

Running head: communicative changes in a psychotherapy group

A conversation analysis of communicative changes in a time-limited psychotherapy group
for mothers with post-natal depression

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Abstract

Objective: To examine qualitatively changes occurring in discussions within a time-limited psychotherapy group for mothers with post-natal depression.

Method: Discussions occurring in a group that comprised five mothers and a therapist were recorded over the course of six one-hour therapeutic sessions. Participants had been referred or had self-referred to the group on the basis of having post-natal depression. The recorded discussions were transcribed and then analysed in accordance with principles of conversation analysis.

Results: Analysis of early and later group discussions showed changes in group members' alignment with the topics that were introduced, in turn-allocation and turn-taking, and in the co-construction of accounts of experience. In contrast to early discussions, in later discussions participants aligned with topics relating to personal emotions, self-selected as next speakers in the discussions, and collaboratively worked up accounts that made sense of their experiences of childbirth and of being diagnosed as having post-natal depression.

Conclusions: Interactional changes over the duration of the group point to the benefits for mothers with post-natal depression of participating in a time-limited psychotherapy group. Fine-grained analysis of group discussions potentially offers a way of examining changes over time in psychotherapeutic groups more generally.

Keywords: conversation analysis; group psychotherapy; mothers; therapeutic change; post-natal depression

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The talk found within psychotherapeutic interactions has provided fertile ground for conversation analytic research in recent times. Since Sacks' (1992) pioneering studies of talk in psychotherapy groups, much attention has been given to examining the psychotherapeutic encounter as a form of social interaction in which therapists and clients through their talk negotiate psychotherapeutic practice. In particular, writers have examined aspects of therapist/client interactions that include therapists' uses of formulations to summarise the client's preceding talk (Antaki, Barnes & Leudar, 2005), how therapists negotiate empathy with their clients (Weiste & Peräkylä, 2014; Wynn & Wynn, 2006), and when and how therapists disclose information about themselves in pursuing therapeutic outcomes (Leudar, Antaki & Barnes, 2006). This approach, of course, stands in contrast to other approaches that treat psychotherapy as primarily an intrapsychic or inter-relational process: a conversation analytic perspective treats the talk in therapeutic encounters as social action in itself and as the focus of attention for studying how participants negotiate the therapeutic process.

To date, much conversation analytic research has centred on psychotherapy as process, that is on how different elements of therapist/client interactions construct these encounters in terms that enact therapeutic practice. More recently, however, attention has turned also to the study of therapeutic change as a feature of therapist/client interactions, focusing on changes in the form of interactions over the course of the therapeutic process and in how potentially difficult issues are discussed. Previous work has pointed to changes found in encounters between therapists and individual clients, particularly changes in how sequences of talk about individual difficulties are modified or

transformed over time (Voutilainen, Peräkylä, & Ruusuvuori, 2011; Voutilainen, Rossano, & Peräkylä, 2018). To date, however, there is an absence of work that has applied this approach to a group psychotherapy context. Here we aim to extend understanding of psychotherapeutic change as an interactional phenomenon by examining if and how change occurs in the interactions found in a multi-party psychotherapeutic setting. We examine specifically the interactions occurring in a time-limited psychotherapy group conducted with mothers who had been referred or had self-referred for psychotherapy on the basis of having postnatal depression. In considering these interactions over the duration of the group, we examine changes in the organisation of this multi-party talk and the consequences of such changes for the process in which the therapist and the group members are engaged.

Talk in psychotherapeutic settings

Reviewing recently the literature on talk in therapeutic encounters, Tseliou (2018) notes that a considerable volume of work has examined how the therapist and client jointly construct therapy in the moment-to-moment of the interaction. Much of this work has focussed on the study of process, looking at how psychotherapy actually gets done in the interaction (e.g. Antaki, 2007; Peräkylä et al. 2008). A particular focus has been on demonstrating how the talk enacts the institution of psychotherapy, that is on how phenomena that other perspectives often treat as psychological or internal to individual clients or as intra-relational can instead be viewed as outcomes of the therapist/client interaction. For example, Antaki (2007) shows how mental health professionals can do rapport with their clients in therapeutic encounters by summarizing in idiomatic terms the accounts that clients provide. Thus, a phrase such as “at the end of the day” can be used to sum up what a client has described in an ostensibly everyday form and introduce a basis

for further therapeutic discussion. On a similar note, Antaki, Barnes and Leudar (2005) show how therapists use formulations to sharpen up or clarify the problems that a client has introduced, thereby attributing the problems to the client and rendering them amenable to the psychotherapeutic process. The therapeutic encounter, thus, can be understood as a collaborative interaction between therapist and client that is produced by the conversational contributions of both parties (Strong & Smoliak, 2018; Sutherland and Strong (2011). Similar forms of negotiation are also seen in studies of interactions in family therapy contexts, especially those in which previous patterns of interaction between family members are taken to be counter-productive and a therapeutic goal is to move towards more effective conversational exchanges (Strong & Tomm, 2007).

Recently, attention has turned from a primary focus on how therapists and clients enact therapy, by negotiating how problems are to be understood, to the study of therapeutic change within the process. For, as Muntigl and Horvath (2014) point out, doing therapy is not simply about engaging in a particular form of interaction but also about engaging in such interaction with an anticipated outcome of change. In taking up this topic, conversation analysis of therapeutic interaction can also shed light on how the therapist and client jointly perform change in the course of the encounter (Peräkylä et al., 2008; Voutilainen et al., 2011). For example, detailed analysis of sequences of therapeutic talk can show how different forms of therapists' turns are taken up or not and the consequential relevance for how the therapist and client co-construct an account of the issues to be addressed (Muntigl, 2016). A therapist's turn that merely acknowledges what the client has said previously can meet with a minimal response, whereas therapists' turns that offer illustrations of clients' difficulties and that signal affiliation with clients' emotions are more likely to result in further discussion of those difficulties. The clients' personal narratives that emerge from psychotherapy sessions can thereby be seen as co-

constructed interactional accomplishments, reflecting the active role of the psychotherapist in facilitating and shaping the troubles-telling that led the clients to engaging in the therapeutic process (Mandelbaum, 2013; Pawelczyk, 2012).

Interaction and longitudinal change

Psychotherapy, of course, usually involves not just a single interaction but a series of encounters between therapist and client(s). It is necessarily a longitudinal process in which change is expected over the duration of the therapy (Voutilainen, Rossano, & Peräkylä, 2018). The question of how to study such change is however a potentially tricky one for methods that foreground the study of talk in the moment-to-moment of the local context. For, the immediate context of talk inevitably changes throughout the course of any single interaction, let alone across multiple interactions.

The challenge for conversation analysis then becomes one of identifying, in a series of interactions in which change will be found in any event, elements that might signal therapeutically-influenced change. A potential way of addressing this challenge, Voutilainen and colleagues (2011) suggest, is for the analyst to examine sequences that are interactionally similar but that occur at different points in the process. As noted above, therapists can respond to clients' descriptions of problematic experiences in a range of ways that summarize those descriptions and that do or do not encourage further descriptions. Thus, the therapist's conclusions following client's descriptions and the client's subsequent responses to these conclusions constitute two-part sequences that offer scope for study. By focusing on these two-part sequences at different points of the process, the researcher can see how the therapist's conclusions and the client's uptake of these varies over time. More recently, Voutilainen and colleagues (2018) argue for the potential applicability of such an approach across different forms of therapy, suggesting

that in each case therapist/client interactions demonstrate “thematic threads” that signal the central areas of continuing discussion. Study of change then comes to focus on the therapist’s interventions at the points where the thematic threads become relevant, the client’s responses, and how the thematic threads and ensuing two-part “focal sequences” are seen to change over the course of the process.

The identification and analysis of thematic threads and focal sequences offers possibilities for studying therapeutic change over time. This focus is however specifically designed to examine changes in two-party talk in settings involving a therapist and a single client. Yet, often psychotherapy is delivered in group settings rather than one-to-one encounters. And in such multi-party settings, talk will not readily fall into sequences similar to those found in therapist/client encounters, in that anyone co-present can potentially contribute to ongoing discussions at any point. In multi-party settings participants design their talk to orient to all present, taking into account who the recipients of talk are and their relationships to the individual speaker (Schegloff, 1997). Moreover, how people design and organise their talk in group settings will reflect also the discursive projects in which the participants are engaged, whether joking, telling stories to others, or otherwise (Sacks, 1978). In contexts such as group psychotherapy encounters, therefore, the organisation of talk will reflect participants’ orientation to that context and how others co-present respond to the talk. For example, Pudlinski (2005) notes that where people describe experiences of personal difficulties, or provide “troubles-tellings”, the responses of peers have particular consequences for how the troubles-teller continues with his/her description. Where peers respond to troubles-tellings by sharing experiences similar to those of the prior speaker their turns demonstrate more than basic concern for the troubles-teller and thereby facilitate the continuation of that description. How participants in group settings co-construct troubles and their potential resolution will,

therefore, not just involve the therapist and an individual client but will instead reflect the contributions (or lack of contributions) of all who are co-present. Studying how these co-constructions change over the course of therapy, then, will necessarily go beyond the examination of two-part sequences to the consideration of talk in the therapeutic sessions more generally. What becomes relevant is if and/or how participants align with topics under discussion, how participants' turns shape the discussions as they proceed, and if and how these interactional elements provide for co-construction of participants' experiences in the group therapy context.

The present study

Here we consider a specific instance taken from a time-limited psychotherapy group involving mothers who had been referred (or self-referred) on grounds of experiencing post-natal depression. As Muntigl (2016) points out, the talk of individuals presenting with depression is often marked by difficulties in expression of emotions, by absence of personal agency, and by lack of disclosure of specific details of life circumstances. Such communicative difficulties, and the consequent disfluency in interpersonal interactions, have long been recognised in studies of the communications between mothers who are experiencing post-natal depression and their children (e.g. Murray, Kempton, Woolgar & Hooper, 1993; Trevarthen & Aitken, 2001). Furthermore, the disfluent patterns of communication shown by post-natally depressed mothers are not restricted to mother-infant interactions but are evident also in their interactions more widely. For example, in a study of calls to “a help-line that women can ring if they want to talk about a traumatic birth”, Kitzinger and Kitzinger (2007) found that a central feature of the interactions between callers and call-takers is how callers are facilitated and enabled to talk about their experiences. In particular, certain forms of opening turns that

use conversational continuers (“mm hm”, “ah”) to invite telling of troubles can signal empathy with the caller and lead to greater fluency in the ensuing talk. The talk occurring within a group for mothers experiencing post-natal depression, then, offers fertile ground for studying if and how therapeutic change can be seen over time in the interactions occurring in a psychotherapeutic group. We pursue that aim in the present study.

Method

Data

The data come from a series of group psychotherapy sessions run weekly over a six-week period. These sessions were organised and provided by a national counselling and psychotherapy service in Scotland, UK, and were facilitated by a fully qualified psychotherapist employed full-time within the service. The service routinely provided psychotherapy to individual clients on a 1:1 basis. In order however potentially to reduce an increasing waiting list of individuals seeking psychotherapy, the service offered to those who had been waiting longest an opportunity to participate in a time-limited psychotherapy group. Such participation was offered on the basis of no detriment to the opportunity of subsequent 1:1 psychotherapy: on the conclusion of the group, members could return to their previous place on the waiting list if they wished to do so. Participants in the group were five mothers who had been referred to the service by general practitioners or health visitors or who had self-referred, on the basis of experiencing postnatal depression. No formal diagnosis or specific symptoms were required for referral. Participants were aged between 29 and 38 years and had babies ranging in age from 3 to 9 months. All participants were first-time mothers. Prior to the commencement of psychotherapy sessions, participants were provided with details of the study and asked if they would consent to take part. They were advised that participation or non-

participation in the study would not affect their eligibility to take part in the psychotherapy group or to receive psychotherapy from the service. All group members consented to participate and to their data being used in the present analysis. Four members of the group attended all six sessions; one member was unable to attend the first session but attended the subsequent five sessions.

The psychotherapeutic approach used within the group drew upon principles of psychodynamic group psychotherapy, combining a focus on intrapsychic and interpersonal phenomena and consideration of the dynamics of the group-as-a-whole (Rutan, Stone & Shay, 2014). Each group session lasted for approximately one hour. The researchers were not present during these sessions. The sessions were audio-recorded and later transcribed in accordance with the notation system devised by Jefferson (2004). Pseudonyms were substituted for participant names in order to ensure anonymity.

The service granted organizational consent for the study to be conducted and ethical approval was granted by a University Ethics Committee.

Analysis

We read and re-read all transcripts in order to gain familiarity with the data set. The transcript for Session 1 comprised introductions within the group setting and discussion of the parameters of how the group would run. This session was formally structured with the facilitator organising turn-taking by selecting next speakers and centred on discussions of pre-determined topics. It was therefore disregarded for purposes of the present analysis. Data from the remaining sessions were analysed in accordance with principles of conversation analysis (Sacks, 1992; Sacks, Schegloff & Jefferson, 1974). Initial analysis focused on the sequential organisation of the discussions, examining turn-taking, and conversational flow, as well as the extent and form of

contributions from the facilitator and other group members. Passages that displayed fluency and disfluency in turn-taking and conversational flow were selected for detailed analysis. Analysis thereafter turned to close examination of first, the forms and organisation of the contributions by members of the group and the therapist during the discussions (“turn-construction”), second, who spoke and was recognised as the appropriate person to speak at different points of the discussions (“conversational floor”), and, third, instances of co-construction of meanings by group members. We examined also if and how group members aligned themselves with or distanced themselves from matters under discussion in the moment-to-moment talk in the group. This analysis was conducted both in relation to talk within individual sessions and across the data set as a whole, in order to explore if and how the sequential organisation of talk within the discussions varied across the six-week duration of the psychotherapy group.

Results

Early group sessions

We begin by examining the talk found in the early stages of group discussions. The first three extracts are taken from Session 2, the first session in which members talked at any length about the issues that had led them to approach the service and participate in the group. Extract 1 comes from an early part of that session and begins with a question from the therapist directed to a specific member of the group, Sarah.

Extract 1

- | | | |
|---|-----------|---|
| 1 | Therapist | I am wondering what you feel it <u>needs</u> to express |
| 2 | | something of the difficulties of this place you are in |
| 3 | | (.) |

4 Sarah For me (.) there is some aspect of failure about it (.) but
5 (.) more than that (.) it's the idea that (.) I can't get that
6 time back and I am worrying that all the time that I am
7 feeling this way (.) that I am missing something which
8 >if I had been myself< would have been really special
9 (.) and it's lost (.) forever

The exchange seen in Extract 1 takes the form of many exchanges found in sessions 2 and 3 of the group meetings. The therapist at lines 1 and 2 begins with a question of the sort commonly found in therapeutic settings, introducing the topic of discussion of difficult feelings and asking how the recipient, Sarah, feels she might express them. The introduction of the topic in this way invites Sarah in her next turn to tell of these difficulties and possible expression of them.

Sarah, however, does not immediately respond by providing a description of the sort that is invited. Rather, the therapist's question is directly followed at line 3 by a pause in the exchange. Such a delay signals some difficulty in the interaction, here indicating a difficulty for Sarah in responding to the question posed. Moreover, the initial framing of the response that does follow, "For me", does not suggest personal investment in the description of feelings that is to follow, and this framing is followed by another pause indicating further interactional difficulty. Conversational turns that display such delay, as Pomerantz (1984) has noted, commonly indicate that the individual is in some way disagreeing with elements of the immediately preceding turn. In the present case, as Sarah continues it becomes apparent what more specifically she is disagreeing with and treating as problematic in this instance. She does not pick up on what the therapist had introduced as the topic for discussion and instead distances herself from what is suggested

by the question. Her use of the neutral and abstract forms “there is some aspect of failure” and “it’s the idea that”, at lines 4 to 5, attribute what is being expressed to an unspecified source external to Sarah and thereby distance her from these feelings. In the second part of her response, at lines 5 to 9, Sarah does ascribe feelings to herself to the extent that she is “worrying all the time” about how she is feeling. This is then developed in terms of a sense of loss, with Sarah at line 7 referring to “missing something” and at line 9 to what she is referring to as “lost forever”. Even in expressing these feelings, however, Sarah attributes their cause to an unspecified source that is somehow distinct from her, in that she would not have those feelings if she “had been [her]self”.

This response, then, works to describe feelings as invited by the therapist’s initial question. To this extent it aligns with that question. At the same time, however, Sarah’s response is marked by hesitations and she distances herself from the feelings that she is describing. In Extract 2 we see a similar form of exchange. This extract also begins with a question from the therapist relating to the feelings of a specific group member, here Julie.

Extract 2

- | | | |
|---|-----------|---|
| 1 | Therapist | I didn’t get a sense of (.) nobody of actually sitting down |
| 2 | | and asking how are you <u>feeling</u> (.) what’s going on for |
| 3 | | you |
| 4 | | (.) |
| 5 | Julie | no (.) the first thing that happened on my six-week |
| 6 | | appointment when another midwife came and gave me a |
| 7 | | post-natal depression form and went oh you have hit |
| 8 | | twelve that’s the score we have to refer you to somebody |
| 9 | | else. (.) and I was like (.) all right (.) ok (laughs) so I |

10 failed my post-natal depression script test (.) so she was
 11 like so (.) you can go to the doctor and get some pills
 12 o::r you can get referred to something like Crossreach
 13 and I was like (.) I think I need to talk to somebody I am
 14 not terribly keen on doctors can I just try them please (.)
 15 and they referred me=
 16 Therapist =was that your health visitor you say
 17 Julie yeah
 18 Therapist uhm
 19 Julie I guess it is pretty bad isn't it?
 20 Anna yeah

The initial question from the therapist suggests that Julie did not have an opportunity to discuss her feelings with any other person. Unlike the question seen in Extract 1, the question here is framed in terms of the actions (or more accurately absence of actions) of others instead of Julie's own expression of her feelings. Again, the therapist's question is followed by a pause. Although this pause might indicate interactional difficulty of the sort seen in the exchange between the therapist and Sarah in Extract 1, any such potential difficulty is here resolved in Julie's subsequent response. Julie's initial "no" at line 5 indicates agreement with the therapist's suggestion that Julie was not asked "how are you feeling (.) what's going on for you".

As she continues, however, Julie does not orient to the question as offering an opportunity for expressing her feelings and instead provides a response framed in terms of the actions of others. She refers to the time when she was first described as experiencing "post-natal depression". This is described in terms of an appointment with

“another midwife”, a description that suggests that the individual to whom she refers was not someone with whom she was previously familiar, and by reference to a “form” and the “score” that led to an outcome of requiring action. The event is thus made out in somewhat impersonal terms, in contrast to any personal discussion of her feelings. Julie at lines 9 to 10 presents herself as being accepting of this outcome, stating that it was “all right” and “ok”. It is also interesting to note her laughter at this point. Given that Julie has been describing experiences in problematic terms, and that she is about to describe these experiences further, laughter at this point would not suggest that she is treating these in a humorous manner. Rather, in the context of an episode of troubles-telling, her laughter here functions in a somewhat different way. Jefferson (1984) noted that troubles-tellers often invoke laughter to demonstrate to others who are co-present that they are not totally overwhelmed and can cope with the troubles being described: laughter can demonstrate “troubles-resistance”. In the present case, this display of troubles-resistance provides the basis for Julie to continue by describing how she sought to address her troubles, rejecting one possible course of action of going to the doctor to “get some pills” and instead opting for being referred to the organization that is providing the psychotherapy.

As with the exchange seen in Extract 1, it is interesting to note how Julie’s response is produced. First, her description of the interaction leading to her referral to the PND service is worked up in terms that are impersonal and external to her. Second, this is given heightened emphasis through the use of “reported speech” throughout the description, with Julie referring to the utterances of the “midwife” and her own responses. By describing her interaction with the midwife in this way, Julie presents it as a replay of an event that others co-present can actually witness instead of it being her second-hand account of that event. As Buttny (2003; 2004) argues, reporting the speech of others in a description distances the speaker from what is being expressed and instead lends the

description an ostensibly more “objective” quality: by locating elsewhere the source of what is being described it provides apparent evidence for the speaker’s claims. Here, the reported speech of the midwife gives a matter-of-fact quality to Julie’s description of how she was classed as experiencing from postnatal depression: her description suggests that the others present are in a position to evaluate her experiences for themselves. It thereby removes Julie further from having any meaningful input into the diagnostic process except for being presented with the option of choosing between two possible outcomes. Third, these elements taken together work to contrast Julie’s experiences that led her to the PND service with what might have been more desirable: instead of anyone asking her how she is “feeling”, she has being identified during an impersonal interaction as having “failed [the] post-natal depression script test” and this failure led to a particular outcome.

Following turns at lines 16 to 18 that refer to the individual who referred Julie to the PND service, Julie at line 19 offers a candidate upshot (Antaki et al., 2005) that draws out the relevant implication of the description of her experience that she has provided. Her upshot provides a negative evaluation of her experience, describing it as “pretty bad”. She provides this evaluation in tentative terms, prefacing it with “I guess” and following it with a questioning “isn’t it” that invites support for the evaluation. As can be seen, however, the support provided within the group at this point is minimal. The agreement marker, “yeah”, provided at line 20 by another group member Anna is not pursued further and Julie’s turn is treated as completed.

In Extract 3, we how the discussion continued thereafter.

Extract 3

- 1 (3)
2 Therapist Was it the same for you?

3 Anna Yeah (.) she noticed after few weeks of coming visiting
4 (.) that I was feeling worse and worse (.) and she talked to
5 me (.) for hours sometimes and she gave me this test to
6 fill in and I had a really bad score (.) she actually worried
7 about me (.) that was a week she called me every day to
8 make sure I am >you know< doing ok (.) and she referred
9 me here as well
10 (3)
11 Therapist and how did that feel for you?

As seen at line 1, the exchange in Extract 2 that concluded with Anna's minimal "yeah" was followed by a lengthy pause. Although this appears to be a transition-relevant place, no group member self-selects as next speaker. Following the pause, the therapist invites Anna to discuss her experiences, thereby selecting her as next speaker and treating Julie's turn as concluded. In response to the therapist's question, Anna describes her feelings as deteriorating over the post-partum period, stating that she "was feeling worse and worse". Like Julie in Extract 2, she refers to a "test" that she was required to undertake and on which she achieved "a really bad score". Similarly, to Julie's descriptions of her experiences in Extract 2, this "score" is stated to be the basis for her subsequent referral to the PND service.

As with the previous extracts, Anna's description makes no reference to her own experiences of her feelings. Instead, the description is developed in terms of how an unspecified individual, referred to as "she", understood Anna's feelings to be. The description thus is framed in terms of that individual's observations, in that "she noticed" these feelings, and on the grounds of these observations that individual engaged in a

series of actions including the provision of the “test” that subsequently led to Anna’s referral to the service.

Setting out her description in this way serves to introduce Anna’s feelings and a negative assessment of them into the discussion, accounting for her presence within the group. Similarly to the descriptions in the earlier extracts, however, this form of description distances Anna from personal investment in the feelings that she describes and attributes the source of these difficulties to an external source. Nonetheless, this description is thereafter treated by the therapist as complete in that it is followed by other questions addressed to Anna on ancillary topics (not reproduced here).

What we see in Extracts 1, 2 and 3, then, are three specific features of how the talk proceeds in these interactions. First, in each case the group member distances herself from the topic of feelings introduced by the therapist. Although in each instance the therapist begins with a question that invites the participant to discuss her feelings and the difficulties surrounding them, each participant responds by distancing herself from expression of personal feelings, except insofar as the relevance of such feelings is attributed to or recognized by an external source. Second, turn-taking in these exchanges takes a very routinised form. Each exchange begins with the therapist directing a question to one participant, thereby selecting her as next speaker, and following a response no group member self-selects as next speaker. The therapist then selects the next speaker, either with either a question to another group member or a question to the prior speaker on an ancillary topic. Third, contributions from other group members to speakers’ descriptions of their experiences are either minimal, as seen in Extract 2, or non-existent, as seen in Extracts 1 and 3. There is no extended interaction among group members or co-construction of experiences in this group setting. All these elements constitute a hesitant and stilted form of interaction in the early group sessions, pointing to the sensitive and

problematic nature of the topics under discussion.

Later group sessions

We turn now to consider exchanges in the later stages of the group's discussions. The next three extracts are taken from the final session (session 6) and comprise exchanges that were markedly different from the forms seen in the early session. The exchange in Extract 4 comes near the beginning of the final session and follows an initial summary by the therapist of the group's discussions to that point and a question as to what the group members would like to discuss in their final session.

Extract 4

- 1 Carol I think >just from listening to everyone< it sounds like
2 we all have been slightly failed by the system and we
3 are still almost fighting it all the time (.) and you kind
4 of go (.) we live in the dark ages and (.) I am not a
5 feminist but it`s like you go to work so it`s work and
6 you have to go to a doctor and they don`t give us right
7 advice and you think somewhere along the lines there
8 is something really wrong isn`t it? That we have all
9 these problems (.) that would be my view
- 10 Therapist so you would see it as connected with the system=
11 Carol =to me definitely absolutely yeah like you were [saying
12 Anna [yeah
13 like for me it`s such a shock (.) I came here (.) to this
14 developed country comparing to my country I mean

15 that country was like thousand years behind I thought
16 or hundred (.) but I came here and I can see now and I
17 can compare with whatever I was staying in before and
18 I now I feel that this in here is like the dark ages

In the exchange above, the participants are discussing what are described as systemic problems with the post-natal care that they received. The exchange begins with Carol at lines 1 to 3 arguing that the participants have been “failed by the system”, leading to an outcome that they need to be “fighting it all the time”. She offers a highly negative assessment of the “system”, describing experience of using it as being akin to living “in the dark ages”. She offers grounds for this criticism at lines 5 to 7 in claiming that when those such as herself have to consult “a doctor” then that doctor does not “give us right advice”. This provides the basis for her subsequent claim that “there is something really wrong isn’t it”. And, these negative assessments pave the way for her upshot at line 8 that it is the failings of the “system” and those who work within it that are accountable for “all these problems”, an upshot that works to attribute responsibility for the difficulties experienced by individuals.

One point of interest here is that Carol’s turn is offered not as an individual one but rather on a collective and shared basis. At the beginning of this turn, she grounds what is to follow in her understandings of what all members of the group have been saying, stating at line 1 that her claims arise “just from listening to everyone”. Many of her claims in the remainder of the turn rely on the use of collective pronouns: the “we” at lines 1, 2, 4, and 8, and the “us” at line 6, all serve to present her claims as applying equally to herself and the other group members. Moreover, the use of the generalized “you”, at lines 3, 6 and 7, suggests that such experiences go beyond herself and other

group members to a more general group of people who will share similar experiences. This serves to present her claims as not in any sense specific to her but instead as part of a more general and common pattern of interactions with the healthcare “system”.

The therapist at line 10 provides a summary and reformulation of Carol’s claims that meets with Carol’s emphasised approval at line 11. Unlike the exchanges seen in the earlier extracts, however, this turn does not lead to lengthy silence or to the therapist posing a further question or re-allocating the conversational floor. Instead, the end of Carol’s turn at line 11 meets with overlapping talk from Anna who expresses agreement with what Carol has stated and who upgrades Carol’s earlier assessment of the healthcare system. Whereas Carol had at line 2 described herself and other group members as having been “slightly failed’, Anna at line 13 describes her experience of the healthcare system as “such a shock”. She thereafter warrants this assessment by means of two interwoven contrasts, one of what she expected from a “developed country” in contrast to her own country which she thought was “like thousand years behind I thought or hundred” and the second of what she found on using the healthcare system and a contrast between those experiences and her experiences of “whatever I was staying in before”. This leads to her upshot at line 18 that both summarizes the claims that she has made and echoes Carol’s earlier assessment, stating “I feel that this in here is like the dark ages”.

Extract 5 comes from a slightly later point in the group discussions of their experiences of the healthcare system. There has been no intervening turn by the therapist.

Extract 5

- | | | |
|---|------|--|
| 1 | Anna | To me like it`s a shock, because for everything there is |
| 2 | | one GP (.) so whatever you feel you have to go to your |
| 3 | | GP first whilst in my country or in Sweden or USA if |

female organs” can go direct to a “gynaecologist” instead of “this GP thing”. The latter element, GPs lack of knowledge is developed at lines 6 to 8 where Anna states that she “feels” that they sometimes have less knowledge than she herself has and that they have to rely on finding necessary information through an internet search.

Again, this description meets with the immediate agreement of other group members, with Carol and Val at lines 9 to 11 stating that they too have witnessed GPs searching for information that they did not have, in the manner described by Anna. Following this agreement, Anna continues by offering a further candidate description of the actions that GPs take in such circumstances, arguing that they are seen to be “looking in a textbook to diagnose something”. She gives a highly critical assessment of such an action, stating that it is “just appalling” before offering an upshot that characterises such experiences as resembling healthcare practice that is long outdated, stating that “it’s like going to a doctor in the 13th century or something”. Not only does this upshot emphasise the extent to which such practice can be viewed as inappropriate, but it also echoes the use of temporal referents in providing critical assessments of healthcare seen in Extract 4.

The collaborative criticism of the healthcare that the participants received continues at line 15 where Carol takes up the topic of medical ignorance and introduces an account of her experiences of consulting a doctor in relation to her son. She frames this account as being something that she can “remember” and sets out her criticism using reported speech of the doctor in question. This however is not presented simply as reported speech but rather as a recollection of what the doctor “actually said”. All of this discursive work functions to emphasise rhetorically the veridical quality of what she is reporting. Carol goes on to describe how the doctor herself questioned her own knowledge of “babies or children”. This questioning, and the lack of knowledge that it implies, becomes all the more culpable through being presented as accurate recall of the

exact words used on that occasion. And, this criticism is reflected in Carol's recall of the emphatic way in which she internally responded to the doctor's lack of relevant knowledge, stating that she "thought, oh my god".

In Extract 6 we see another exchange in which the participants collaboratively work up an account of their experiences. This exchange follows a question by the therapist that asked whether the group members have reached a different understanding of what was going on for them. Here, in contrast to Extracts 4 and 5, the participants are discussing the topic of how they make sense of themselves as mothers.

Extract 6

- 1 Val I am a type of person that doesn't give myself any time
2 (.) I beat myself with a stick
3 all (laughter)
4 The doctor was telling me >last time I saw him< (.) put
5 yourself down and beat yourself with a stick (.) you
6 always do that (.) he said just forget about that
7 Therapist How did you feel when he said that?
8 Val I started laughing (.) cause I thought do I? (.) and I
9 thought (.) I do (.) I give myself hard time even when I
10 am doing ok
11 Sarah Do you think you are a perfectionist?
12 Val yeah (.) probably (.) I try to be
13 Sarah Do you recognize it?
14 Val I have never been asked that (.) do you think you are a
15 perfectionist? I would have [probably said

16 Sarah [cause you like to get things
 17 done in a certain way and you feel happy when it`s done
 18 in [a way
 19 Val [yeah=
 20 Anna =yeah, I am the same way.
 21 Therapist So (.) is it ringing bells for you?
 22 Sarah Yes yes (.) so would you say you are a perfectionist (.) it
 23 means (.) when you have a baby you can`t achieve
 24 perfection because there are so many side balls coming
 25 and you just have to go with a flow but more and (.) it`s
 26 hard to do that when you are used to being in control and
 27 doing things your way or getting things done (.) you
 28 have to accept that those things probably won`t get done
 29 that way >you just have to accept that< otherwise you`ll
 30 be miserable for months (.) I have
 31 all (laughter)

In the first part of the exchange above, Val at lines 1 to 10 develops an account of type of person who she is, namely a person who gives herself a “hard time even when I am doing ok”. This description of herself is emphasised through the repeated use of the idiomatic “beat yourself with a stick” that treats the description that Val is producing as one that is readily recognisable and in need of no further warrant. It is however further established through her use of the reported speech of the doctor who is described as referring to her in this way, and also by the turn of the therapist at line 7 that treats the reported speech as an accurate recall of the instance to which Val refers. More than this,

however, we can note that at line 3 the other group members produce laughter in response to the first part of Val's description. Unlike the laughter produced by Julie herself in Extract 2 as part of her troubles-telling, the laughter here is shared by all members of the group. Here, the shared or "collusive" quality of the laughter (McKinlay & McVittie, 2006) serves to align all group members with the initial part of Val's description and the further account of herself that it projects.

At line 11, Val's description of herself is taken up in a question not by the therapist but instead by another group member Sarah. In doing so, Sarah introduces a candidate explanation as to why Val might describe herself in the way set out, asking if Val considers herself to be "a perfectionist". There follows a sequence of further turns from Sarah and Val, with Sarah providing further detail as to why she has produced the candidate explanation of Val's personality and ultimately leading at line 19 to Val's agreement with the candidate personality trait that Sarah has ascribed to her. The reference to being "a perfectionist" also leads Anna at line 20 to attribute the same trait to herself, thereby lending weight to its relevance as an explanation in this context.

The relevance of the explanation on offer is also taken up in the subsequent question from the therapist to all members of the group at line 21, where she asks if the explanation on offer is a familiar one that is "ringing bells". In response to this question, and following the agreement of Val and Anna with the candidate explanation that she introduced earlier in the exchange, Sarah again takes the conversational floor. She continues by further developing the explanation that has now met with agreement, working up the relevance of being "a perfectionist" in terms of what happens "when you have a baby". This is set out in terms of the inevitable consequences of being a mother and letting go of previous ways of living in that "you have to accept that those things probably won't get done". The development of this explanation then paves the way for

Sarah's upshot of her turn at lines 28 to 29 that if a person fails to recognise the inevitability of changes that result from having a baby then "you'll be miserable for months", an outcome that she states has applied to her.

We can note that this expanded description of the consequences of being a particular type of person meets with the agreement of the remainder of the group, as indicated by the collusive laughter at line 31. Following an initial description by one group member (Val), another member (Sarah) has introduced and developed a description of a candidate explanation as to why this outcome has come about, and this explanation has received explicit agreement from two group members (Val and Anna). The relevance of the explanation for other members of the group is signalled through the collusive laughter at the beginning and end of the exchange. As importantly, the exchange is marked by the absence of hesitations, by what appears to be seamless turn-taking, and by group members themselves building on prior turns and using the conversational floor as necessary. And, this agreement marks the successful outcome of the group members' collaborative efforts: with minimal input from the therapist, the group members have themselves worked up an explanation as to why they have been "miserable for months".

Discussion

This study has examined how the patterns of interaction within a time-limited psychotherapy group changed over the duration of the group. The study is, of course, a case study of a specific psychotherapy group that comprised participants with a shared basis for referral to psychotherapy, namely experiences of post-natal depression. Furthermore, the therapeutic approach used within the group followed a particular model, based on principles of psychodynamic group psychotherapy. Given these limitations, further work is required to investigate the applicability of the present findings across the psychotherapeutic realm more generally. Nonetheless, these findings do point to the

benefits of examining in detail the communications of all involved in the group context. Adopting the conversation analytic approach used here, we can see how members design their talk to orient to all who are co-present (as facilitator or co-participant) and how they respond to and enact the changing and evolving group context of group psychotherapy.

The present findings show that over the duration of the psychotherapy group the patterns of interaction changed in three ways. First, the group members altered their alignment with the topics being discussed, specifically in relation to their own feelings. Second, the pattern of turn-taking within group discussions was seen to change from one in which the facilitator predominantly selected the next speaker to one in which the next speaker self-selected. And, third, and relatedly, the forms of discussion within the group moved from sequences primarily comprising question and answer adjacency pairs to extended exchanges in which participants collaboratively worked up accounts of their experiences. These changes we consider in turn.

As regards the first change, one recurring finding in the literature is that therapists use various discursive means to attribute to their clients personal agency for what is being described. It is this, after all, that enacts psychotherapy as institutional practice, framing clients' problems in a manner that renders these amenable to psychotherapeutic intervention. Thus, therapists produce formulations and upshots that treat what is being described as belonging to the individual and thereby as being potentially available for change. Clients, of course, can resist such attempts to attribute the sources of problems to them personally. Such resistance, however, is likely to be taken up as displaying resistance to psychotherapy (e.g. Muntigl, 2013; Weiste, 2015). In the present case, the externalising and resistant responses seen in the early extracts met with little response from the group facilitator; instead of providing a basis for reformulation of issues raised within the group they were instead not continued at that point and not pursued further

until later in the group sessions. By contrast, participants' alignment with their feelings and others in the later sessions of the group displayed the sort of personalisation required for therapy to function as therapy: this change demonstrated a greater readiness to engage with the therapeutic process than the distancing seen in the early stages.

The second change, in patterns of turn-taking within the group, also pointed to participants' greater engagement with the process in the later sessions than in the early stages. In so far as participants self-selected as next speaker, so the role of the facilitator in selecting next speaker became less necessary, eventually to the point where her turns became less visible: the participants picked up on transition-relevant points and contributed to ongoing discussion without being directed to do so. Moreover, the flow of discussion was over time punctuated by fewer pauses, especially of any length, and fewer hesitations. All of this suggests that participants came to treat matters under discussion as being less immediately sensitive and as more open to discussion (cf. Sacks, 1978).

The third change, reflected in the participants' collaborative efforts in developing accounts of their experiences, similarly points to greater fluency in the group discussions. As noted earlier, how participants design their talk will orient to the contributions or absence of all who are co-present in the group context. And, in settings in which other group members do not contribute to the troubles-tellings of individual members then such stories will be marked as problematic, as seen in the early stages of this particular group. Where, however, others share experiences similar to those of a prior speaker then this will produce benefits in the group context. One benefit, consistent with the findings of Kitinger and Kitinger (2007), is that sharing of experiences will be treated by individual members as displays of concern and encourage the telling of difficult experiences. A second benefit, as noted by Pudlinski (2005), is that the communicative processes resulting from displays of concern will reflect collaboration within the group in

developing an account of troubles and potentially also their resolution, thereby enabling the co-construction of accounts that make sense of the participants' post-partum experiences. In this, the interactions in the later sessions of the present psychotherapy group resemble those found in other therapeutic groups. For example, in a study of discussions in Alcoholics Anonymous groups, Arminen (2004) found that the "second stories" or responses by other group members to a description of difficulties signalled alignment with the previous speaker's experiences while also offering re-interpretations that might point towards possible resolution. Moreover, as Halonen (2008) notes, a group setting offers opportunities to share and learn from others' accounts of their experiences even where the precise nature of those accounts differs from one group member to another. And, in examining individuals' stories of suffering in a group context, Bülow (2004) found that sharing of experiences enabled participants to develop collectivised understandings of experience that allowed them to make sense of their own experiences.

Taking these changes over the course of the sessions to indicate that the participants had benefitted from participating in the psychotherapy group, this leaves the question of the basis for that change, that is to what extent the changes seen here should be attributed to the process of psychotherapy and to what extent these might be attributed to group processes and peer support. In large part, these possibilities are inseparable, especially in relation to the integrative approach to group psychotherapy used in the present case. The approach used sought to balance a focus on intrapsychic and interpersonal processes on the one hand, with a focus on the dynamics of the group-as-a-whole on the other. From this perspective, psychotherapeutic change in a group setting might be viewed as cyclical: in so far as participants individually discuss issues that have brought them to therapy, then the group context will more likely involve sharing of experiences. Such sharing can in turn facilitate individuals' efforts to make sense of their

own experiences. These potential changes are particularly relevant for post-natally depressed mothers. Given that their patterns of interpersonal communication are found to be problematic across a wide range of potential interactions, and that more effective interpersonal communication relies heavily on how others respond to mothers' interactional turns, it might reasonably be anticipated that group interactions will demonstrate greater fluency when participants both produce and respond to turns with increased investment in the descriptions of experiences that are being discussed.

One implication of these findings for psychotherapeutic training and practice lies in the value of paying close attention to the linguistic details of discussions in a group context. Group settings have the potential to amplify therapeutic change occurring at any part of the cycle: changes occurring for any individual group member can feed into changes in the discussions of the group, and vice versa. While such possibilities for group therapy have long been recognised, the present findings offer the therapist more precise ways of identifying how and where therapeutic change occurs in group discussions. Attention to the immediate context of discussion might usefully inform understanding of the changes for individual members and the group in general and thereby shape further contributions of the therapist and other group members.

Finally, it should be noted that this study is the first to examine in detail interactional changes occurring over the duration of a psychotherapy group. More research is needed to examine if and how patterns of interaction can be seen to demonstrate psychotherapeutic change in other instances, considering other groups of participants, and other models of psychotherapy. Further work is also needed to examine the range of linguistic cues available to the therapist in the exchanges within a group and the consequences of different forms of turn for the subsequent interaction. Previous work on mental health more generally has shown that particular forms of intervention, or an

absence of intervention, can be taken up very differently in the ensuing interaction (Hepworth & McVittie, 2016); more work is needed to examine how specifically these contributions might function in the context of group psychotherapy. The present findings do, however, point to the potential contribution of such work for examining how change is negotiated in the moment-to-moment of the discussions of a psychotherapy group.

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