Social Science & Medicine 333 (2023) 116111

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Storytelling and affiliation between healthcare staff in Schwartz Round interactions: A conversation analytic study

Sarah Atkins [a,*], Alison Pilnick [b], Jill Maben [c], Laura Thompson [d]

[a] Aston University, UK
[b] University of Nottingham, UK
[c] University of Surrey, UK
[d] Metanoia Institute, UK

ARTICLE INFO

Handling Editor: Medical Sociology Office

Keywords:
Conversation analysis
Affiliation
Interaction
Storytelling
Emotion
Wellbeing in healthcare

ABSTRACT

It is well known that the demands of working in healthcare can take a psychological toll on staff. Schwartz Centre Rounds are an intervention aimed at supporting staff wellbeing through providing a forum to talk about the emotional, social and ethical complexities of such work, employing facilitated storytelling and group discussion to try and achieve this. However, while prior research, through extensive interviews and surveys, has found Schwartz Rounds to be effective in fostering compassion and wellbeing amongst participants, the talk that occurs within Schwartz Rounds themselves has not been explored. One mechanism that has been considered in how Schwartz Rounds function is the creation of a 'counter-cultural', conversational space, suggesting the nature of the interactions themselves may be important in achieving their beneficial effects. Using conversation analytic (CA) methods, we examine Schwartz Rounds in the UK to address, at a detailed micro-level, how sequences of talk work to accomplish the key aims of this setting. Five separate one-hour Schwartz Rounds were recorded across three UK hospital Trusts, between January 2019 and February 2020. Our analysis addresses how panellists tell their stories in a way that emphasises the uniqueness of their experience but also provides a generalisable emotional 'upshot' and 'stance' for the audience to later respond to. We then focus in on how audience members are able to respond to these stories affiliatively, offering *endorsements, generalisations* and *second stories*. Drawing on prior CA literature examining support groups and psychotherapy, we consider how the format of Schwarz Rounds creates important opportunities for interpersonal affiliation in this context. Considering these interactional features alongside other research findings on Schwartz Rounds, we discuss how opportunities for interactional affiliation may be central to their success, with implications for how these interactions can be best facilitated.

1. Introduction

Schwartz Rounds are designed to be supportive, interdisciplinary forums for groups of healthcare staff to meet together and reflect on the emotional, ethical and social complexities of their jobs. They originate in the USA, were introduced to the UK in 2009 by The Point of Care Foundation, and now run in over 200 UK healthcare settings. The report of the Francis Inquiry (2013), which examined the causes for poor care at a UK healthcare trust, recommended Schwartz Rounds as one means of promoting compassionate care and they have been found to be effective in fostering wellbeing and compassion for patients and other staff (Maben et al., 2018, 2021). In their face-to-face format in the UK, each Schwartz Round follows roughly the same structure:

- They last one hour in total, beginning with a short introduction by a facilitator or clinical lead (who is also usually a senior member of staff).
- The short introduction is followed by a multidisciplinary panel of 3–4 staff, presenting stories to an audience from across the hospital for a total of 15–25 min. These stories have been prepared in advance, with guidance from a Schwartz Round facilitator.
- After the panellists' stories, a trained facilitator guides the subsequent group discussion for the remainder of the Round (roughly

* Corresponding author. School of Social Sciences and Humanities, Aston University, Aston Triangle, Birmingham, B4 7ET, UK.
E-mail address: s.atkins@aston.ac.uk (S. Atkins).

https://doi.org/10.1016/j.socscimed.2023.116111
Received 15 March 2023; Received in revised form 18 July 2023; Accepted 20 July 2023
Available online 26 July 2023

30–40 min), allowing the audience to reflect on similar experiences and themes to those in the panellists' stories.

This structured interaction in Schwartz Rounds is explicitly aimed at nurturing staff wellbeing and compassionate care, with a central function being to share experiences across different specialisms and roles (including non-clinical roles). Although not part of the original programme design for Rounds, Maben et al. (2021) theorise that this activity works to establish a 'counter-cultural', 'third' space for Rounds, momentarily removing healthcare workers from the urgency and problem solving that are typical of their everyday healthcare work into a space where they can talk about experiences in a manner deliberately not oriented to institutional outcomes (p. 15). Maben et al. (2021) build on Wren's (2016) characterisation of Schwartz Rounds as counter-cultural, in the way that they 'shift an organisation and its workers away from their default position of urgent action, reaction and problem solving to an hour of stillness and slowness' (Wren, 2016: 41) as well the concept of 'third space', communal, hybrid spaces established 'in between' home and work (Oldenburg, 1999; Soja, 1996). The interaction between staff is central in generating this counter-cultural, third space, 'a space for dialogue between participants that is safe, secure and supportive, that 'stands in between' the formal areas of practice' (Maben et al., 2021: 17).

Maben et al. (2018) highlight how this space to share experiences through interaction can trigger 'resonance' with others (p. 108), something interviewees in their realist-informed evaluation commented on:

> [I]t's kind of 'oh I didn't know it was like that for you'. I think it strengthens the connections and the relationships with other people [...] it's this kind of shared experience around challenges.
> (Maben et al., 2018: p.105 – Ash–400-Schwartz Round Facilitator).

Audience responses to panellists' initial stories in Rounds may be a key means through which this sense of joint experience and joint endeavour is achieved. In the interview data from Maben et al. (2018), the few occasions when affiliative responses were not achieved were felt as a notable absence, as this interviewee suggests:

> I actually found that quite difficult 'cause I couldn't work out why that was and I felt like I'd actually made myself really quite vulnerable there […] and so I felt like I probably overstretched myself in terms of thinking it would be all right to present her [the challenging client] and maybe it wasn't […] people didn't respond to me, I didn't know why that was, and maybe it was too difficult for other people, as well […] I kind of regretted doing it afterwards.
> (Maben et al., 2018 – Elderberry-2-Facilitator-speaking-as-Panellist, supplementary file)

For this panellist, the space to recount a story was not sufficient for the Schwartz Round to feel like a helpful experience – there needed to be affiliative responses from the audience that expressed an understanding of the themes and emotional stance articulated. This echoes conversation analytic work on affiliation in ordinary conversation, which suggests that if story recipients do not adopt an 'affiliative stance' after the completion of a story, the responses are treated as insufficient by the original storyteller (Stivers, 2008: 49), as well as CA research on psychotherapeutic contexts identifying the importance of affiliative, attuned responses from counsellors and therapists (Voutilainen et al., 2010; Peräkylä, 2008). How this affiliation is done (or not done) within the structural constraints of Schwartz Rounds seems important to the sense of their success and taking a CA approach to these data enables us to unpack the interactional processes through which this can be achieved.

2. Conversation analysis: storytelling and affiliation

Conversation analysis (CA) is a sociological method, drawing on insights from psychology and linguistics, that examines how we perform everyday social activities through talk. A general aim is to systematically analyse the 'orderliness' of naturally occurring interactions using audio or video recordings, with an emphasis on analysing participants 'in the activities in which they are employed' in the everyday sites in which they occur (Sacks, 1992: 27). These naturally occurring interactions are transcribed using notation which captures the compositional qualities (vocabulary, prosody, speed) and sequential order (including turn-taking and silences) of the talk, representing as much as possible of not only *what* is said but also *how* it is said (Jefferson, 2004). The recordings and transcripts are analysed together for how talk is jointly achieved between speakers through; (1) coordinating turns at talk, (2) organising actions into patterned sequences (such as question and answer), and (3) dealing with difficulties in shared understanding.

Storytelling, and the interactional opportunities it affords for others to respond, has been the subject of significant CA research. In telling stories, speakers do not simply recount sequences of events but convey their 'affective treatment of the events' or *stance* toward them, indicating to recipients the kind of responses likely to be desired (Stivers, 2008: 27). Stivers (2008) defined two important CA concepts in how recipients respond to storytellers: *alignment* (defined as a 'structural level of cooperation' with the activity of storytelling) and *affiliation* (an 'affective level of cooperation'). Aligned responses 'cooperate by facilitating the proposed activity or sequence', such as providing short continuers ('mhm') to allow a storyteller the floor (Stivers et al., 2011: 20). Affiliative responses, though, associate the recipient with the storyteller's *stance* and are 'maximally pro-social when they match the prior speaker's evaluative stance, display empathy and/or cooperate with the preference of the prior action' (Stivers et al., 2011: 21). In performing social interaction then, there is a preference to display not just structural cooperation with the storyteller (aligned responses) but also to show understanding and agreement with their stance (affiliative responses), particularly where a speaker recounts a first-hand experience with some degree of emotional intensity, providing the opportunity to respond during what Heritage (2011) terms 'empathic moments' in the talk.

In this context of Schwartz Round interactions, we use the term 'emotion' to refer to the expression of strong feelings by participants in the discussion. The term 'empathy' is significant in these emotionally complex interactions; participants in Maben et al.'s (2018) study used the term in describing benefits of participation. However, empathy can be a difficult phenomenon to define in interaction. The term has sometimes been used interchangeably with 'affiliation' in CA, with Jefferson (2002) suggesting affiliative responses 'could be understood as 'I feel the same way', 'I'd do the same thing'' (p. 1345) or affiliation described as the display of empathy (Steensig, 2019). Empathy though, as an inwardly experienced emotion, is difficult to evidence in interactional terms, with enactment through particular phrases sometimes interpreted as insincere or overly formulaic by participants (Atkins, 2019; Atkins and Roberts, 2018). A speaker in one of the Rounds recorded for this paper does herself note this difficulty of performed empathy (Extract 1):

Extract 1 – Empathy as a problematic term for participants (Round 2)

```
1379  PAN1: I just want to sa::y (0.7) anyone can do something
1380        sympathy and empathy: anyone can tilt their head and
1381        go aw:: that's really (0.2) .mtk sa:d and that's go aw::
1382        that's but compassion is different (0.5) cos it's action…
```

This speaker problematises how we can distinguish the production of gestures that might be seen to perform 'empathy' compared with genuinely felt 'compassion' shown through 'action', indicating that in-group members do themselves recognise an analytic difficulty here. In this paper then, while acknowledging its importance for some participants, we also accept the explicit difficulties highlighted by participants and avoid the term 'empathy' in our analysis. Instead, we follow Stivers' (2008) term, in evidencing how 'affiliation' is expressed by speakers in Rounds.

CA research has documented interactional practices geared towards facilitating affiliation with storytellers in everyday talk, such as nodding, 'response cries' (non-lexical sounds such as 'ohh') and telling 'second stories' (stories which purposely pick up on the themes and upshot of a prior story) (Heritage, 2011). Furthermore, some CA work has addressed storytelling and affiliation in more institutional, therapeutic group settings, akin to Schwartz Rounds. Particularly relevant is Arminen's (2004) work on Alcoholics Anonymous meetings, which are a similar kind of semi-structured setting. Here, the sharing of personal revelations is encouraged, but disengaged advice-giving and hierarchical relationships discouraged (p. 341). A Schwartz Round attendee in Maben et al. (2018) commented on the interactional similarities;

> 'If I switch my cynical head on it almost felt a bit like Alcoholics Anonymous (…) where you kind of make four people share an experience as a catalyst to try to get the audience to participate..'
>
> (Maben et al., 2018, p. 65 – Mulberry-19-Attender).

The noted parallels are interesting, particularly in light of how Arminen's research identifies affiliation enacted through 'second stories' in these types of groups (Arminen, 2004: 320), correspondences considered further in our analysis. Similarly, CA has been helpfully employed in analysing affiliation and support in group interactions around mental health, including peer-based support groups (Weiste et al., 2020, 2023) where affiliative responses to displays of emotion or accounts of difficult experiences are found to be important to successful interactions. In a group counselling setting between health professionals and clients that, analogously to Schwartz Rounds, aims to even out inequalities between members and have them interact as peers, Stevanovic et al. (2023) found that hierarchies were still made relevant in the interactions, a phenomenon we consider further in this paper.

Schwartz Rounds, in their discussion of emotion, also share some features with psychotherapeutic settings, for which there is a large body of relevant CA research. Worth highlighting in this overview are findings on the importance of affiliative responses in settings where emotion is explicitly being attended to. CA has identified how psychoanalysts may respond to and express mutual understanding with a client and their emotions (Voutilainen et al., 2010; Peräkylä, 2008) but also how clients may affiliate with a psychoanalyst's interpretation, in therapeutically significant moments of mutual understanding (Peräkylä, 2013: 567–569). There has also been work on the recognition of emotions in psychotherapeutic settings, in which the therapist recognises 'and considers valid, the emotions that patient descriptions are implicating or explicating' (Peräkylä, 2013: 571), a notion also helpful to our analysis.

This prior CA research is of relevance to understanding the interactional achievement of affiliation in Schwartz Rounds then. Nevertheless, it is important to keep in mind that Schwartz Rounds are also a separate and somewhat different setting, not explicitly meant to be 'therapy' and often much larger than a traditional 'help group', with any member of the organisation usually able to attend the event. Rounds groups size can range from 10 to 150 people, with the majority being 30–50 attendees (Maben et al., 2018). Given the unique nature of the setting, the data description and analysis below initially provide the reader with some grounding in the how this interaction is set up and institutionally organised, before moving on to examine the responses of audience members to panellists' stories in detail.

3. Data and methods

The data consist of five one-hour long Schwartz Rounds from three UK hospitals, consented for use in research. Four were recorded between August 2019 and January 2020, with one pre-existing, consented recording of a Schwartz Round from 2017 also used. Schwartz Rounds are a sensitive setting and key ethical considerations concerned how to record interactions without causing distress to participants and respecting rights to confidentiality. Some Schwartz Rounds have, in the past, been filmed for training purposes and we built an ethics procedure informed by these established processes, in consultation with Schwartz Round steering groups at a number of hospitals. The agreed procedure involved several steps for consent prior to recording, with participants notified in advance and also consented on the day. All participants were given the option to contact the researcher prior to the event and could also retrospectively request the deletion of sections of the recording (though it should be noted no participants requested this). The procedure was discussed and approved as a 'highly sensitive' ethics application at Birkbeck, University of London. As an evaluation of NHS staff data, the application was exempted from NHS REC approval. The first author, Atkins, was present at each Round to answer participants' questions during check-in and to conduct the recordings.

Schwartz Rounds broadly fall into two types, with panellists' stories either focusing on the case of a single patient and different staff perspectives (Case-based Rounds), or separate stories by panellists, centred on a common theme (Thematic Rounds). Both formats were collected for this study, and so our dataset comprise;

- Round 1. Case-based – Video-recorded. Three panellists describe their experiences working with the family of a new-born baby who was dying.
- Round 2. Case-based – Audio-recorded. Three panellists discuss the case of a homeless patient and the difficulties they faced in securing accommodation and treatment for him.
- Round 3. Thematic – Audio-recorded. Four F1 junior doctors describe different experiences in their first few months working in hospitals.
- Round 4. Thematic – Video-recorded. ('Christmas Round') Four members of hospital staff describe something they succeeded with through perseverance.
- Round 5. Thematic – Audio-recorded. Two panellists describe the impact of bereavement and stressful personal experiences on their work.

The Rounds were transcribed using Jeffersonian conventions (Jefferson, 2004), with names replaced by pseudonyms and other identifying features, such as locations and ward names, altered. Data sessions are a commonly used method in CA in which a group of analysts will meet and review data excerpts to make observations through a process of 'unmotivated looking' (see Albert et al., 2018: 402). For this project, data sessions were held between the authors, as well as two larger data sessions with analysts at external universities, with features of affiliation a key focus. For the purposes of this paper, all five transcripts were subsequently analysed for interactional features of affiliation, informed by prior CA work, and collections were made of recurring features across Rounds.

4. Analysis

We have outlined how Schwartz Rounds have two broad phases, first with stories given by the panellists (15–25 min) followed by audience discussion. In order to orient the reader to the interactional structure, our analysis begins by presenting a brief outline of how Rounds are opened (Section 4.1), the way 'first stories' are delivered by panellists (Section 4.2) and then the floor opened up by a facilitator for contributions (Section 4.3). Following this, we give a detailed analysis of

responses from the audience (Section 4.4), addressing; 'endorsements', 'generalisations' and 'second stories'.

4.1. Schwartz Round openings – establishing the interactional structure

A formal introduction by the facilitator or clinical lead for the Round sets out the aims for the discussion and some institutional expectations on 'allowable contributions' (Levinson, 1992), including responses that should be avoided. For example, there is oft-stated guidance to avoid 'problem solving' and 'Q and As' (Extract 2):

Extract 2 – Opening the Schwartz Round (Round 2)

```
56    LEAD:    and these are not Q and As and they're not
57             designed to be problem solving in any way .h it's
58             really to shar:e the emotions the thoughts the
59             feelings that are evoked in you as you hear our
60             panellists' story.
```

Extract 3 – First panellist's storytelling (Round 1)

```
177   PAN1: y- expect to be able to work with the parents towards some sort of
178          (0.3) shared understanding.
179          we might not (0.8) get to the position we want straight away
180          and again we're very well use to dealing with that
181          but this was ↑really unusual in that there was a brick wall
182          they weren't open (0.3) to: (0.3) our professional views about the
183          way this sort of case should happen. (0.6)
184          ·tk ·hhh um somewhere through the (0.3) er first couple of weeks
185          this family was s:o: (0.4) insistent on more information that we
186          arranged er (.) to transfer the baby out for a second opinion. (0.3)
187          again (0.3) we don't ↑mind that but it is the first (.) or the o:nly
188          time it happened to me in twenty two years working here
```

After stating what the audience discussion should *not* be (lines 56–7), the clinical lead here goes on to describe the kind of responses that are appropriate – that this is an opportunity to 'share the emotions the thoughts the feelings' evoked by the panellists' stories (lines 58–60). In all Rounds, this invite to the audience to reflect on emotions or 'similar experiences you've had' (Round 1), is repeated at several points.

4.2. How panellists tell their stories

In casual conversation, speakers usually work to gain the floor for the extended project of a story (Selting, 2000) but, in institutional settings, storytelling is often elicited in a more overt way (Liddicoat, 2011). This is the case in Schwartz Rounds, where panellists are explicitly given the floor and an extended space to tell their story. The panellists' story sequences themselves can resemble conversational 'troubles tellings' (Jefferson, 1984, 1988; Jefferson and Lee, 1981), a recognizable interactional activity where speakers provide accounts of personal experience in which they encounter a difficulty. One exception to this in the data might be Round 4, which takes place just before Christmas and, following general guidelines for Christmas Rounds, focuses on staff members' positive experiences. Even here though, panellists tended to recount experiences where they had overcome something challenging to reach a positive outcome. Stories were also very often presented as being outside the norm of day-to-day experiences.

To take a detailed example, in Round 1, the panellists describe the case of a sick baby and interaction with the family. Each panellist describes their perspective on the difficulties they faced agreeing a way forward, and all refer to how unusual the case was. Extract 3 comes from the first panellist's telling, a few minutes into his story:

Throughout this extract, the panellist uses 'extreme case formulations' (Pomerantz, 1986) that emphasise how unusual this case was, particularly his account that this is 'the first (.) or the o:nly time it happened to me in twenty two years working here' (lines 187–188). From lines 177–180, the panellist begins to describe what might be the usual, expected behaviour; 'y-expect to be able to work with the parents towards some sort of (0.3) shared understanding' (lines 177–8). Following this, he highlights how the behaviour of the parents in this case did not follow those expected norms, beginning with, 'but this was ↑really unusual in that there was a brick wall' (line 181). There are a large number of emphatics, such as, '↑really unusual', 's:o: (0.4) insistent', often with prosodic emphasis, all of which serve to underscore the unusual nature of the case. In contrast to the parents, the speaker emphasises the reasonableness of the hospital professionals, including their willingness to gain a second opinion ('we don't ↑mind that' (line 187)). The speaker continues to draw on some of these extreme case formulations when he comes to sum up his story (Extract 4 below):

Extract 4 – First panellist's story 'summing up' (Round 1)

```
222   PAN1: So for me the the overwhelming (.) feelings were of (0.3)
223         frustration that you can't work with a family a:nd (0.6)
224         disappointment that we were continuing (.) treatments that
225         that (0.3) were not going to help this baby in any way
226         >an- th- an- and< I don't think that happened to me at all
227         in- in the twenty two years I was here
228         we never (0.4) never got to such a sad situation.
229            (0.9)
230   FACL: ·tk thank you *Luke*
```

Here, he commences a story 'summing up', with a turn-initial 'So' at line 222, suggesting a shift from the main telling to giving the 'upshot' of the prior talk, a regular practice for the use of 'so' in conversation (Raymond, 2004: 186–189). He also switches from the collective, professional 'we', which he has used throughout the story to describe the team's actions, to a singular 'I/me' in summarising the emotional upshot of the events. As well as explicitly describing the emotions and feelings these events elicited ('frustration', 'disappointment'), the panellist repeats his assessment of this as an exceptional case that had not 'happened to me at all in the twenty two years I was here' (line 226), echoing the formulation used earlier, in Extract 3 (line 188). His summing up is important, since the purpose of the Schwartz Round is to reflect on the emotions around providing care, and the sequence provides a clear emotional stance for audience members to respond to. It is an action the facilitator also hears as a completion of the story, since he gives a 'thank you' at line 230 in acknowledgment.

Using extreme case formulations or emphasising the unusual nature of the difficulty being described was common across panellists' stories (e.g. 'This was such an unusual situation (.) something I'd never come across before' (Round 2, lines 307–8)). Emphasising the unusual nature of a story is one way a speaker can make a claim for its 'tellability' (Sacks, 1992), that is, that the speaker has something newsworthy or of interest to the listener. However, it also indicates something of the speaker's affective stance, with the storyteller warranting the emotional intensity of the feelings they experienced because of the unusual difficulty of the situation. The story constructions we see in Rounds, often presenting these unusually difficult experiences, therefore demonstrate the 'affective treatment' of events that Stivers (2008: 27) described in looking at the establishment of stance, with which recipients are preferentially expected to affiliate.

4.3. Transitioning from panellist stories to audience responses

Following the panellists' stories, a facilitator indicates the transition to audience discussion and, in doing so, identifies more generalisable aspects of the panellists' stories as candidate experiences for audience reflection. For example, Extract 5:

Extract 5 – Facilitator transitions from panellists' stories to audience discussion (Round 1)

```
401 FACL:   … the themes that (.) really resonated with me
402         an- they're reflected in the title of this round
403         was that (.) frustra:tion (.) but also the rejection (1.4)
```

However, this move to generalisability contains a potential interactional difficulty for the operation of Rounds; panellists presenting their stories as exceptional might make it harder for participants to express shared understanding, since others are unlikely to have had precisely the same experiences. Here, though, the facilitator signals a shift from the specifics of the exceptional events described into more generalisable experiences, first by indicating the themes that 'resonated' for her (line 401), and then also picking up on emotional terms used by the speakers, 'frustration' and 'rejection', to suggest generalised emotions others may have experienced in different contexts. Facilitators in the five Rounds signalled this shift from panellists' stories to audience discussion in comparable ways ('maybe you've had something happening that was similar', Round 2) and often used the term 'resonate' to describe commonality of experience ('FACL: think about what's resonating with you?', Round 3), indicating ways in which the audience might identify points of correspondence and offer an appropriate contribution. It is to these audience responses, following the facilitator prompts, that we now turn.

4.4. Affiliative audience responses

There are various types of audience response during the discussion, some of which map to interactional resources for affiliation identified in casual conversation (Heritage, 2011) and others more akin to the ways in which affiliation has been described in help groups and institutional settings. In this section, we give an overview of the most frequent types of responses across the Rounds: endorsements, generalisations and second stories.

4.4.1. Endorsements

Audience members recurrently provided positive evaluations of the panellists' stories and the emotions expressed, showing affiliation in the sense Stivers (2008) describes: 'the hearer displays support of and endorses the teller's conveyed stance' (p. 35). We describe these utterances as 'endorsements', actions indicating approval of the panellists' contributions. In Extract 6, the audience member provides an endorsement for the story outlined in Section 4.2 above, on the frustration with the behaviour of a family:

Extract 6 – Audience member's endorsement of emotional stance (Round 1)

```
476   AUD2: The (.) fact that you all feel as you do is obviously a very
477         strong reflection of the wonderful (0.8) attitude you have (0.6)
478         because if you [weren't show]ing that sort of attitude=
479   FACL:                [mmm]
480   AUD2: =you wouldn't be frustrated
481            (0.5)
482   AUD2: so I think it's (0.5) it's a very marvellous (0.5) piece of
483         evidence (.) for the way in which you [(w-) ]
484   FACL:                                      [yeah]
485   AUD2: and I just wo:nder (.) how you are now. (0.5)
```

The audience member opens by grouping together the panellists' feelings, 'The (.) fact that you all feel as you do' (line 476). She goes on to say these feelings are 'obviously a very strong reflection of the wonderful', pausing before selecting 'attitude' as a descriptor and then overtly endorsing the emotions the panellists have previously expressed as being appropriate. She goes on to provide an account for why she feels they are appropriate: 'because if you weren't showing that sort of attitude / you wouldn't be frustrated' (lines 478–80). This picks up on the emotional term, 'frustration', we saw the first panellist (in Section 4.2) and the facilitator (Section 4.3) use earlier, but here the audience member is transforming an emotion that might ordinarily be viewed as

negative into something that results from a positive underlying 'attitude'. The audience member goes on to suggest that this is a 'a very marvellous piece of evidence (.) for the way in which you (w-)', trailing off the ending in a way that is not quite audible but suggests that she is continuing to provide an assessment of the negative emotion ('frustration') as one that can be viewed positively, this time with a clear 'yeah' (line 484) from the facilitator to show her agreement. This sequence, then, endorses the emotional stances the panellists gave in their stories, indicating that their 'frustration' is as an acceptable emotion to be feeling, akin to 'recognising utterances' in therapeutic settings (Peräkylä, 2013: 571), even transforming this negative emotion into something to be viewed positively.

These kinds of endorsements of the acceptability and appropriateness of emotions panellists express occurred in every Round. However, audience members also provided a different type of endorsement worth noting here; showing approval for the very act of *expressing* emotion and the 'openness' of the panellists. In linguistics, this might be termed a 'metapragmatic comment', where the talk itself becomes the object of discourse and speakers' turns become self-referential about the appropriateness of contributions in the particular context (Ciliberti and Anderson, 2007; Verschueren, 2022). For example, in Extract 7 from Round 2, the audience member thanks a panellist for articulating her initial negative reaction to a patient:

Extract 7 – Audience member's 'metapragmatic' endorsement of expressing emotion (Round 2)

```
1309 AUD12: I'd just like to say thank you to *An↑drea*(0.5)
1310        also thank you for s- your sharing with us your:
1311        initial reaction was >oh my goodness I hope he's
1312        not one of ours< .hh and I really thank you for that
1313        cos it's very easy to talk about when we've
1314        been kind and when we've be-been compassionate .h
1315        and what you've shown us is your openness and
1316        vulnerability .h in talking about the whole range
1317        of your emotions so ah- I'm really grateful to you
1318        .h for that because it was-it was just so °poignant°
1319        do you know what I mea:n >yeh< so thank you.
```

Here, the audience member addresses a specific panellist, Andrea. After the opening 'thank you' (line 1309), she adds 'also thank you for s-your sharing with us your: initial reaction' (lines 1310–1) before quoting back the panellist's own reported initial thought from her storytelling 'oh my goodness I hope he's not one of ours' (lines 1311–2), ('ours' meaning one of her team's patients). She goes on to offer an additional, emphatic, 'really thank you for that', with an account of why from line 1313. She indicates that it might be much easier for a health professional in this context to describe moments that show compassion and kindness, here switching to a collective 'we' that encompasses all the health professionals in the room, not just the panellist (lines 1313–4). Similarly to the audience member in the previous extract, she goes on to present a positive outcome arising from a potentially negative occurrence, suggesting that by expressing a negative reaction to a patient, 'you've shown us […] your openness and vulnerability .h in talking about the whole range of your emotions' (lines 1315–7). She concludes her turn with emphatic thanks, 'I'm really grateful to you'.

The interactional work being done here is different from the endorsement in Extract 6. The 'metapragmatic' nature of this sequence, endorsing the interactional contribution of the panellist, is apparent from the number of words relating to the talk itself ('sharing' line 1310, 'talk' line 1313, 'talking' line 1316), pointing to what has already been said in the story. In thanking the panellist for 'sharing with us' and her 'openness', the audience member endorses this as being the right type of action to perform in a Schwartz Round – endorsing the act of *sharing* emotions, rather than directly endorsing the emotions themselves. The speaker links this to a more collective experience around sharing emotions, suggesting this is something they all find difficult as healthcare staff, by switching from second person 'you/your' to a more collective 'we': 'it's very easy to talk about when we've been kind' (lines 1313–4). Unlike Extract 6, this audience member does not explicitly endorse the emotion itself or transform it into evidence of a more positive, professional attitude but she does endorse the *act* of expressing this emotion. In doing so she perhaps challenges a professional orthodoxy about not expressing negative feelings towards patients, demonstrating how the counter-cultural, conversational space of Schwartz Rounds outlined in the Introduction can be interactionally achieved. Endorsements of this kind occurred across all five Rounds, often at the opening of audience members' turns before they went on to offer further contributions. Our analysis here suggests that the function of these endorsements is twofold. On the one hand, they provide affiliation with the speaker(s) who have shared their stories and the emotions they report experiencing. On the other, they work to reinforce the particular nature of Schwartz Round interactions as a setting in which it is safe and acceptable to express emotions that might not be permitted or prioritised in the day-to-day workplace setting. This safe, counter-cultural conversational space of Schwartz Round is a stated aim, which we see reinforced and maintained not only by the facilitators but by the audience members themselves.

4.4.2. Generalisations

An action we have already seen in responses above is the making of generalised statements about staff experiences, often through the use of a collective 'we' to broadly refer to healthcare staff. The audience member in Extract 7, for example, made the generalisation 'it's very easy to talk about when **we've** been kind'. Our analysis shows not only usage of 'we' to refer to all staff in general, but also to invoke a collective experience in relation to more specific categories, such as 'carers', 'nurses', 'doctors', 'patients'. These generalisations may be used alone or in conjunction with the endorsements above, as well as being used to frame connections with subsequent 'second stories', explored further in Section 4.4.3 below. Extract 8 gives an example of an audience member's contribution in Round 5, following the panellists' stories about their experiences of bereavement while working.

Extract 8 –Generlaising statements as story preface (Round 5)

```
1018 AUD6: Again I just want to say a really big thank you to
1019        both *Nasrin* and *Tom* for.hh actually talking
1020        about very very difficult subjects a:nd .h
1021 →      as healthcare professionals we all put on this
1022 →      faca:de we're perfect people and we're there to
1023 →      care for other people .h and we don't need that
1024 →      care ourselves.
1025        .hh And >you know< (0.5) I:: certainly went through
1026        a really terrible time when I was in my training.
1027           (0.5)
1028        .h A::nd I was- so I did the ↑opp↓osite to what
1029        other people here have done and I (0.2) kept going
1030        with this very professional façade_[...]
1031        .hhh I didn't think anybody would be able to tell
1031        I was having a crisis.
```

Here, the audience member opens with a metapragmatic endorsement for the panellists 'talking about very difficult subjects' (lines 1019–20), before then going on to provide a generalisation; 'as healthcare professionals we all put on this faca:de' (lines 1021–22). This generalisation, that healthcare professionals generally feel they need to show that they are caregivers and not in need of care for themselves (lines 1022–24), works to endorse the feelings that the panellists expressed in their stories, about the difficulties of coping with bereavement at work. It also provides a link with the story this audience member goes on to provide, in which she talks about her own experiences of bereavement and how she tried to 'keep going' with this 'professional façade'. The generalisation at lines 1021-4 serves to claim an affiliative connection between the panellists' initial stories and her own, in terms of how they collectively tend to behave 'as healthcare professionals'.

Generalising statements rely on forming categories, whereby social groups and identities are ascribed particular attributes and characteristics. Category-based conceptions of the social world through 'generalisations' have been studied extensively in CA, evidencing how common-sense understandings are negotiated in and through talk-in-interaction, and can be a resource for participants to display affiliation (Jefferson, 1984, 2002). Their occurrence has been noted in support group interactions (Sacks, 1992: 169–175) and therapeutic groups (Pino, 2021), where generalisations can function to build a sense of shared experience. This is a function investigated by Arminen (2004), looking at AA group interactions, where 'the meaning of a singular episode becomes generalised so that it can be used for making sense not just of identical experiences but also of all experiences that bear a symbolic resemblance to an original story' (p. 339). In the Schwartz Rounds, generalisations may therefore act as a similar means of showing affiliation, particularly effective when such overtly 'exceptional' first stories from the panellists can be hard for audience members to claim directly comparable experiences. The next section on 'second stories' further demonstrates how audience members manage this difficulty of claiming equivalent experiences.

4.4.3. *Second stories*

It is a stated aim of Schwartz Rounds, and often an aim specifically expressed by facilitators at the segue point to the audience discussion (see Section 4.3), to inspire stories of similar experiences from the audience (e.g. 'now is your opportunity for to-to- actually reflect for yourself on […] moments that maybe you've had something happening that was similar' Round 2). In CA research, 'second stories' are responses which are designed to show they are touched off by or pick up on the point of the first story to which they are responding (Sacks, 1992: 767–768). Sacks also noted that second stories are carefully fitted to and specifically 'stand as analysis of' the prior story (Mandelbaum, 2013: 771), meaning they can fulfil an affiliative function of demonstrating understanding of the initial teller's stance (Goodwin, 1990; Sacks, 1992). Their use in establishing a sense of shared experiences in institutional group settings has been noted in help groups (Arminen, 2004) and we suggest here that they may serve a similar function in Schwartz Rounds.

One function of second stories in our Rounds data was to provide an account from another staff member who had to overcome a similar difficulty. In Round 4, the 'Christmas Round', we see an example from an audience member who provides a 'second story' describing a change she is proud to have achieved, demonstrating her analysis of the panellists' stories as being about overcoming obstacles to achieve something positive. Extract 9 gives the opening to this second story, which we analyse below:

Extract 9 – Preface to an Audience member's 'second story' (Round 4)

```
654   AUD3:    I just wanted to >talk about< it's nothing gra:nd
655            compared to what you guys are doing=but I had a
656            (.) .h >I< I treat a patient () patient er with
657           with polycystic kidney disease (0.7) and […]
```

It is interesting that the speaker, at the opening to her second story, stops herself after 'I just wanted to > talk about<' and adds a quick interjection that frames her story in a way that downplays how comparable her experiences are - 'it's nothing grand compared to what you guys are doing' (lines 654–5) - before then giving an account of a patient she is treating with kidney disease. This expressed hesitancy by audience members in claiming direct equivalence in their second stories was notable but perhaps unsurprising given the way in which we saw panellists construct their opening stories as highly unusual. This difficulty in expressing equivalent experiences when affiliating with others' has similarly been noted in therapeutic mental health group interactions, particularly where support workers could not claim to have access to the same experiences as their clients (Stevanovic et al., 2023). Even though the mental health group interactions were, like Schwartz Rounds, deliberately aimed at establishing equality as peers and flattening hierarchies with support workers, inequalities still tended to be invoked in the interaction (p. 11). Here in the Schwartz Rounds, such contributions perhaps show that audience members *do* orient to an official or elevated

status of the 'panellists' in Round interactions, a hierarchy in the participation framework that we consider further in the conclusion.

Another strategy for demonstrating the linkage between stories was to provide the kind of 'generalisation' that we saw in Extract 8 above. In that extract, the audience member emphasised the difference in the way in which she dealt with her experience of bereavement as a preface to her story, that she 'did the ↑opp↓osite to what other people here have done' (Extract 8, lines 1028–9). However, by prefacing the storytelling with a generalisation about how 'we' healthcare workers put on a 'façade' and endorsing the value of actually articulating personal difficulties, she is still able to link this 'opposite' behaviour to the overarching themes of the panellists' stories.

Finally, just as with the metapragmatic endorsements in Section 4.4.1, second stories could function to endorse the act of talking *about* emotional experiences, rather than providing comparable experiences. In Round 1, for example, the first audience responder, following the facilitator's initial invite, embeds a short second story about another staff member, who apologized to her for what she describes as 'ranting', within her response to the panellists (Extract 10).

Extract 10 – Round 1

```
434   AUD1: °ok ??now??° I'd just like to say thank you very much to the pa:nel
435         for being(.) >so open<
436            (0.5)
437         to everyone I think it's very difficult when we're (0.5)
438         doing the jobs that we do,
439         we're expected to be (1.0) not robots but we're not expected to have
440         the depth of feeling that we do?
441         when we encounter the people that we meet in our jobs?
442            (1.1)
443         Um I had someone (.) apologise to me: recently for (.) ranting as it
444         were_ (0.7)
445         ((makes two finger quotation marks for the word "ranting"))
446         um (0.2) and I said no that's fine (0.3) it's the situation
447         you're in (1.1)
448         I would v- feel exactly the same way as you↑
449         and I think we forget the human elements sometimes. (0.3)
450         or↑ (0.3) sometimes you feel we're not allowed to be (0.4) human.
451         and respond to our patients or our visitors (.) or the carers that
452         we meet (1.0)
453         they ↑do touch us. u:m (.) and I don't think there's anything (.)
454         wrong with admitting that they do touch us. (0.6)
```

As with the endorsements described in Section 4.4.1 above, the speaker here begins by offering a positive evaluation to the entire panel for the act of openly expressing emotions in their stories ('I'd just like to say thank you very much to the pa:nel for being (.) >so open< ', line 435). She follows this with a generalised statement of shared experience about the difficulty of expressing or perhaps even experiencing emotions towards patients, where she switches to a generalised professional 'we' ('I think it's very difficult when we're (0.5) doing the jobs that we do, we're expected to be… ' line 437). This expression of her affiliative stance to the panellists, in this case for their act of expressing emotion rather than the particular emotions themselves, works to preface a short second story she goes on to tell from line 443, about how other staff can find it difficult to articulate negative emotional responses to their work. Here she invokes the specific case of a member of staff she recently spoke to ('Um I had someone (.) apologise to me: recently for (.) ranting as it were' line 443). She makes the term 'ranting' problematic by adding an 'as it were' and using hand gesture to give quotation marks to highlight the word, which perhaps carries negative connotations, as being the staff member's description rather than her own. In providing quoted speech of her own response to the staff member, she highlights how talking about negative feelings is commendable - 'I said no that's fine (0.3) it's the situation you're in' (line 446) – and, after a pause, provides further reported speech, that she told the staff member she would feel, 'exactly the same way as you↑' (line 448). 'Ranting' is transformed into an action that, far from being negative or deplorable, is something she too would do in the same situation. She then moves out of the story to provide an overarching analysis of working in healthcare; 'and I think I think we forget the human elements sometimes' (line 449), adding that sometimes staff feel they are not even allowed to 'be human'. In summing up her story, she goes on to reiterate her affiliative stance, that it is ok as healthcare professionals to feel emotions towards patients, using a generic formulation of professionals' experiences with a collective first person 'us': 'they ↑do touch us' (lines 453–4).

This audience member's embedded second story does not recount a similar set of events to the first stories, which are about the death of a baby and families who resist medical advice, but it explicitly links to perhaps more easily generalisable themes around the admission of experiencing negative emotions working in healthcare, and of articulating these. The teller uses her second story, about another member of staff who framed their expression of negative emotions in a pejorative way, as a means of demonstrating that this is acceptable for staff to articulate. Stating this acceptability before and after her own story ('I don't think there's anything wrong' lines 453–4) frames it as an analysis and a type of endorsement of the panellists' prior stories - not of the particular circumstances they experienced, which have been acknowledged as exceptional, but a more metapragmatic ratification of them *talking* about their emotions. Again then, a means of showing affiliation in Rounds is through this more reflexive, metapragmatic approval of the activity itself, creating and reinforcing the counter-cultural, conversational space established between participants.

Interestingly, for this particular second story, the point about discussing emotions is then picked up by the first panellist who, a few turns later, offers his own account of giving younger staff members permission to 'be a bit emotional' (Round 1). Arminen (2004) observed in AA group therapeutic settings that tellers of the first stories do not tend to respond to subsequent second stories, but in Schwartz Rounds we do find panellists connecting back to audience responses, particularly when they are given the opportunity by facilitators to have the 'last word' at the end of the Round. This structure, and the way it is oriented to by participants, potentially enables a consensus to be established amongst the group by the conclusion of the discussion, highlighting points that all participants can agree on.

5. Conclusions

Interaction in Schwartz Rounds can be seen ultimately to foster a sense of social solidarity. Audience members, who have been guided to

respond and connect to panellists' 'first stories', use a range of responses to demonstrate affiliation during the discussion phase of the Rounds. These affiliative responses echo resources that have been identified for expressing affiliation in casual conversation, but some are perhaps made more visible in this more institutional and facilitated interaction. We saw that *endorsements*, both for the emotions the panellists expressed as well as more metapragmatic endorsements of the act of talking about emotions, were present across all Rounds. *Generalisations* were used in linking panellist contributions to wider experiences and *second stories,* designed to connect to the panellists' first stories, were employed in building a sense of shared experience, even though these related stories were sometimes explicitly qualified as not being of equivalent status to the panellists'.

The metapragmatic contributions identified in Schwartz Rounds, i.e. the commendations for talking about difficult topics and emotions, are particularly notable. This interactional option perhaps makes affiliation easily achievable for all members since, even where speakers do not share the same experiences or might disagree with the attitudes expressed, the *act* of expressing these feelings can still be affiliated with. These reflexive contributions therefore serve to structure Schwartz Rounds as a space in which sharing difficult topics is overtly encouraged, an important interactional function in achieving the more broadly stated aim of creating a safe, counter-cultural communicative context, within this institutional setting, where contributions that might be risky in everyday healthcare work can become actively supported. The sharing of difficult topics therefore becomes much lower risk for speakers in the Schwartz Round setting, because this action is likely to be validated by other participants as the correct behaviour.

Metapragmatic comments have been identified as important features of spoken interaction in various institutional contexts, such as education, where they work to instruct and socialise participants into particular ways of talking (Ciliberti and Anderson, 2007). They may well work to socialise newer members to this relatively unfamiliar setting of Schwartz Rounds too, but it is interesting that such metapragmatic guidance is not solely the preserve of those managing the interaction, such as the facilitators, as tends to be expected in institutional settings (see Ciliberti and Anderson, 2007); these contributions are in fact most frequently offered by the audience members themselves. This too perhaps serves to achieve an aim of Schwartz Rounds, to break away from the typically hierarchical cultures of everyday healthcare work (Maben et al., 2021: 15). Nevertheless, the Rounds do not serve to entirely dismantle participation hierarchies, with audience members often going to some lengths to avoid claiming equivalence of their own contributions, perhaps elevating the panellists' first stories as being more exceptional in the process. However, this hierarchy does not relate to existing institutional roles or status as healthcare staff but is interactionally achieved according to people's roles in the conduct of the Round, privileging the panellists who opened with their carefully prepared stories. Shifting the focus from professional role or status is perhaps another means through which commonalities can be built across different staff roles in the organisation. In identifying this difficulty in the invocation of hierarchies in a group therapy context with support workers in mental health settings, Stevanovic et al. (2023) describe a need 'to understand how experiences can be shared without an orientation to a need to create an illusion of sameness' (p. 13), particularly for training professionals in skills to best support such interactions. In the interactional data from the Schwartz Rounds, there is evidence to suggest how members do manage this sharing of experiences while avoiding the difficulty of claiming 'sameness', providing material that may indeed be useful for professional training in this area.

Beyond the specific context of Schwartz Rounds, this analysis may have wider relevance for understanding similar interactional contexts in healthcare, such as Balint Groups and other contexts for health professional interactions outside of usual clinical care. The study demonstrates the value in looking closely at interactional practices as part of process evaluations for such interventions and how they achieve their aims. This point is made in Pilnick and James (2013), who employ CA methods to understand the processes that work to accomplish a complex therapeutic intervention for the parents of deaf and autistic children. They make the case 'for continued, detailed qualitative research which focuses on the process of interventions in terms of how their guiding principles are enacted, in order to make sure that these fundamental interactional aspects are not lost from consideration' (pp. 99–100). This type of analysis, they argue, is not only important for understanding how the apparent success of an intervention is achieved but also for ensuring its reproducibility, by providing a descriptive account of the interactional practices and competencies required. Barnes et al. (2018) similarly show the value in employing CA methods to address the 'implementation fidelity' of a talk-based intervention in UK general practice. Applied CA studies in institutional settings and even interventions to bring about change in professional practice, grounded in CA findings, have grown in the discipline in recent years, especially in healthcare contexts (Robinson and Heritage, 2014). Nevertheless, such applications can be expensive and time consuming, particularly when assessing the effectiveness of implementation, and so examples remain relatively scarce. However, at the initial stages, the 'noticings' of professional practice represent an important step in developing such applications (Robinson and Heritage, 2014: 203). We hope, in this paper, through our analysis of the interactional features of Schwartz Rounds, to have begun providing just such a descriptive account of the practices which underly the successful achievement of their overall aims. There remain additional features it would be helpful to explore, such as work that facilitators do to guide the discussion and manage responses which do not affiliate with the prior discussion. Overall, though, we have made the case that Schwartz Rounds can offer an important means for discussing the complex experiences of working in healthcare and demonstrated some of the specific interactional means through which participants achieve this, establishing an environment that encourages sharing and contributions that might not be possible in other healthcare settings. We suggest that this helps us to better understand why participants report positive consequences from participating in Rounds, as well as providing a descriptive account that has the potential to feed into training and future adoption of Schwartz Rounds across healthcare organisations.

Credit author statement

Sarah Atkins: Conceptualization, Methodology, Formal Analysis, Writing - Original Draft, Project administration, **Alison Pilnick:** Conceptualization, Formal Analysis, Writing - Review & Editing **Jill Maben:** Conceptualization, Supervision, Writing - Review & Editing, **Laura Thompson (PI):** Conceptualization, Methodology, Supervision, Funding acquisition, Writing - Review & Editing, Project administration.

Funding

The study was funded through a Wellcome Trust 'Institutional Strategic Support Fund', awarded at Birkbeck, University of London, under Dr Laura Thompson, PI.

Data availability

The authors do not have permission to share data.

Acknowledgments

We would like to thank the Point of Care Foundation for their assistance with the project and in contacting hospital trusts for data collection. We are also grateful to the three NHS hospital trusts and Schwartz Round steering groups who provided invaluable advice and assisted with access to Rounds, as well as all the participants who consented to be recorded for this study.

References

Albert, S., Albury, C., Alexander, M., Harris, M.T., Hofstetter, E., Holmes, Edward J.B., Stokoe, E., 2018. The conversational rollercoaster: conversation analysis and the public science of talk. Discourse Stud. 20 (3), 397–424.

Atkins, S., 2019. Assessing health professionals' communication through role-play: an interactional analysis of simulated versus actual general practice consultations. Discourse Stud. 21 (2), 109–134.

Atkins, S., Roberts, C., 2018. Assessing institutional empathy in medical settings. J. Appl. Ling. Prof. Pract. 13 (1–3), 11–33.

Arminen, I., 2004. Second stories: the salience of interpersonal communication for mutual help in Alcoholics Anonymous. J. Pragmat. 36 (2), 319–347.

Barnes, R.K., Jepson, M., Thomas, C., Jackson, S., Metcalfe, C., Kessler, D., Cramer, H., 2018. Using conversation analytic methods to assess fidelity to a talk-based healthcare intervention for frequently attending patients. Soc. Sci. Med. 206, 38–50.

Ciliberti, A., Anderson, L., 2007. Metapragmatic comments in institutional talk: a comparative analysis across settings. In: Hübler, A., Bublitz, W. (Eds.), Metapragmatics in Use. John Benjamins, Amsterdam, pp. 143–166.

Francis, R., 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Retrieved from: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry [Date Accessed 10th March 2023].

Goodwin, M.H., 1990. Retellings, pretellings and hypothetical stories. Res. Lang. Soc. Interact. 24 (1–4), 263–276.

Heritage, J., 2011. Territories of knowledge, territories of experience: empathic moments in interaction. In: Stivers, T., Mondada, L., Steensig, J. (Eds.), The Morality of Knowledge in Conversation. Cambridge University Press, Cambridge, pp. 159–183.

Jefferson, G., 1984. On stepwise transition from talk about a trouble to inappropriately next-positioned matters. In: Maxwell, J., Heritage, J. (Eds.), Structures of Social Action. Cambridge University Press, Cambridge, UK, pp. 191–222.

Jefferson, G., 1988. On the sequential organization of troubles-talk in ordinary conversation. Soc. Probl. 35 (4), 418–441.

Jefferson, G., 2002. Is "no" an acknowledgment token? Comparing American and British uses of (+)/(−) tokens. J. Pragmat. 34 (10), 1345–1383.

Jefferson, G., 2004. Glossary of transcript symbols with an introduction. In: Lerner, G.H. (Ed.), Conversation Analysis: Studies from the First Generation. John Benjamins, Amsterdam/Philadelphia, pp. 13–34.

Jefferson, G., Lee, J.R.E., 1981. The rejection of advice: managing the problematic convergence of a 'troubles-telling' and a 'service encounter'. J. Pragmat. 5 (5), 399–422.

Levinson, S.C., 1992. Activity types and language. In: Drew, P., Heritage, J. (Eds.), Talk at Work. Interaction in Institutional Settings. Cambridge Univeristy Press, Cambridge, pp. 66–100.

Liddicoat, A.J., 2011. An Introduction to Conversation Analysis, second ed. Bloomsbury, London.

Mandelbaum, J., 2013. Storytelling in conversation. In: Sidnell, J., Stivers, T. (Eds.), The Handbook of Conversation Analysis. Wiley-Blackwell, Oxford, pp. 492–507.

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., Ross, S., Shuldham, C., Bennett, L., Foot, C., 2018. Health Services and Delivery Research. Retrieved from, Southampton (UK).

Maben, J., Taylor, C., Reynolds, E., McCarthy, I., Leamy, M., 2021. Realist evaluation of Schwartz rounds® for enhancing the delivery of compassionate healthcare: understanding how they work, for whom, and in what contexts. BMC Health Serv. Res. 21 (709).

Oldenburg, R., 1999. The Great Good Place: Cafes, Coffee Shops, Bookstores, Bars, Hair Salons, and Other Hangouts at the Heart of a Community. Marlowe & Company, New York.

Peräkylä, A., 2008. Conversation analysis and psychoanalysis: interpretation, affect, and intersubjectivity. In: Peräkylä, A., Antaki, C., Leudar, I., Vehviläinen, S. (Eds.), Conversation Analysis and Psychotherapy. Cambridge University Press, Cambridge, pp. 100–119.

Peräkylä, A., 2013. Conversation analysis in psychotherapy. In: Sidnell, J., Stivers, T. (Eds.), The Handbook of Conversation Analysis. Wiley-Blackwell, Oxford, pp. 551–574.

Pilnick, A., James, D., 2013. "I'm thrilled that you see that": guiding parents to see success in interactions with children with deafness and autistic spectrum disorder. Soc. Sci. Med. 99, 89–101.

Pino, M., 2021. Challenging generalisations: Leveraging the power of individuality in support group interactions. Lang. Soc. 50 (5), 695–722.

Pomerantz, A., 1986. Extreme case formulations: a way of legitimizing claims. Hum. Stud. 9 (2–3), 219–229.

Raymond, G., 2004. Prompting action: the stand-alone "so" in ordinary conversation. Res. Lang. Soc. Interact. 37 (2), 185–218.

Robinson, J.D., Heritage, J., 2014. Intervening with conversation analysis: the case of medicine. Res. Lang. Soc. Interact. 47, 201–218.

Sacks, H., 1992. Lectures on Conversation, s vols. 1 & 2. Blackwell, Oxford.

Selting, M., 2000. The construction of units in conversational talk. Lang. Soc. 29 (4), 477–517.

Soja, W.T., 1996. Th*ird Space: Journeys To Los Angeles and Other Real-And-Imagined Places*. Blackwell, Oxford.

Steensig, J., 2019. Conversation Analysis and Affiliation and Alignment. In: Chapelle, C. A. (Ed.), The Encyclopedia of Applied Linguistics. Wiley Online, pp. 1–6. https://doi.org/10.1002/9781405198431.

Stevanovic, M., Nevalainen, H., Niska, M., Weiste, E., 2023. Power differentials in the counseling relationship: a conversation analytic study on goal-setting meetings in a Clubhouse mental health rehabilitation community. Group 47, 67–90.

Stivers, T., 2008. Stance, alignment, and affiliation during storytelling: when nodding is a token of affiliation. Res. Lang. Soc. Interact. 41 (1), 31–57.

Stivers, T., Mondada, L., Steensig, J., 2011. Knowledge, morality and affiliation in social interaction. In: The Morality of Knowledge in Conversation. Cambridge University Press, Cambridge, pp. 3–26.

Verschueren, J., 2022. Metapragmatics. In: Östman, J.-O., Verschueren, J. (Eds.), Handbook of Pragmatics: Manual, second ed. John Benjamins, Amsterdam, pp. 948–953.

Voutilainen, L., Peräkylä, A., Ruusuvuori, J., 2010. Recognition and Interpretation: responding to emotional experience in psychotherapy. Res. Lang. Soc. Interact. 43 (1), 85–107.

Weiste, E., Stevanovic, M., Uusitalo, L.L., Toiviainen, H., 2023. Peer support for accepting distressing reality: expertise and experience-sharing in psychiatric peer-to-peer group discussions. Health 0 (0), 1–20.

Weiste, Elina, Tiitinen, Sanni, Vehviläinen, Sanna, Ruusuvuori, Johanna, Laitinen, Jaana, 2020. Counsellors' interactional practices for facilitating group members' affiliative talk about personal experiences in group counselling. Text Talk 40 (4), 537–562.

Wren, B., 2016. True Tales of Organisational Life. Karnac, London.