P. Sneijder
12.25 – 14.00	Lunch
14.00 – 15.40	**Presentations – session 4** *Coming to new understanding: forms and use of interpretations in family treatment homes* M. Noordegraaf *How GP's raise psychosomatic attributions in consultations about unexplained symptoms,* I. Stortenbeker et al. *'What is your domicile?': how police officers practice instructions with child witnesses,* G. Jol et al. *Juggling accounts of normalcy and blame: caregivers use of direct reported speech when describing their child's recovery from trauma in psychological interviews,* J. Lamerichs & M. Schasfoort
15.40 – 16.00	Round off & coffee and tea

October 4th, 10.35 – 12.00 (Lecture 1)
13.30 – 15.00 (Lecture 2)
16.05 – 17.15 (Data session)

Invited speaker

Anssi Peräkylä is Professor of Sociology at the University of Helsinki. From January 2019, he will be in a holder of a distinguished position of Academy Professor. Since his PhD at the University of London in 1992, he has investigated social interaction in health care settings (counselling, primary care consultations, psychotherapy, psychiatric interviews) and emotion in social interaction. He uses conversation analysis as his research method, recently also combining it with psychophysiological measurements and experimental designs. His books include *AIDS Counselling* (CUP 1995), *Conversation Analysis and Psychotherapy* (co-edited, CUP 2008) and *Emotion in Interaction* (co-edited, OUP 2012). His articles have been published in major journals such as *American Journal of Sociology, Social Psychology Quarterly, International Journal of Psychoanalysis,* and *Language and Social Interaction*.

Psychotherapy, psychiatry and emotions

Anssi Peräkylä[1]

[1] University of Helsinki

In the plenary presentations, I will be presenting conversation analytical studies on psychotherapy (presentation 1) and studies on emotion in interaction using combinations of conversation analytical and experimental methods (presentation 2). The data to be explored in the data session involves psychiatric intake interview.

The first presentation will lay out an overall view of conversation analytic (CA) study on psychotherapy. In a sociological perspective, psychotherapy is to be understood as a particular form of institutional interaction. The key characteristic of psychotherapy as institutional interaction arises from its particular inferential frameworks (see Drew and Heritage 1992: 21-25): the clients' talk is understood beyond the speaker's intended meaning, as indication of the particular (usually dysfunctional) ways of working of the patient's mind (Peräkylä 2013). The goal of psychotherapy, accordingly, is to transform these ways of working of the mind in the client. In achieving that goal, psychotherapy is organized around sequences of actions, which can be characterized as being initiatory, responsive, or "third position" actions. CA studies have mostly focused on therapist's actions, such as questions, formulations and interpretations. I will be arguing that through the sequences of actions, three transformation processes take place: the transformation of referents, emotions, and momentary relations between the participants. I will argue that these are key processes in enhancing therapeutic change in the patient. Key challenges for CA studies on psychotherapy will be discussed. One of them involves study designs that encompass long term processes extending the boundaries of single session. Another key challenge involves the understanding of interaction patterns pertaining to specific psychic disorders (such as

depression, anxiety, or personality disorder). Finally, the contribution of CA on psychotherapy to CA studies on institutional interaction more generally will be discussed: particularly, I will argue that CA of psychotherapy highlights the importance of management of referents and the processes that go beyond single sequences and encounters, as targets of CA analysis.

The second presentation will give an overview of a string of studies on emotions in interaction using CA and experimental methods. In studies on facial expression, we have been exploring how facial expressions are coordinated with the initiation and completion of turns at talk, doing work to initiate, enhance or transform the emotional stances that are being conveyed by the speakers. In studies on emotion in psychotherapy, we have explored the different combinations of empathy and challenge in therapists' responses to patients' emotional expressions and narratives. For example, prosodic matching and mismatching between the patient's and the therapist's talk anticipatorily conveys either empathy or challenge by the therapist, in relation to the patient's emotion descriptions. In a set of experimental studies, we have explored the ways in which the expressed stance of stories, and the affiliation displayed by the story recipients, are linked to the autonomous nervous system responses in the participants. These studies have uncovered linkages between the "interaction order", and the physiological processes in the participants, thus elaborating Goffmanian view of interaction.
The data session will focus on psychiatric assessment interviews in an outpatient clinic. The data are in Finnish. The goal of psychiatric assessment is to define the patient's diagnosis and treatment plan. In discussing diagnosis, the roles of the clinician and the patient seem to be different from what they are in somatic medicine: in the psychiatric assessment, the clinician seems to encourage and solicit patient participation in discussion on diagnosis, in ways that are rather rare in somatic medicine.

Abstracts

October 5th, 10.45 – 12.25

Talking with families about redirection of care in the NICU, PICU and ICU

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[2] VU University

Introduction

In this presentation, we describe our conversation analytic research project on complex communication with families in the Neonatal Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU) and Intensive Care Unit (ICU). In these settings, difficult decisions are made about the redirection of care. These decisions mainly concern decisions to withhold or withdraw life-sustaining treatment (LST). These decisions are particularly difficult in situations in which the life of a patient can be extended with the use of all means, but at the same time there are major concerns about quality of life and – sometimes – about the quality of dying. Because patients in the NICU and PICU are not legally allowed to make treatment decisions and most critically ill patients in the ICU lack the capacity to make such decisions, decision-making often involves surrogate decision-makers. The cognitive and emotional complexity of this kind of decision-making raises the question of how to best communicate with family members about decisions to withhold or withdraw LST and of how to best involve them in the decision-making process. In this project, we aim to contribute to the concrete improvement of complex communication with family members within the NICU, PICU and ICU by gaining insight into how doctors and family members communicate about decisions to withhold or withdraw LST, into which dilemmas arise in these conversations and into how all parties deal with these dilemmas.

Data and method

For this purpose, we audiotape formal interactions between family members of intensive care patients and their doctor(s). We have started our data collection in Amsterdam UMC. Eventually, all academic medical centres will be involved in our research project. In each unit, the family members of at least four patients will be included. Approximately 180 conversations (based on an estimation of three conversations on average per family) will be transcribed and analysed using conversation analysis (CA). The analysis focuses primarily on how parties exchange important information, how they elaborate about their points of view and underlying values, and how they eventually reach a decision to continue or discontinue LST on behalf of the patient. We are especially interested in (dis-)alignment, how this is displayed and how disalignment is dealt with. Effective and less effective strategies can be identified in this way.

In order to validate our findings, the analytical results will be presented to a representative group of neonatologists and (pediatric) intensivists. Shared best practices will be formulated around the most common and/or complex conversational dilemmas. The validated insights will form the basis for the development of a training program for neonatologists and (pediatric) intensivists.

First part of the study

This will consist of a case study aimed at exploring the unique fingerprint of conversations between doctors and family members of intensive care patients. In this endeavor, we will focus on the types of friction that arise and how they are dealt with. We would like to present the preliminary findings of this study and subsequently discuss the applicability of CA to analyse our larger data set.

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Tutors' sharing of own experiences during collaborative reflection in GP training

M. van Braak[1], M. Huiskes[2], M. Veen[1]

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Collaborative reflection is an essential part of Dutch programmes for General Practitioners in training. At the start of their weekly day release, GPs in training participate in 'Exchange of Experiences'-sessions (EoE). During these sessions, they reflect on and learn from practice expriences in groups of 8-15 residents. One or two tutors are present to facilitate the process. Facilitating EoE can be quite complex given the open, interactive nature of the setting and the wide variety of content discussed. Indeed, beginning tutors find that learning to facilitate EoE is a challenging task. GP training institutes, therefore, provide tutors with various guidelines on how to optimally facilitate Exchange of Experience-sessions. These guidelines are part of tutors' Stocks of Interactional Knowledge (Peräkylä & Vehviläinen, 2003) and inform their professional behavior.

One of the guidelines for facilitating EoE is for tutors to be careful with presenting one's own practice experiences as a tutor. In actual EoE, however, tutors quite frequently bring in their personal experiences, showing a participant orientation to the relevance of sharing their experiences. In this presentation, we present the results of our collection study of tutor's own experiences in recordings of EoE-sessions at various GP training institutes in The Netherlands. We discuss the sequential slots in which tutors bring in their own experiences, their interactional function, and their influence on how the interaction develops. By comparing practices of different sessions and different institutes, we aim to formulate evidence-based advice for tutors on how to use their own practice experience to enhance the value of EoE for GPs in training.

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October 5th, 10.45 – 12.25

“The foot in the door”: negotiating rights to speak

L. van Burgsteden[1], H. te Molder[1]

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This conversation-analytic project focuses on interactions between participants involved in the Dutch societal debate around the effects of livestock farming on human health. The research data consist of 5 video-recorded meetings, with a total duration of approximately 400 minutes, between experts (e.g., GGD/RIVM/municipalities) and residents living in the vicinity of livestock farms. In these meetings, the results of research concerning livestock-related health effects are discussed.

In the Netherlands, a country with a significant number of livestock farms and high human population density, human health is threatened by diseases transmitted from animals to humans (e.g., zoonoses). The outbreak of Q-fever in 2007, resulting in 74 deaths and numerous (chronic) patients, has had a big influence on the Dutch debate concerning livestock farming and human health (Bokma-Bakker et al., 2011). Moreover, recent research pointing to other livestock-related health risks, such as pneumonia (Maassen et al., 2016), has even intensified the debate.

Typically, conflicts in societal debates are regarded as epistemic conflicts, in which experts should restrict themselves to providing the facts (Te Molder 2012). Yet, these facts are strongly connected to participants’ identity concerns, such as what it means to be a (good) farmer, a (competent) citizen or an (autonomous) patient. However, despite their apparent importance, these social-moral concerns are routinely dismissed in the debate or treated as non-consequential (Swierstra & Te Molder, 2012). The conversation-analytic approach we use enables us to identify such concerns and to make them available for deliberation and change.

Analyses of the video-recordings shed light on an ostensible dilemma in these meetings: “how do I, as resident, create entitlement to speak?” These meetings are organized for residents; yet, rights to speak do not seem to be self-evident. We find experts spending a lot of time on setting the agenda, focusing on what can be discussed, and what cannot. On the other hand, residents also spend much time on ‘initiating their own agenda’, thereby negotiating rights and responsibilities to speak (cf. Heritage & Raymond, 2005; Sacks, 1984; Stivers et al., 2011), and resisting the experts’ agenda. We focus on two emerging practices by which residents seem to ‘initiate their own agenda’: (a) asking for evidence (e.g., “that has been investigated?”), and (b) asking for confirming the entitlement to speak (e.g., “but surely we can talk about that?”). With these practices, residents seem to “get a foot in the door” (Freedman & Fraser, 1966): when experts subsequently respond to residents’ turns, they thereby indicate that residents have the right to speak or ask about these matters. Once residents have acquired these rights, they also pursue additional responses (Pomerantz, 1984; Stivers & Rossano, 2010) from the experts. Experts ostensibly find these turns difficult to handle, as reflected by, amongst others, perturbations (Schegloff, 2007), and pauses (Sacks et al., 1974) in their responses. We discuss the implications of these two practices for facilitating interactions between the different participants.

October 4th, 15.15 – 16.05

Either/or questions in general practice triage telephone conversations: should we send an ambulance or not?

T. Van Charldorp[1], C. Erkelens[2], V. Vinck[1], E. de Groot[2]

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Triage telephone conversations at out-of-hours primary care services consist of patients calling the service to share their concerns, ask medical questions, and ask for help. Triage nurses answer these questions and must decide on the urgency of the call: is there a need to send an ambulance, are smaller measures sufficient (for example an appointment at the service or a home visit by the general practitioner), or is reassurance that nothing is the matter warranted? In order to assign an adequate urgency level, triage nurses use a standardized decision support system and ask further questions. The ways in which these questions are formulated and responded to gives us additional insight into question-answer sequences in an emergency setting (Lee & Kim, 2015; Heritage & Clayman, 2010).

We recorded 70 out-of-hours primary care triage phone conversations in the Netherlands within the UMCU Safety First project. The callers all present themselves with symptoms suspected of acute coronary syndrome and it is therefore highly important that the triage happens fast and accurate. However, people with symptoms of acute coronary syndrome may have a wide variety of symptoms, which makes an accurate urgency decision difficult. It is not only important to prevent underestimation of the urgency (which can possibly lead to fatal adverse events), but also to prevent overestimation (to avoid an unnecessary burden on the healthcare system).

Within our corpus of 70 triage conversations, we collected over 100 either/or questions (hereafter referred to as or-questions) in the urgency decision phase of the triage call. These or-questions come in a variety of formats: 1) two-choice format (“Do you feel pain on the left or on the right side?”) where the options can be mutually exclusive or not; 2) multiple-choice format (“Do you feel sweaty, nauseous or clammy?”); 3) open-ended format (“Do you feel like you might faint, or are you sweaty or-”); or 4) tag format (“Are you experiencing palpitations, or not?”). Using conversation analysis, we show that these various formats of or-questions lead to various uptakes and consequently lead to various repairs, further questioning and topic shifts. Based on our analyses the tag-questions are most frequently followed up by type-conforming answers (Raymond, 2003) after which a next question is asked concerning a new topic. The more options given in a multiple-choice question, the more elaborate and non-conforming the answer seems to be. With respect to efficiency, the tag and two-choice format are interactionally efficient. However, with regards to accuracy, such questions may not lead to the best results, resulting in over- or underestimation.

In this presentation we will demonstrate 1) how the caller and call-taker move from the opening to the urgency decision phase of the triage call; 2) examples of the four different or-question formats and their uptake; 3) an advice on which type of questions could be used for accurate and time-efficient triage.

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October 5th, 14.00 – 15.40

‘What is your domicile?’: how police officers practice instructions with child witnesses

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[1] Radboud University Nijmegen

Police officers in the Netherlands attribute great importance to instructing child witnesses at the beginning of interviews. Such ideas about ´good interaction´ are also known as professional ‘stocks of interactional knowledge’ or SIKs (Peräkylä and Vehviläinen 2003). For police interviews with child witnesses, these SIKs include telling child witnesses to say ‘I don’t know’ if they do not know an answer, to say ‘I don’t understand’ if they do not understand the police officer, and to correct the police officer if necessary. These instructions are meant to enhance the reliability of the testimony. Police officers are also encouraged to practice these three instructions in order to check if children understand the instruction and to train the child for the ongoing interview.

In our presentation, we will discuss how police officers practice the instructions in actual interviews, what this implies about the relationship between police officer and child witness and how the practicing activities relate to the SIKs, including the purposes of the instructions.

The analysis is based on excerpts collected from 39 police interviews with child witnesses. The children are 6-11 years old. The interviews have been recorded by the police as a part of the interview procedure. We used insights from conversation analysis to study the excerpts.

Our analysis reveals that the practicing activities differ from the SIKs in three ways. First, the ways in which instructions are practiced can work in ways that are in conflict with the SIKs themselves. For example, the ways in which instructions are practiced highlight the police officer’s greater knowledge while police officers are also urged to make explicit that they do not know the answer to questions. Second, the ways in which the instructions are practiced sometimes convey other or more things than the instruction that is intended to be practiced. For example, police officers sometimes treat ´I don´t understand´ as incomplete by demonstrating that the child could ask for clarification. Third, we found that the typical ways to practice the instructions seem in conflict with the tacit assumption in the SIKs that the exercises prepare the child for the interview as it unfolds. For example, police officers ask test questions such as ‘what is my dog’s name’ to test and train the I don’t know-instruction. Such test questions are unrepresentative of actual interview questions because the reason for the interview is that the child knows something that the police officer does not know.

The analysis has both practical and theoretical implications. First, it indicates that how the instructions are practiced establishes other and more things than the SIKs predict or envision. The findings thus correct and add to the SIKs. Second, the analysis adds to the claim that role play as training method is unrepresentative of the encounters that it is supposed to represent (Stokoe 2013). Our analysis suggests

that training within the actual institutional encounter (in contrast to training as separate encounter) is also insufficiently representative of the focal activity.

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How treatment conditions shape therapist formulations

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This study used Conversation Analysis to examine the way in which psychotherapists reformulate depressive patients' talk during individual therapy sessions, and whether differences between schools of psychotherapy manifest in the practices that accomplish these (re-)formulations. As previous research has shown, formulations can do fixative work in larger conversational undertakings, demonstrate understanding and render conversations preservable and reportable (Heritage & Watson, 1979). Prior talk is reproduced and thereby undergoes some degree of transformation (Antaki, 2008). The reformulated version may also propose a different or selective focus on the aforementioned (Deppermann, 2011). Formulations extract and make relevant aspects of preceding talk, explicate implicit or missing elements and therefore allow therapists to explore their therapeutic meaning or implication (Weiste & Peräkylä, 2013). As the results show, therapists from different schools of psychotherapy hereby take varying approaches.

To investigate the differential use of formulations by different therapeutic approaches, qualitative data (audiotapes of therapy sessions) of the Ghent Psychotherapy Study (Meganck et al., 2017) were analysed retrospectively. This Randomized Controlled Trial focussed on interactions between depressive patients' personality types (anaclitic versus introjective) and psychotherapy type (PDT versus CBT). Both types of patients were randomly allocated to receive either supportive-expressive psychodynamic (PDT) or cognitive-behavioural (CBT) therapy treatment. PDT is primarily explorative in nature, uses no pre-structured therapy plan, and stresses the importance of patients gaining insight into unconscious thoughts, motivations and their meaning. CBT, on the contrary, is more directive in nature, follows a rather strict treatment protocol, and focuses more on the symptoms that patients experience in the here and now, and takes a practical and hands-on approach.

Formulations find themselves at the intersection between patient talk and therapist interventions, or as Ferrera (1994) states: "If insight is the ability to see inside, then therapists' formulations are models of insight for clients" (p. 111). Our analysis identified different types of reformulating practices, which we clustered into two more general groups: non-transformative and transformative reconstructions. It was argued that non-transformative and transformative reformulating practices have common features, yet differ in regard to projected response type and alignment with respective treatment style. Non-transformative practices, such as (partial) repetitions and quotative expressions, are in line with a psychoanalytic therapy approach. This form of mirroring highlights and makes relevant a key aspect of patient talk that is worth expanding (Fink, 2007), and serves locally as an indirect request for elaboration (Ferrera, 1994). Quotative expressions are also used as means to topic management, readdressing

matters that came up earlier on. In PDT, reconstructions largely consisted of these non-transformative practices and of transformative specifications. CBT reconstructions, on the contrary, predominantly consisted of marked, transformative practices that confront patient with explicit inferences. Finally, this study also reports on differences in the display of affiliation and alignment in the responding actions to therapist reconstructions.

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October 5th, 14.00 – 15.40

Juggling accounts of normalcy and blame: caregivers' use of direct reported speech when describing their child's recovery from trauma in psychological interviews

J. Lamerichs[1], M. Schasfoort[1] (in collaboration with R. Veul and E. Alisic)

[1] VU Amsterdam

In our talk we report on a systematic conversation analytic study of 7 caregiver-psychologist interviews in which caregivers are invited to talk about their child's recovery of a traumatic occurrence. We report in particular on the ways in which caregivers tell these stories of recovery by coupling them with quotations. With these quotations they may convey their own words or thoughts or the alleged words and thoughts of their child.

The interactional work that is being accomplished by making use of quotations, as 'showing rather than telling', and which has been explored quite extensively in interactional research on everyday talk, has demonstrated how quotations give the listener access to the reported situation. Access is being provided both by conveying the alleged words as well as the prosodic features of what is reported by the 'composer'. In doing so, quotations may offer what is reported up for evaluation by the speaker. In story-telling, conveying instances of reported speech are also examined for the ways in which they highlight dramatic detail and work to convey the climax of the telling. Detailed interactional studies of the work quotations might accomplish in the environment of psychological interviews are still scarce.

The data for this study were part of a Dutch qualitative research project among caregivers of 25 children aged 8-12 years old, who had experienced an instance of single-incident trauma at least 6 months prior to the interview. Instances of single-incident trauma might involve a serious accident, sudden loss or exposure to violence. The interviews that were conducted with a trained psychologist, lasted from 15 to 72 minutes.

The present study is based on a secondary analysis of 7 interviews with caregivers who gave permission to use their interview for research purposes. Insights from conversation analysis and discursive psychology informed our study. In the interviews, a total of 333 quotations were identified. These quotations conveyed the alleged words or thoughts of the caregiver, the child or a third party.

In our talk, we want to highlight the interactional work caregivers attend to when conveying the words or thoughts of their children. We want to compare these uses to the functions quotations seem to fulfil when they are being used to convey the caregiver's own words or thoughts. Where quoting the child may be employed to show how the child has been capable to cope well after the traumatic occurrence, and as 'showing regained normalcy', we want to demonstrate that the instances in which caregivers

employ quotes to convey their own words and thoughts manage quite different interactional concerns, such as matters to do with accountability and blame.

In our discussion, we relate our findings to the goal of this qualitative study, which aimed to gain a more in-depth overview of how trauma recovery takes place, and how caregivers see their role in this process. We also want to discuss our findings in relation to some of criticisms raised in the field of interaction research about the use of psychological interviews. This critique has most notable dealt with the complex footing positions of interviewer and the interviewee in these interviews and the ways in which interviewees may orient to the interestedness of their talk. As our study shows, an interactional approach to psychological interviews as interaction is able to highlight how caregivers are not merely 'neutral informants on their own practices' and how psychological interviews run the risk of 'offering up their own agendas'.

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October 5th, 14.00 – 15.40

Coming to new understanding: forms and use of interpretations in family treatment homes

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In this presentation excerpts coming from (300 hours of-) dinner-conversations between out of home placed adolescents and professional foster parents in six Dutch family treatment homes are analyzed using Applied Conversation Analysis as a method (Antaki, 2011). Out of home placed adolescents often show behavioral disturbances due to traumatic events and poor parenting. At least one of the foster parents is a trained professional. This makes the relationship hybrid; it is both pedagogical (the adolescent is part of the family) and therapeutic (the adolescent gets professional attention) (Van Nijnatten & Noordegraaf, 2016).

From this data a collection of interpretations as produced by professional foster parents in interaction with adolescents are presented. Interpretations are utterances that invite the recipient to orient to and to work with a new understanding that is proposed (Vehvilainen, 2003). These kinds of utterances have been studied before in the context of psychotherapy where interpretations serve as interventions in which a counsellor 'links a client's prior talk to a suggested underlying mental pattern, disposition, thoughts and beliefs' and which 'elicit conformation or rejection' (Peräkylä, 2005: 199/ 203).

In our data, interpretations come in different forms and seem to serve different pedagogical functions. All interpretations sequentially come as insertion- or as post-expansion and thus as a response to something said or done by the adolescent. They elicit different responses. In our analysis, we use this nextness to scrutinize how the uttered interpretation (presenting a new understanding) is understood by the adolescent and whether we can differentiate different interpretative operations (see also: Mondada, 2011).

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Towards a shared understanding of the pain: patient-practitioner interaction in chronic pain rehabilitation

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Chronic pain is a complex health condition, involving physical, social and psychological components (Gatchel, Peng, Peters, Fuchs, & Turk, 2007). It affects the patient's quality of life, everyday functioning and mood, and may lead to absence from work through illness (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006). Social and psychological factors – such as emotions, thoughts and behaviours – may contribute to the continuation of the pain and the limitations patients experience as a consequence (Oosterhof, Dekker, Sloots, Bartels, & Dekker, 2014).

In today's multidisciplinary chronic pain rehabilitation programs patients explore these social and psychological factors together with various healthcare professionals (i.e. physiotherapists, psychologists and social workers) (Gatchel et al., 2007; Köke et al., 2005; Oosterhof et al., 2014; Scascighini, Toma, Dober-Spielmann, & Sprott, 2008; Smeets & Verbunt, 2014).

For positive treatment outcomes to be achieved, it is highly important that patients and their practitioner(s) develop a shared understanding of the causal and maintaining factors contributing to the patient's pain (Oosterhof et al., 2014; Verbeek, Sengers, Riemens, & Haafkens, 2004). Unfortunately, in practice a shared problem analysis is often difficult to achieve and patients do not always (successfully) finish the rehabilitation program. Healthcare professionals indicate that patients often tend to particularly emphasize the physical causes of their pain and disabilities. Practitioners frequently encounter resistance when introducing psychological and social maintaining factors of the pain.

Research in the context of chronic pain seeking for explanations for this resistance has primarily focused on mental aspects, such as a lack of motivation (Goossens, Vlaeyen, Hidding, Kole-Snijders, & Evers, 2005; Mertens, 2015; Smeets et al., 2008). Discursive psychological research however suggests that when talking about their illness patients may face particular interactional concerns, that may influence the way they talk about their health condition (Horton-Salway, 1998, 2001b, 2001a) and patient-practitioner interaction concerning psychosocial explanations for the patient's health situation can be a delicate practice (Monzoni & Reuber, 2015).

In this research a discursive psychological research perspective is taken to gain insight into the interactional concerns that may impede the development of a shared understanding of the pain between patients with chronic pain and their practitioners. Patient-practitioner interaction is studied in different phases and settings of the rehabilitation treatment. Next, we will explore the feasibility of an intervention aimed at increasing practitioners' awareness of patients' interactional concerns, so as to improve the quality of the interaction with their patients. The intervention will be developed based on

the results of the analyses as well as insights from conversation analysis based intervention approaches such as the Discursive Action Method (Lamerichs & Te Molder, 2011) and the Conversation Analytic Role-play Method (Stokoe, 2011). A pilot study will be conducted to assess its feasibility.

Our paper presentation will focus primarily on the research design and we will present our preliminary findings. Our aim is to exchange ideas and experiences regarding the challenges of applied CA. We think it would be particularly valuable to discuss how to incorporate CA insights when developing an intervention to improve patient-practitioner interaction.

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Openings of face-to-face versus video-mediated medical consultations

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While studies of physically so-present, face-to-face physician-patient interaction are abundant, little is known about the ways in which the affordances and drawbacks of video-mediated technology affect the interactional order, let alone the organisation of medical encounters. Conversational openings are known as the eminent occasion to establish the identities and relationship of the participants and the purposes of the conversation. Previous studies have shown that the opening phase of face-to-face medical encounters consists of a succession of doctor-initiated turns separated by gaps in interaction along with patient inactivity which instate the doctor as the owner of the conversational floor. Inherent to these openings are body orientations and gaze while the patient enters the door, mutual greeting, shaking hands and offering/taking a seat. The question is how physicians manage openings of video-mediated consultations given the absence of physical co-presence (including doors, hands, seats etc.) and how this affects the consultation and its organisation.

We recorded 18 post-operative video-consultations and 13 equivalent face-to-face consultations two weeks after a tumor resection. The main purpose of the consultations is informing the patient about the pathology results of the resection and the secondary purpose is checking on the patient's recovery. We have analysed the opening sequences until the onset of the pathology results sequence. It appears that in face-to-face consultations some small talk or talk to the researcher who manages the camera frequently occurs in the process of entering the room and taking a seat. Once the patient (and relative) is (are) seated, the physician formally opens the conversation by making explicit the consultations' main purpose and thus initiating the pathology informing. In video-consultations, the opening sequence appears to include a variety of other activities such as checking of the video and/or audio channel, commenting on the medium, a "how are you?" or extensive small talk before the physician states the main purpose of the encounter. These activities are usually initiated by the physician. Our preliminary analysis shows that these sub-activities show an orientation of the physician to establishing the relationship as a prerequisite to "getting to the point" of the pathology results. In this presentation, we will discuss the interactional consequences of video-consultation openings for instance that sequences concerning the communication technology may function as an interactional resource. We will conclude that opening video-consultations compared to face-to-face openings requires different and sometimes additional interactional work by physicians.

October 5th, 14.00 – 15.40

How GPs raise psychosomatic attributions in consultations about unexplained symptoms

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General practitioners (GPs) find it difficult to explain symptoms that do not have a detectable underlying disease (Dowrick, Ring, Humphris, & Salmon, 2004). The experience of these medically unexplained symptoms (MUS) is often related to psychosocial circumstances such as experienced stress, but previous research has shown that patients often react defensively to these so-called psychosomatic attributions (PAs) (Monzoni, Duncan, Grunewald, & Reuber, 2011a). PAs are perceived as stigmatizing patients as malingerers or having emotional problems (Burbaum et al., 2010).

Previous conversation analytic research in neurology practices has shown that physicians treat the discussion of PA as a delicate activity. They explain symptoms by stressing what other patients may experience (i.e. “detached footing”) (cf. Teas-Gill & Maynard, 1995) and via general formulations, such as “seventy per cent of patients or so have things in the past that are important “ (Monzoni & Reuber, 2014, p. 294). Raising such attributions is a crucial moment in the interaction as it could construct a basis for treatment recommendations. When patients resist PAs, physicians can refrain from making recommendations at all (Monzoni et al., 2011a). This study will add to the current literature by investigating identifiable practices of GPs in raising PAs, and by evaluating the different types of responses they elicit.

The data were derived from a large corpus of video-recorded GP consultations (Houwen et al., 2017), including 36 consultations with patients who were post hoc classified by the GP as having MUS. GPs initiated PAs in 16 of those consultations. PAs were defined as practices creating “a link between the patients’ biographical incidents and experiences, their emotions or psychosocial stress factors, and their physical ailments” (Burbaum et al., 2010, p. 209). In this presentation, we present our preliminary analysis.

We found that GPs avoid to refer to the specific experience of symptoms and the patients’ psychosocial circumstances. Similar to neurologists, GPs use modality, back references, and vague and general terms to raise PAs (Monzoni, Duncan, Grunewald, & Reuber, 2011b; Monzoni & Reuber, 2014). However, it also appeared that GPs raised PAs in two different interactional activities: questioning and explaining. First, GPs can pose the attribution as a question, making relevant an answer by the patient. Second, GPs can formulate the attribution as a (potential) explanation, to which a response is not always relevant.

These two practices have different degrees of epistemic stance towards the potential role of PA for the patients' experience of symptoms. The GP claims a weak epistemic stance when the PA is embedded in a question, while explanations claim a high epistemic stance (cf. diagnosis). Questions about PAs receive relatively straightforward denials or confirmations, which signal patients' epistemic superiority regarding their own body and symptoms. Explanations, on the other hand, are more indirectly resisted, for instance by withholding confirmation. GPs seem to implement explanations after patients have denied psychosomatic aspects in response to a PA posed as a question. This suggests that PAs as explanations are a way to deal with patient resistance.

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October 5th, 09.00 – 10.15

Building collections from complex concepts: Identifying reflection sequences in collaborative group meetings of GP residents

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The purpose of the collaborative group meetings “Exchange of Experiences” at the GP education in The Netherlands is for residents to reflect on their experiences. The purpose of my research is to study how tutors stimulate reflection during these meetings. In this talk I focus on how to identify sequences in which reflection takes place. This addresses a larger question of how to relate complex concepts to features of talk. Peräkylä and Vehvilfinen (2003) have introduced the term Professional Stocks of Interactional Knowledge to explore the dialogue between CA and models and theories that are present in the institutional context we study. Often, SIKs offer points of reference in interactional terms. But container concepts such as “reflection”, “professionalism”, and “patient-centeredness” are contested notions that are ill-defined, ambiguous and mean many things to many people. They are not easily translated into features in discourse that we should look for to build a collection that is relevant to that concept. In addition, they are not expected to manifest in individual turns, but rather over sequences of talk. And there is no clear “racetrack” (Stokoe, 2014), or rather, there are many possible trajectories and outcomes that can arguably be relevant to the process of reflection. Without going into close analysis of the reflective sequences yet, I present sequences that ‘look like’ they could be sequences in which reflection takes place, and the rationale for identifying these sequences as such.

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October 5th, 09.00 – 10.15

Teachers instigating, fostering and closing moments of actual discussion between students

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This presentation reports on a conversation analytic case study of teacher conduct during whole-class discussions about text in upper-primary school history lessons. The study focuses on an episode of actual discussion: a part of the lesson during which the students respond to each other without the teacher interfering. Our analysis demonstrates what the teacher does and does not do before and during this episode that may lead the students to have a discussion independently.

Previous research has indicated that discussions, and specifically discussions about texts, are an important means for learning. They can enhance students' text comprehension (e.g. Applebee, Langer, Nystrand, & Gamoran, 2003; Murphy, Wilkinson, Soter, Hennessey, & Alexander, 2009) and offer them the opportunity to build knowledge together by reasoning collaboratively. This encourages them to share perspectives (Chinn, Anderson, & Waggoner, 2001) and can lead to improvement of their individual reasoning (Mercer, 2000).

Our own prior research into teachers' conduct during whole-class discussions about text has indicated that teachers employ different means to convey that the students are encouraged to have a discussion and to take and hold the floor for extended periods of time. They produce open invitations (Willemsen, Gosen, van Braak, Koole, & de Glopper, 2018), use pass-on turns to invite responses to a student contribution (Willemsen, Gosen, Koole, & de Glopper, submitted) and utter elaboration invitations to let students expand on their own contribution. These teacher turns seem to be occasioned by the fact that both teachers and students are still getting used to the discussion framework, as their usual participation framework can be characterized as teacher-fronted interaction in which the teacher takes every other turn at talk (McHoul, 1978).

The episode we selected for this study comprises a larger lesson fragment in which the students take subsequent turns and share perspectives and arguments with each other. They do not orient to the teacher as the primary respondent and/or the one who is allocating the turns. The detailed analysis of this single episode brings our previous studies together and enables us to uncover how exactly the participants realize and retain the discussion framework. Focusing on the teacher, we reveal different aspects of his conduct before and during the episode of discussion that occasion and foster the discussion framework. We also pay attention to the way in which the discussion episode is finally concluded, in order to show how the teacher orients to and treats this episode in hindsight.

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