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Formulations in Psychotherapy: Admission Interviews and the Conversational Construction of Diagnosis

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Abstract

In this article, we contribute to understanding the interactional aspects of making clinical diagnosis in mental health care. We observe that therapists, during the "problem presentation" sequence in clinical encounters, often use a specific form of diagnostic formulations to elicit more diagnostically relevant information. By doing so, they often substitute one type of verb with another, following a diagnostic hypothesis. Specifically, in interviews that arrive at a diagnosis of neurosis, therapists formulate with behavioral verbal processes; in interviews that arrive at a diagnosis of psychosis, they do so with material ones. Such formulations often prove useful to define clinical diagnoses. They can, however, also be dangerous in that they may favor the therapist's agenda over the patient's. Our analysis helps therapists not only better understand the diagnostic process but also reflect upon their own use of diagnostic formulations and become aware of the clinical effects of their interactional performance.

Keywords

qualitative; doctor–patient; nurse–patient; communication; mental health and illness; sociology; social construction; illness and disease; screening; health care; psychiatry; psychology; psychological issues; conversation analysis; discourse studies; Latin-America

Diagnosis in mental health care is a process. This process usually involves several encounters, tests, and questionnaires. It is conditioned by the first contact between professional and patient and evolves over several clinical encounters (Bonnin, 2013; Woolgar & Scott, 2014). Making an accurate initial diagnostic hypothesis is thus vitally important.

One of the resources used by professionals during this diagnostic process is what Antaki, Barnes, and Leudar (2005) call "diagnostic formulations." Indeed, although therapists believe their own formulations are a "neutral" account of what the patient said, they nevertheless transform it. In what follows, we examine this interactionally constructed phenomenon, focusing on observed correlations between diagnosis and the reorganization of the patient's previous utterances. We first review the literature on diagnostic formulations in medical and mental health care contexts to inform our analysis theoretically. We then present our research and analyze our data on transformations as a correlate of diagnostic outcomes of interviews: We observe strategic applications of diagnostic formulations, not as closing actions but as opening ones intended to generate meaningful information to feed therapists' diagnostic interpretations. We attempt to show how they concomitantly shape, and potentially mislead, these diagnostic interpretations, as therapists use formulations to reconstruct their patients' narratives and satisfy diagnostic imperatives. Finally, we discuss some theoretical and practical consequences of this analysis.

Formulation and Diagnosis

The term *formulation* has different meanings according to whether it is defined from a clinical or a conversational standpoint. Here, we focus on "diagnostic formulations" and review how the term has been characterized within the field of mental health. Within the discipline of psychiatry, the term *formulation* has a specific meaning as a

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part of a clinical practice, opposed to (or, at least, different from) simple *diagnosis*:

> Diagnosis does not identify and explain what is unique about a particular client's presentation. Diagnoses are primarily descriptive in format while formulations provide an explanatory summary of what is happening for a particular client. Formulations provide more than a description of a particular category of mental disorder and this requires the nurse to seek additional information such as a sense of how the client feels and responds in a variety of situations, the sequence of significant events in the client's life and the meaning of these events for the client. (Crowe, Carlyle, & Farmar, 2008, p. 801)

Macneil, Kasty, Conus, and Berk (2012) prefer the term *clinical case formulation* to avoid diagnostic labeling, such as is promoted by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Clinical case formulations are generally used to avoid categorizing patients and offer a contextualized approach to their mental health concerns.

Some understand "diagnostic formulations" differently, especially those using a discourse analytical perspective on language and mental health (Pardo & Buscaglia, 2008, 2013). Antaki et al. (2005) and Antaki (2009) suggest using the term to signify a specific professional approach to "sharpen, clarify or refine the client's account and make it better able to provide what the professional needs to know about the client's history and symptoms" (Antaki et al., 2005, p. 627). Thus comprehended, professionals orient the information they gather toward therapeutic interpretations—"symptom formulations." They interpret clients' words and acts as meaningful symptoms within a diagnostic framework.

Heritage and Watson (1979) define formulations as an adjacency pair of turns in which one speaker offers a version of what has been said during conversation and the other is expected to acknowledge and ratify this version. These formulations can represent either a summary of previous words (*gist formulation*) or its implication (*upshot formulation*). Antaki et al. (2005) clarify this point: "although a gist formulation must delete, select and rephrase what has been said, and an upshot formulation must extract an implication from the surface of what is said, the original speaker may accept such reworking without demur" (p. 628). Indeed, there is a notable preference for agreement with formulations, as any disconfirmation might be seen jeopardizing "the sense of the talk thus far" (Heritage & Watson, 1979, p. 144).

Formulations (including reformulations and transformations) are cognitively, ideologically, or axiologically oriented (Arnoux, 2006); they are never "neutral." "Therapists work to transform the raw material of their client's talk, and get this transformation accepted by their client" (Antaki et al., 2005, p. 629); as such, diagnostic formulations may aid or harm the diagnostic process. To avoid substituting the clients' accounts with their own accounts and definitions (Bartesaghi, 2009), mental health professionals therefore must develop an awareness of how they use diagnostic formulations in therapy talk. Otherwise, they risk using them to terminate courses of actions (Schegloff, 2007), either by referring to previous words or "articulating the unsaid" (p. 186 ff.) in the addressee's preceding talk (Bolden, 2010). Such use of formulations has been confirmed by studies within the field of institutional talk, from a functional point of view (Depperman, 2011).

Psychoanalysis and Diagnosis in Argentina

In Argentina, public mental health care relies largely on psychoanalysis (Lakoff, 2006). The hospital where we conducted our research follows a heterodox perspective initiated by Jacques Lacan, which generally rejects the practice of diagnosis in mental health care (Bonnin, 2014a; Lakoff, 2006). To Lacanian psychoanalysts, diagnosis means identifying an "underlying structure" that can only be classified as neurotic, psychotic, or perverse (Thompson et al., 2006). From this perspective, different types of disorders (usually understood under the *DSM*'s classification) are seen as superficial phenomena that emerge as "symptomatic features" of these underlying structures. Such symptomatic features include, among others, substance abuse, obsessive–compulsive disorder, and conversion disorder.

From an "actors' point of view" (Garfinkel, 2002) regarding the verbal interactions between therapists and patients, when psychologists and psychiatrists in Argentina discuss "diagnoses," they are specifically referring to the three above classifications (neurotic, psychotic, or perverse). From this point of view, symptoms take on roles of critical importance: Once a structure is detected, the only possible cure—the only possible way to mitigate suffering—is to treat the symptom. The "case presentation" adopted by Lacanian psychoanalysts in Argentina (Lakoff, 2006, p. 75 ff.) thus coincides with the "clinical case formulation" advocated by Macneil et al. (2012).

Method

The present work is a part of a larger research project on language, interaction, and access to mental health care at an outpatient service at a public hospital in Buenos Aires, Argentina. Following a flexible, participatory research design, in the larger study, we are working together with psychiatrists and psychoanalysts to understand how

diagnosis is achieved through interaction. Our interest here, diagnostic formulations, emerged after observing that the organization of the sequences of "diagnosis" and "treatment recommendations" influences access and adherence to treatment (Bonnin, 2014b).

Data and Setting

We observed and audio-recorded 108 admission interviews at the outpatient mental health service from 2011 to 2014, after obtaining written informed consent from both professionals and clients. The research project was conducted in collaboration with the professionals of the hospital, who cooperated in the process of accessing the study site and obtaining data, as well as with the interpretation of data and providing feedback on the analysis. We obtained approval from the hospital Bioethics Committee to conduct our research. To protect confidentiality, we did not identify the hospital of record and replaced the names of patients and professionals with randomly selected letters.

The admission interviews were held in consulting rooms and lasted, on average, 20 minutes in duration. They were usually conducted by two professionals (either both psychologists or a psychologist and a psychiatrist). Patients were generally interviewed alone, although occasionally a relative or friend accompanied them. Although initially the principal investigator observed the interviews, we later decided it was less intrusive for the professionals to tape the interactions by themselves. Interviews were transcribed using a standard format (see online appendix), and the results were discussed with those professionals at the service who were willing to participate in the process of analysis.

Theory and Analysis

We adopted two analytical tools for our study, Conversation Analysis (CA) and Systemic Functional Linguistics (SFL). CA offered a sequential approach to meaning making. From this perspective, the meaning of each turn depends on how it is understood in the next turn: "the meaning of a speaker's turn is what the next speaker makes of it" (Wagner, 1996, p. 223). This allowed us to observe how therapists' formulations attributed a diagnostic meaning to the patients' previous turns. However, as Fogtmann Fosgerau and Davidsen (2014) point out, meaning making exceeds sequential analysis as there is a grammatical substance of language that is, up to a certain point, previous to each actual interaction. SFL helped resolve this problem by attributing language three different meaning-making aspects, called "metafunctions" (Halliday & Matthiessen, 2004): (a) It represents the world, its actions, and participants through an *ideational* dimension, (b) it expresses a certain relationship between the speaker and the hearer through an *interpersonal* dimension, and (c) language organizes these meanings in a coherent and cohesive text through a *textual* dimension. In this article, we focus on ideational dimension and the kind of meaning it produces: How through specific verbal choices or "processes" participants help representing the world in their texts (Halliday & Matthiessen, 2004, p. 170).

By combining both perspectives, we were able to observe how certain formulations made by therapists changed the ideational meaning of the patient's previous words, thus imposing a new meaning in the conversation and framing its diagnostic outcome. Adapting both the CA and SFL perspectives, we complemented interactions with an "account of the ways in which grammatical structures establish meaning" (Fogtmann Fosgerau & Davidsen, 2014, pp. 643–644).

New Perspectives

This analysis differs from previous studies on diagnostic formulations. Antaki et al. (2005) and Antaki (2009) conducted extensive analysis of formulations for closing a discussion around diagnosis (a diagnostic sequence)—formulations were explored as acknowledgments of a diagnosis prepared by the professional after fitting several signs into a symptom frame. On the contrary, our analysis focused on diagnostic formulations as a way for professionals to *open* a sequence aimed at eliciting more data about symptoms. Therefore, we included continuative expressions such as "hmmm" or "aha" that encouraged the client to talk. After all, if psychotherapy "cures with words," formulations help to produce and orient those words.

The second difference from previous research consisted of our focus on verbal substitution through formulation. As we were interested in how therapists manipulate patients' previous words to fit them into a diagnostic frame, we observed those formulations that changed processes of conducting intake interviews. Because formulations have preference for agreement, psychoanalysts' formulations can drive the patients' previous words to a different ideational meaning: A material process is a physical action in the real world that involves an actor who affects another participant.

Results

In what follows, we present six short interactions, translated from Spanish to English, using a standardized transcription format. A supplementary online file contains the original Spanish transcriptions; line numbers between the original and the translated transcriptions are maintained for comparison's sake.

We group results into three sections that show the use of verbal formulations in different settings, to (a) explore

different diagnostic hypotheses, (b) orient the interview toward a neurotic diagnostic hypothesis, or (c) orient the interview toward a psychotic diagnostic hypothesis.

Exploring Different Hypotheses

The optimal use of formulation in diagnosis is oriented to elicit more data without altering the core meanings of the patient's previous turn. Instead of simply checking a routine list of symptoms, it can help developing a strategy for clinical inquiry that does not silence the patient's voice (Ventres, 2015). In the next excerpt, we observe how the therapist's "fidelity" to the patient's words encourages elaboration but does not orient it in ideational terms.

Excerpt 1: Exploring

1. D. aha (.) why did you feel scared?
2. R. hm: because I didn't like what was happening
3. D. aha
4. R. maybe it was what I wanted: and and kind of nobody supported me
5. and everybody tried to- to:: throw him out I don't know (0.5) and then
6. then I began-
7. D. I do not understand (.) what you wanted::
8. R. was that it wouldn't happen (.) it wouldn't happen (inaudible) I wished they would carry on
9. supporting I don't know: I don't know: it's: (.) it's something political (inaudible)
10. this is what led me: to such↓ depression all that
11. D. you were depressed?
12. R. yes it depressed me so much and then: on the 19th that
13. they began to attack:: the parliament: I don't know
14. where=
15. D. = hhmm hmm:=
16. R. =and then I was just going to work because I used to w-
17. I used to work near Lomas (.) then this:: I got to work about
18. eight and then this kind of buzzing began
19. D. aha
20. R. a buzzing in my ear which was clogged and it didn't didn't::
21. unclog: it didn't unclog: then I kept
22. working I kept working four more hours and I went
23. home and I endured it that day (.) and still had that ear=
24. D. =anything else in addition to the buzzing?
25. R. and then I went to the Clínicas

When exploring different hypotheses, the therapist's formulations do not change patients' verbs; on the contrary, they allow for elaboration. The therapist's formulation in Line 11 restores an agent for the nominalized process "depression" (presented by R at Line 10), but this attribution of agency is presented as an interrogation. "To be depressed" is a behavioral process that can be disambiguated in either of two ways: (a) Behaver and phenomenon have the same reference ("you were depressed," Line 11), or (b) the behaver is affected by an external phenomenon ("it [social crisis] depressed me," Line 12). The patient's verbal repair is not presented as a contradiction or a correction. On the contrary, she begins her turn with an affirmation ("yes," Line 12) and introduces her own contribution as a formulation of the professional's. The therapist encourages elaboration with semantically empty continuative expressions ("hmmm," Line 15; "aha," Line 19). This strategy proves to be diagnostically successful, as the emergence of body experiences is typically associated with delusional discourse (that emerges at Line 18).

When the account of the "buzzing" begins, in Lines 18 and 20, the therapist begins to explore a psychotic hypothesis, encouraging further elaboration without imposing a formulation of her own:

Excerpt 2: Continuation.

1. R. at the Clínicas they gave me they did an ultrasound: a
2. magnetic (.) electromagnetic: I don't know how is it called=
3. D. hhmm hmm
4. R. =that they (inaudible) you in the head: they gave me pills (.)
5. and stuff (.) and:: well so I kept on (.) I took the pills (.)
6. I don't know (0.5) but the noise remained (1) the noise remained
7. D. anything else apart from the noise?
8. R. and then I broke down:: then (a wreck)(1.5) then

9. I began to suffer vertigo↓ vertigo and dizziness (.) vertigo and dizziness:
10. and I paid no attention (.) and vomiting: and vomiting
11. D. aha

Both Excerpts 1 and 2 show the diagnostic potential of formulating without altering the ideational meaning proposed by the patient. In Excerpt 2, the strategy is the same: A question that includes the formulation, which is as close as possible to the patient's words, is followed by continuative expressions that encourage elaboration: "to be depressed" (Excerpt 1, Line 11) is followed by "hhmm hmm" (Line 15) and "aha" (Line 19); "buzzing" (Excerpt 1, Line 24) is followed by "hhmm hmm" (Excerpt 2, Line 3); "noise" (Excerpt 2, Line 7) is followed by "aha" (Excerpt 2, Line 11). This strategy leads to interpreting this "noise" through a psychotic diagnostic frame.

Formulating Toward Neurotic Diagnosis

In some interviews, therapists seem to adopt an early diagnostic hypothesis. In these cases, verbal formulations are oriented toward the confirmation of such a diagnosis, even substituting the verbs used by patients in previous turns.

Excerpt 3: Substituting action by behavior.

1. D. (cipramil)(.) right (.) one question: why does Doctor
2. (García) now: refer you:[what did he say?
4. R. [because:: the:: the (inaudible) kind of took me to a
5. more extreme situation
6. D. how?
7. R. ((crying)) to wanting to kill myself
8. D. (oh: right)
9. R. I don't know
10. D. ((empathically?)) to wanting to kill yourself? tell me ¿how did
11. this killing yourself thing happen?
12. R. (inaudible) I felt that I was being dragged up °°by- a
13. person and that (inaudible)°°
14. D. that over overexcited you? [that stimulated you] a lot
15. R. [very excited] besides I am already like that
16. D. aha
17. R. and first when it was rai:ning and then I began to (inaudible)
18. and then everything was like that everything:
19. D. what do you mean by everthing like that?
20. R. everything like like like just- like cleaning like
21. tidying: like giving orders: like saying and:
22. D. oh (.) you became very obsessive [so to] speak
23. R. [very obsessive] (inaudible)

We observe in this excerpt the opening of the problem presentation sequence, extremely important to arrive at a tentative diagnosis in admission interviews (Bonnin, 2014b). While entering an anguish stage (Lines 4–7), the professional begins to intervene to organize the patient's narrative, asking her to elaborate on the death wish expressed in Line 7. Then she begins to describe a typically psychotic experience, "I was being dragged up by a person" (Lines 12–13), which can be understood as a psychotic dissociation. This experience is perceived as *real*, as a physical action taken over her by other person; therefore, it is presented through a *material process*, which affects the patient, as a goal, and whose actor is not identified: somebody who "drags her up."

The Spanish expression, "llevar para arriba" ("to drag somebody up"), can also be understood as an idiomatic expression, which means "to cheer up" or "to overexcite." Thus, the professional misses the literal interpretation and, instead, adopts the metaphorical one, interpreting it as an effect of medication, precisely an anti-depressive prescribed by a psychiatrist (Doctor García, Lines 1–2). The professional's formulation in Line 14 substitutes a *material process* ("[a person] dragged me up") by a *behavioral process* ("overexcited you," "stimulated you a lot," Line 14), which typically has a material aspect (because it designates an action, a "doing") and a mental aspect (because behavers are characterized as conscious of what they do). Although this substitution appears to offer an equivalent version of the patient's words, it explains the patient's suicidal attempt as a consequence of a sensation of euphoria caused by the antidepressant, misinterpreting the patient's hallucinatory experience.

As formulations are oriented toward agreement, the patient immediately adopts the agenda proposed by the professional: When the therapist, D, formulates "that overexcited you? that stimulated you?" (Line 14), R acknowledges, "very excited" (Line 15). When D proposes, "you became very obsessive" (Line 22), R repeats, "very obsessive" (Line 23). The latter is offered by the professional as a typical diagnostic formulation that disambiguates the Spanish expression "todo así" ("everything was like that," Line 18). By doing so, she definitively

discards the psychotic hypothesis and develops on an obsessive–compulsive neurotic one.

Formulations can be used to increase the patient's amount of talk, as they usually project toward the following turn. In our analysis, they do not close a sequence as much as they project over the next turn to obtain further elaboration. Formulations' preference for agreement is especially well suited to achieving this:

Excerpt 4: Substituting feeling by behavior.

1. R. ☺ I got (2) so angry (1) ten millions ten eh:
2. e- I you know what happens to me? Eh: all these things happen to me and I
3. feel, you know? very helpless (1.3) and when I feel
4. helpless: (1)
5. =¡o:::h!=
6. D. =ahh= (0.5) you get very angry::
7. R. and I react badly (.) [and that's what=]
8. D. [and this happens] on a daily basis too?
9. R. yes[::]
10. D. [mmm]
11. R. because today I also got very angry because of a woman
12. that::: oh (.) I was:::: because they were not here: yes (.) I
13. when I arrived to the [little room]
14. D. [and when] you get angry, what do you do? you don't
15. control yourself, so to speak: you don't control yourself or how (1)
16. because the last thing- (1.5) what happens to you let's say when you get angry
17. R. no:: it hurts me
18. D. aha
19. R. it hurts me (1) I don't: I don't do anything
20. D. aha
21. R. I wish I could strangle [someone]
22. you know?
23. D. [right] maybe it crosses your mind
24. R. ri:ght it crosses my mind (0,5) if I strangled someone maybe
25. I would feel, you know? relieved (1)
26. D. hmm
27. R. (2) but, you know? It's not politically correct
28. D. aha

R gets emotional and presents herself as senser of a feeling ("I feel," Line 3; "I feel helpless," Line 4). The therapist, however, to evaluate the patient's impulsivity, presents her as agent of a behavior ("you get very angry," Line 6). In SFL terminology, a mental verbal process (which categorizes actions in terms of perceptions and feelings, "to feel helpless") is substituted by a behavioral one ("getting angry," "not controlling," Line 14, 15). The new verb is at the "near mental" side of behavior: "to worry" (Halliday & Matthiessen, 2004, p. 251). This formulation does not simply propose a different verb; it changes the ideational meaning projected by the patient's previous turn: Impulsivity is no longer an inner feeling, but an actual impulsive behavior of R.

Formulating Toward Psychotic Diagnosis

In the interview we analyze next, the therapist arrived at a psychotic hypothesis. Throughout interaction, she substitutes previous verbs by a material one:

Excerpt 5: Substituting feeling by action.

1. R. when he says those things I feel that people are bullying me(1.3)
2. and I feel the same way about the mother of the girl I take care of
3. you know?
4. D. what does the mother do to you?
5. R. oh: when people, you know? always ahh- now I kind of
6. cured her (.) because otherwise, you know? as I took care of the girl
7. if she had anything to do in the morning (.) because she is a lawyer
8. you know? I had to go t- she would call me to take the
9. girl::: to school
12. D. aha
13. R. then she would return at half past eleven at night to get the
14. key for the next morning (0.5) but she had me for a few
15. pesos twenty four hours a day

In this excerpt, the therapist begins to explore a "kind of paranoid side" hypothesis, as she explained after the interview. Therefore, she formulates "what [I feel] happens with her mother" (Line 2) as "what does her mother do to you" (Line 4) and assumes this to be an objectively true phenomenon although the patient presents it as a subjective feeling. The mental process used by the patient is now replaced by a material one, adopting a paranoid point of view: It is not something the patient feels about

other person, but something the other person is actually doing to her. Through this mechanism, the therapist orients the interaction toward her own agenda, eliciting more talk through "aha" (Line 12). With this formulation, she inadvertently substitutes an ideational representation of the world (a perception) with another (an action).

In the next example, also with psychosis as the diagnostic frame, the professional replaces a behavioral process, centered on the patient as behaver, with a material process, in which the patient is the goal of the action of an abstract entity presented as agent:

Excerpt 6: Substituting behavior by action.

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 1.R. sometimes (.) right (.) sometimes
   I take it: when I can't
 2.sleep (0.5) I take it at night
 3.D. too
 4.R. >yes yes yes<
 5.D. well (.) well (.5) and what::-?
   What keeps you awake?(3)
 6.R. e:::h like: some ti:mes I have a
   lot of thoughts (2) my
 7.A lot of thing from the past: go
   through my head=
 8.D. = aha
 9.R. ehmm:: my children (.) who I miss
   (who are far away from
10.me)(1) well (.) sometimes because: I
   sleep an hour let's say in
11.the afternoon (inaudible) but it's
   difficult to sleep because of:: my
   head
12.it wanders a lot: let's say
13.D. you have a lot of thoughts (.)
   right? right
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Again, as formulations change, so does the meaning projected by verbs. In the patient's account, he adopts the role of someone who experiences his own inability to sleep: "I can't sleep" (Line 1), and that is the reason to self-medicate ("I take it [a sleeping pill] at night," Line 2). In the therapist's account, on the contrary, the patient is presented as the goal of a material process whose agent remains indeterminate: "What keeps you awake?" (Line 5). With this change, the patient is now a passive entity who is affected by something/someone else. After a noticeable pause of 3 seconds, the patient adopts the agenda proposed by the therapist and identifies the "thoughts" (Line 6) as the reason why he cannot sleep. After encouraging the continuation, as in other cases, through "aha" (Line 8), in Line 13, the therapist again formulates what the patient said in previous turns in his own terms: "you have a lot of thoughts" (Line 13). This is a typical diagnostic formulation that, after obtaining diagnostically relevant information, closes the "problem presentation" sequence with a non-verbally agreed formulation ("right? Right," Line 13). These "thoughts" were later identified as "ideations," leading to a diagnosis of psychosis.

Discussion

Diagnosis is not an individual activity conducted by psychiatrists or psychologists who objectively elicit data from their patients. On the contrary, the strategic use of questioning and other interactional devices during the process of diagnosing illustrates how professionals can orient conversation, and the patients' contribution, toward a diagnostic outcome (Bartesaghi, 2009; McGee, Del Vento, & Bavelas Beavin, 2005; Mehan, 1990). In this article, we explore one aspect of this process from the perspective of a specific type of diagnostic formulation that affects verbs and is oriented toward the next conversational turn, with a purpose of generating more therapeutic talk by the patient. In this sense, as noted above, the use of diagnostic formulations is not exclusive of psychoanalysis. On the contrary, our results may help understand how psychotherapists' utterances affect the whole diagnostic process in other mental health care settings.

With these formulations, therapists make a double move. On one hand, it is prominently a move forward, asking for further elaboration, either by using a question or projecting toward the next turn. On the other hand, it offers a formulation of the patient's words as a presupposition, frequently in the form of a definite description. Therefore, the therapist's formulation is incorporated as a part of the frame of discourse and becomes extremely difficult to argue with, under the risk of being impolite or oppositional.

As seen in Section A of the "Results" section of this article, one of the optimal functions of formulations in developing a diagnosis is to disambiguate the patient's previous turn, which can be confusing or obscure. We observed how certain words (especially nouns derived from verbs, called nominalizations), can be presented as problematic, thus asking the patient for disambiguation in the next turn. This case shows that by respecting the ideational meaning provided by the patient, diagnostic-relevant information emerges with no need of intrusive formulations by the therapist. Furthermore, when discussing the roles related to the behavioral process, more talk is generated by the patient, helping the therapist to make more accurate formulations ("the noise"), generating more relevant information, which only requires short, semantically empty expressions to encourage continuation.

Sections B and C, on the other hand, show active therapists who, by replacing the verbs offered by patients, condition the whole development of the symptoms presentation. When listening to a patient, psychoanalysts tend to interpret the other's words not as a transparent description of events but as a belief or experience about those events. In psychoanalytic terms, the matter with which professionals work is the patient's account of the facts, not the facts recounted.

Behavior, as a type of process that lies between acting and feeling, was targeted by formulations that contributed to a neurotic diagnosis. In some cases, as in Excerpt 3, the substitution of a material process by a behavioral one can lead to a diagnostic mistake. Research and the collaborative analysis of the interviews help to identify and correct this kind of error: When discussing the transcripts with the mental health care team, we were able to detect and redirect mishearings.

When the interview arrives at a psychosis diagnosis, on the contrary, professionals formulate in *material* terms, as a way into the patient's delusional world. Therefore, what a patient presents as his or her own behavior can be reinterpreted as a hallucination, which he or she thinks is being affected by someone else's action.

Although these co-occurrences do not express causal relationships, they may help us to understand the interactional process of diagnostic development within a clinical context. When psychologists build a neurotic hypothesis, they seem to interpret patients' words as related to behaviors; neurosis becomes accessible through a symbolic order that is made manifest in language that describes the experience of the patient. When exploring a psychotic hypothesis, professionals seem to endeavor to enter the patient's delusional world, as a way to understand its internal logic. Language is understood in its more "referential" side, as a means to interpret behaviors and feelings as actions exerted by patients.

Limitations

First, although there seems to be an association between behavioral processes and neurotic diagnosis, on one hand, and material processes and psychotic diagnosis, on the other, there is not enough evidence to interpret it as a causal relationship. Second, we focus on formulations that affect ideational meaning as projected by verbs; it may be that verbal substitutions do not always affect the diagnostic outcome or that diagnoses do not always condition verb substitution. Third, we reviewed one particular area of formulations in our study, which can be used to open clinical conversations (rather than close them prematurely, for diagnostic purposes). This may not reflect how formulations may occur in other aspects of therapist–patient communication. Finally, the excerpts we present are translations of the original interviews; as with any translation, alternative renditions are possible.

Conclusion

We expect our analysis will help health professionals to understand how they can impose diagnostic agendas on patients without being aware of it. By recognizing this possibility, they may better avoid orienting the therapeutic talk of clinical interactions to an a priori defined diagnostic frame. They may also find clinical relevance to this understanding, to gather diagnostically relevant information at the same time they satisfy clinical and institutional criteria. Above all, admission interviews are not just quasi-experimental interventions that elicit data from patients. Ideally, they can function as exploratory devices that foster therapeutic interactions

Transcript Symbols

Symbol	Meaning
[	Indicates the point of overlap onset
]	Indicates the point of overlap termination
=	Inserted at the end of one speaker's turn and at the beginning of the next speaker's adjacent turn, it indicates that there is no gap at all between the two turns
(3.2)	An interval between utterances (3 seconds and 2 tenths in this case)
(.)	A very short untimed pause
word underlining	Speaker emphasis
:::	Lengthening of the preceding sound
-	A single dash indicates an abrupt cutoff
?	Rising intonation (not necessarily a question)
!	An animated or emphatic tone
,	A comma indicates low-rising intonation, suggestingcontinuation
.	A full stop (period) indicates falling (final) intonation
CAPITALS	Especially loud sounds relative to surrounding talk
° °	Utterances between degree signs are noticeably quieter than surrounding talk

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