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A Psychoanalyst’s Reflection on Conversation Analysis’s Contribution to His Own Therapeutic Talk

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The topic of this chapter is almost embarrassingly self-referential. I would certainly have declined the invitation to write it, had I not agreed with the editor that the curious situation I find myself in – as academic and practitioner – fitted peculiarly well with the theme of this book. If there is a chance that a personal account of my work might advance our understanding of the applicability of Conversation Analysis, then I ought at least to try to provide one.

I started psychoanalytic training six years ago. The training is given by The Finnish Psychoanalytic Association, by a member of the International Psychoanalytic Association (IPA). My training, in other words, is in a ‘Freudian psychoanalysis’ (and not in some other form of psychotherapy, such as Cognitive Behavioural Therapy, Interpersonal Therapy or the like). For about five years now, I have been practicing psychoanalysis, under the supervision of a senior psychoanalyst. I see one patient four times a week in 45-minute sessions. I expect my training to be finished in about a year’s time. Not much will change in my practice after graduation, except that I will be free to stop going to supervision (which I will hardly want to do) and I might be able to charge higher fees from my patients (which they can’t afford to pay, so that will not change).

Alongside being a candidate psychoanalyst, I am a conversation analyst. My professional history as conversation analyst is longer than that as psychoanalyst: it started with a doctoral dissertation on AIDS counselling almost twenty years ago, and has continued ever since with studies on medical interactions and everyday interactions. After having studied routine medical interactions for years, I turned to psychoanalysis as a new research topic. Examining the ways in which language is used in examining mind appeared to me as an exciting extension to my earlier studies that focused on the ways in which language is used in examining body.

At the beginning part of this new project, I started to feel that it might advance my understanding if I acquired a practitioner’s perspective to this new research topic of mine. And, to be honest, becoming a psychoanalyst had been my professional dream many years ago, and realising that dream now became possible.

I’m well aware of the theoretical tension, if not antagonism, between some forms of psychoanalysis and some forms of Conversation Analysis. In what might be called a social constructionist reading of Conversation Analysis, ‘mind’ is understood as an interactional construction, references to which serve as a resource for local accounts and justifications of social action. In what might be called a ‘one person psychology reading of psychoanalysis’, the processes within individual minds are the real motivational source and shaper of human action and interaction. In spite of this tension, I enjoy being where I am, as an inhabitant of both worlds.

In what follows, I will try to explicate what it means to inhabit both worlds. The chapter is divided into two parts. In the first part, using my clinical notes and ethnographic notes taken for the purposes of this study, I will describe how conversation-analytical understandings have shaped my ways of perceiving my interactions with my clients. In the latter part, I will try to explicate what kind of conceptual rethinking in my version of Conversation Analysis has been instigated by my clinical work. I shall also offer – if briefly – some thoughts on how we might solve the apparent impasse between the social constructionist and the realist account of mind, an impasse that is troubling to someone who, like me, works both with the mind’s outer expression and its inner workings.

Part 1  CA informing the work of a psychoanalyst

Moments of (CA-informed) reflection during the sessions

People make myriad choices in any social interaction, but usually they are not aware of these choices. Yet the choices people make are extremely meaningful as, on the basis of those choices, ordered actions and mutual understanding is achieved. Harvey Sacks was well aware of the non-reflective or automated character of interactional choices, and he encouraged his students just to focus on what comes off in interaction, and not to worry about how can people think so fast (Sacks, 1992a, p. 11).

Psychotherapy is no exception to this: there is also that the choices participants make are largely not conscious. (This in spite of the fact that an overall goal of psychoanalysis is to make the patient more conscious about his or her mind.) Thus, as what I do as an analyst escapes my conscious attention, it is all the more difficult to account for the ways in which my training and
experience as conversation analyst has shaped my doings as an analyst. But for the purposes of this book, with its commitment to showing how CA and practice intertwine, I will try.

For some months, I took ethnographic notes after my psychoanalytic sessions, with the aim of describing how my choices of action during the sessions are possibly informed by conversation-analytical considerations. I did not find myself being involved in conversation-analytical reflections prior to choices of action. Choices of action – for example in terms of how to respond to the patients talk – appeared to take place in a non-reflected way. What I did find, however, was that occasionally I became aware of choices that I had just made, and reflected upon those choices in what appeared to be a CA-informed way. There were two recurrent environments for this occurrence of awareness: emotional responses and responses that have to do with the maintenance of local accountability by the patient.

Recognition through response tokens

Conversation Analysis emphasises the importance of the placement and design of any utterances in interaction. I presume this has sensitised me to pay attention to the ways in which I respond to the talk of my patient. Design and placement of response tokens is a case in point (for response tokens in conversation, see Gardner, 2001; and Sorjonen, 2001; and for their use in psychotherapy, see Fitzgerald 2009). In Example 1, the patient is telling me about her latest visit to her parents’ house where she does a lot of practical maintenance and repair work. In her utterance, she analyses her ambivalence. (The italicised extracts labelled ‘ethnographic notes’ are my own near-contemporaneous write-ups of parts of the therapeutic session; either remembered exchanges, or commentaries about my or the client’s actions and motives).

Example 1 (ethnographic notes)

PA: This thing is kind of multi-faceted, I’m quite reluctant to be there, but at the same time, I’m unable to leave.

AN: Mm:

When I produce my response token, I emphasise it in such a way that makes me hear what I say as recognising what the patient just said (cf. Voutilainen, Peräkylä and Rusuvuori, 2010). This recognition involves both what the patient says (her ambivalence) and what she does (observes her own mental states): both the ‘content’ and the ‘action’ are treated as valid here and now. The patient is doing what she is supposed to do as a patient in psychoanalysis.

Emotion descriptions are one recurrent environment for such recognising response tokens. Example 2 is a rather straightforward case. The patient is describing a moment, a few years ago, when she was cleaning in the magnificent library that belongs to her father, who is a scholar of great eminence.

Example 2 (ethnographic notes)

PA: I lifted my gaze up and saw all these books, and at that very moment I understood that I hate these books.

AN: \(\downarrow\)Mm:

My emphasised ‘\(\downarrow\)Mm’ is designed to convey recognition of the patient’s experience. It treats the patient’s experience as one that I can understand and consider as valid. This narrative is a nodal point in the analysis: inaccessibility of aggression appears as a key issue for this patient, and this story (which has been told a few times during the analysis) represents a moment at which she, for a short moment, felt in touch with her aggression.

Sometimes such a recognising response token may carry with it a package of orientations that link the current moment to some aspect of the history of dialogues between me and the patient. Consider Example 3. The patient is telling about a piece of academic work that she has concentrated on for a long time, and which she now wishes to complete.

Example 3 (ethnographic notes)

PA: I want to leave this behind, this research has for such a long time been, as it were hanging in the air, in the same way as in my life things have been hanging in the air.

AN: Mm,

PA: ((continues))

This response token is located after the patient has drawn a parallel between her research having been unfinished (‘hanging in the air’), and the many other things in her life that are unfinished. My response token is again emphasised, conveying recognition of what has been said. In this case, the recognition is targeted at the idiom ‘things hanging in the air’. This idiom creates a linkage to what the patient said a few sessions earlier: when her mother fell ill, several years ago, a ball was thrown into the air, and after that, she feels that her life has been characterised by a kind of temporariness, lack of conclusiveness, as if the ball were still in the air. Now, by using the same idiom, she hearbly invokes this tragic family history as a context for her current academic plans. I recognise this invocation, which is conveyed by the placement and emphasis of my ‘Mm;.’.
It is clear that ethnographic notes cannot convey the details concerning placement or design of utterances in any way comparable to the exactness of an audio or video recording. Therefore, the instances of interaction presented in this chapter are not research data in a CA sense. However, my notes on cases 1–3 do indicate that during the course of my daily work as psychotherapist, I have paid attention to my choice of response tokens, and especially the choice of the prosodic shape, as well as placement, of these tokens.

These tokens may stand out as exceptional in the psychoanalytic dialogue, which is normally characterised by the analyst’s neutrality (and also by scarcity of any ‘back-channel’ items). Hence, it is possible that my awareness of my action in these particular cases has also to do with a conflict of some sort: I could have remained neutral (through different prosody in my response tokens, or by withholding response tokens altogether), but I didn’t. In the following set of examples, such ‘post hoc motivational conflict’ becomes apparent.

**Maintenance of accountability**

One of the well-known (and often criticised and/or parodied) features of psychoanalysis is the silence of the analyst. At junctures where an interlocutor in everyday interactions would take a turn at talk, the psychoanalyst often remains silent. My conversation-analytical training serves as a resource for some additional understanding in those moments when I become aware of my silence. Consider Example 4, which is from the beginning of a session.

**Example 4 (ethnographic notes)**

**PA:** I’m sorry for being late again.
(silence)

**PA:** (states a reason for being late.)
(silence)

I choose not to respond to the apology by the patient, nor to the reason that she gives. Through my silence, I maintain the momentary accountability of the issue; should I have accepted the apology, or the reason for being late, I would also have treated the issue as closed, and ‘not-any-more-accountable’. (For accountability in interaction, see, for example, Heritage, 1988; and Antaki, 1994). I feel my silence in myself as some kind of tension (which I think arises from the fact that acceptance is so strongly preferred in ordinary conversation in this kind of context); this feeling reveals itself as a distinct choice that I have made.

There are moments when I choose to respond to the patient’s talk, and I become aware of this choice, probably because conflicting motives are involved. The response dissolves accountability, which I on the other hand would have wanted to maintain. Consider Example 5, which is from the same session as Example 4. Prior to the segment, the patient has talked about how taxing it feels to come to the sessions, and how she feels that the burden remains there throughout the day, after a session in the morning.

**Example 5 (ethnographic notes)**

**PA:** And then on the other hand, those days usually feel better, when there is no session.

**AN:** Mm:

I respond to the patient’s assessment with a recognising ‘Mm:’. Reflecting back to this response after having produced it, it appears to me as one through which I convey to the patient that her experience is valid, and that I accept it and don’t criticise her for that. And at the same time, I wonder if the recognition I gave to the patient’s experience may have come too early. Did the recognition through emphasised ‘Mm:’ also close down the issue of taxing sessions? If I had withdrawn any response at this moment, the patient’s relief on those days when she doesn’t have to come to the analytic sessions might have remained an accountable issue for some time longer, and she could have elaborated more upon that very experience.

A similar question arises in my mind after a response token in Example 6 below. The note is taken after the last session of a week that has included one missed session and another one to which the patient arrived late.

**Example 6 (ethnographic notes)**

**PA:** In the events this week, there’s been encapsulated the whole history of my analysis.

**AN:** Mm.

After having produced my acknowledgement token, I begin to doubt. Did I treat what PA said, ‘understood’ in a premature way?; would silence have enabled him to explore the meaning of the past week more, and also the meaning of the whole analysis to him?

A question that topicalises something that the patient talks about can raise the same doubt: did I dissolve the accountability too early. Consider Example 7.

**Example 7 (ethnographic notes)**

**PA** tells me that she didn’t come to the session yesterday morning because there was a piece of work that she needed to finish by 11 am. I ask her ‘what was that
piece of work’ and she tells me. My question validates the reason that PA had for not coming, and by so doing, it also halts the investigation of the very fact that PA did not come yesterday. While the conversation goes on, I am thinking whether my question, for that reason, came too early.

Maintenance of accountability involves not only the choice of withholding response or giving it – it also involves the design of the response. In Example 8, I find myself producing a ‘designedly neutral’ response token, through which I understand that I am trying to maintain the patient’s accountability concerning her difficulty to speak freely during the analytic hour. After having come late to a number of consecutive sessions, she has at last arrived in time. Example 8 shows my recollection of her first utterance during that session.

Example 8 (ethnographic notes)

The patient says, ‘It makes me laugh that when I come here in time, then I just stay silent.’ I am controlling my response: It is a ‘Mmm’, but one that does not acknowledge the humorous tone in the patient’s utterance. I understand this as an effort on my side to maintain PA’s accountability, to not close the sequence PA has initiated, to maintain the state of talk where PA continues to think about what is happening right now in the consultation room.

There is a paradigmatic question that psychoanalysts use: ‘what comes to your mind’. That particular question seems to have the power to maintain accountability on the very issue that is, through its placement and design, targeted at. Sometimes the maintenance of accountability through this question may involve a conflict of motives and the analyst becomes aware of his choices. This happened when my patient apologised for not having arrived for the session the day before. I responded to the account by asking ‘what comes to your mind’. After having asked the question, I asked myself whether I had been invoking moral accountability in the disguise of an invitation to self-observation.

In all cases shown thus far, I, as the analyst, became aware of some choices of action that I made while listening and responding to the patient’s talk. In the data fragments presented above, the actions of the patient and the analyst are described in a summary fashion; it is clear that these descriptions lack the level of detail of conversation-analytical transcripts. Of interest, however, are the analyst’s immediate post hoc reflections of what he is doing or not doing. They are moments where a Conversation Analyst meets a psychoanalyst: moments during which, to make sense of the state of the talk that I shared with my patient, I used some of the sensibilities regarding interaction that I have gained through my conversation-analytical work.

Much more goes unnoticed. It is possibly conflict of some sort that makes us aware of choices that we make in interaction. At some moments, I will become aware of a choice that I just made in my dialogue with the patient; and these choices may involve a motivational conflict.

It should be added that I don’t have any empirical evidence to indicate whether or not my actual interactions with my patients are in any systematic ways different from the practices of my psychoanalyst colleagues without conversation-analytical training. When I asked my supervisor’s view, she told me that she thinks there is a difference – suggesting that I have more of a researcher’s attitude to my interactions with the patient, not feeling a need to intervene therapeutically as often as the average psychoanalyst or candidate analyst does. But this difference may consist more in ways of reporting interactions (in supervision) than in the interactions themselves; and even if it concerned the very interactions, it would have more to do with the general distinction between a ‘therapeutic’ and a ‘research’ orientation, and not so much to do with CA as a specific approach to interaction. Basically, I am ready to accept that CA has not made my practice different.

As the observations and reflections presented in this chapter suggest, the therapist’s actual interactions with the patient are largely pre-reflective. Therefore, in my hands, CA has been a resource to enhance understanding of this practice at some particular junctures. What kind of loops these new understandings possibly have back to the shaping of these practices, in my own work and in the psychotherapeutic community, remains to be seen as our understanding grows.

Reading interaction after the sessions, in the light of research findings

After their sessions with the patients, psychotherapists typically make some notes about what happened during the session. The note taking is particularly important when the therapist is having supervision for his work, because the notes are the material that will be discussed in the supervision. In this section, I will be exploring my clinical notes from the past few years. (In the preceding section, the ‘data’ were ethnographic notes produced for this particular chapter.)

The clinical note taking after the session is a moment of reflection. While taking notes, I memorise what happened during the session, which inevitably creates some distance between the memoriising (and writing) subject, and the events that I memorise. My notes should reveal if conversation-analytic work has had some influence on the ways in which I organise my recollections. Of particular interest, I think, are my own findings of psychoanalytic interaction.
(reported in Peräkylä, 2004, 2005, 2008 and 2010; see also Vehviläinen 2003 and 2008 for closely related work); have they left some impact on my way of reporting my interactions with the patient? This is a reflective, textual variant of the question that other contributors to this book have asked, namely does CA knowledge affect subsequent talk; here, my question is whether it affects subsequent writing about the talk.

Much of Vehviläinen's and my work revolves around what might be called an interpretative trajectory: a continuum of interactional moves which prepare for an interpretation to be given by the analyst, and after the interpretation, work on the patient's response. Only a part of the steps and interactive phases involved in this trajectory have found their expression in my own way organising my recollections from the sessions. What my notes do not attend to includes the preparation of interpretation through invoking a 'puzzle' by means of formulations, extensions and confrontations (see Vehviläinen, 2003), the patients' ways of evading some aspects of interpretation in their agreeing responses (Peräkylä, 2005) and analysts' ways of shifting the perspective of description in third-position utterances after the patients' agreeing responses to interpretations (Peräkylä, 2010). I will come back to these practices, after having shown the points at which conversation-analytic work has influenced the organisation of my recollections, as reflected in my post-session notes.

A point in the interpretative sequence where my clinical notes and my conversation-analytical research by and large align involves agreement, disagreement and elaboration shown in the patient's responses to interpretations. In Peräkylä 2005 (pp. 164–5), I described the variation of patients' responses as involving, as most basic types, straightforward rejections or acceptances, as well as 'in-between' responses (of the type 'I'll have to think about that'). The most interesting responses, however, were elaborations, where the patients convey their agreement and understanding of the interpretation by taking it up and by continuing talking about it. The same variation of response types can be found from my notes.

Compact agreements with interpretation have found their way into my note taking with a special symbol. In my clinical notes, I use the sign % to convey that the patient accepted an interpretation. Consider the following example. Text between double parentheses (( )) involves my summarising descriptions of topics and events, text between 'smaller than' and 'greater than' < > signs involves talk by the analyst, all other text involves talk by the patient. All talk is paraphrased on the basis of post-session recollection. Reading the extracts from the clinical notes requires some patience, because the notes are like shorthand, the text being condensed. (I have put the clinical notes in a different font, to mark them off from my ethnographic notes.)

Example 9 (clinical notes)

((talk about PA being able to at last leave things behind, not be mentally stuck in his past misfortunes)) – <what comes to your mind about leaving things behind in life? > – guilt, disappointment – guilt for X's death – external and internal in the same time – <that you are betrayed, disappointed and guilty at the same time> – % – things are not so overwhelming any more 10.8.09

In my latter utterance (see the penultimate line in the segment), I summarise the patient's experience as involving three overlapping feelings: being betrayed, disappointed and guilty. The % sign conveys my recollection at the time of the note taking that the patient agreed with this characterisation, without taking it up or further developing it. A similar kind of compact agreement is shown in Example 10. The patient is describing her recent visit abroad, comparing it to previous holiday travels. Now, unlike before, she was able to relax during the holiday.

Example 10 (clinical notes)

- no compulsive buying of things – sitting in parks, taking photos – (...) – <as if you had now more space inside yourself> – % – perhaps the best trip that I have ever done 1.11.07

The % sign indicates my recollection that the patient agreed with my characterisation of her having now had more internal freedom ('space') during the holiday. The next thing I have taken note of is her overall assessment of the trip, which, although being topically related to the previous talk, does not deal with the 'internal' perspective brought about in the interpretation.

So, in recollecting patient's responses to interpretation, I seem to have adopted the category of compact agreement that I arrived at in my CA studies on psychoanalytic interpretations. The compact agreement is different from elaboration, which also figures in my note-taking practices. Sometimes the word 'elaboration' is used as shorthand, to refer to a response in which the patient takes up the interpretation. Consider Example 11. The patient had recently painted walls in the living room of her flat, which she initially felt as deeply rewarding. Now, however, she has started to feel depressed again.

Example 11 (clinical notes)

- wish that painting the walls would have been part of some internal process ((not PA's words)) – it was not that – ... <disappointment that you didn't have time to paint the bedroom> – % – ((elaborates)) 27.11.07
In my recollection of the session, the patient first indicates her agreement with the interpretation (coded as %), thereafter moving into elaboration. This sequence of events is very common in my CA cases of interpretations; I have used the same template to describe the course of events in my notes.

In Example 11, the patient’s action after interpretation is coded as ‘elaboration’, but how the patient elaborates, is left unspecified. In Example 12 below, the design of the elaboration is paraphrased. The category of ‘elaboration’ is not used in my notes, but the action conveyed by the patient’s utterance paraphrased in the notes involves an elaboration, as I have described it in my conversation-analytical work. The patient is talking about her recurrent exhaustion during the analytic sessions.

Example 12 (clinical notes)
- difficult to talk – no strength – sometimes I have the strength to continue 45 minutes, like yesterday, then again I don’t have the strength – ... <it appears that talking here is taxing. It consumes your strength> – % – it’s like lifting a wet cloth from water – then it falls down there again. 4.12.07

In my interpretation – which actually does not involve much more than reflecting back to patient what she already has told me, but not packaging this as a formulation of patient’s words, but as my own view – I suggest that talking to me is taxing for the patient. In her response, as I have reconstructed it after the session, the patient first agrees with the interpretation, and then moves on to elaboration in which she illustrates her experience through a metaphor.

In yet another example, both agreement and elaboration are depicted by utterances that I paraphrase in my notes:

Example 13 (clinical notes)
((talking about plans regarding place where to live in future)) – ... – ((silences)) – <my feeling: not much is happening now, but you are expecting things to happen -> that was a good way to put it, I am like in traffic lights, waiting for the green – ((silence)) 22.10.09

In his response to the interpretation, the patient first agrees (‘this was a good way to put it’) and then elaborates with the metaphor of being in the traffic lights.

While compact agreement with interpretation is usually expressed by shorthand (%) in my notes, and elaboration is often expressed by shorthand (‘elaborates’), disagreement tends to be paraphrased in full utterances. Consider the following example:

Example 14 (clinical notes)
<perhaps: the beginning of the analysis ‘woke up’ the good, healthy mother. Then, as the analysis goes on, the mother falls ill again. -> I cannot get hold of what you say, it may be like that – the sentences that you say would work also without the reference to mother – it woke up the good, then it falls ill.

The patient’s disagreement with the interpretation is paraphrased through accounts which do notflatly reject what I suggested, but cast it as something that is subjectively inaccessible for the patient. However, in some cases, categorical descriptions are also used in my notes in paraphrasing rejections. Consider the following:

Example 15 (clinical notes)
((P tells me about having spoken with a close friend about the possibility of terminating the analysis)) – I told her that one of my feelings is that I would leave you [the analyst] with nothing in your hands. This has to do with a similar thing in my relation to other people in my life, my feeling of responsibility – ((talks further about her understandings about how long analysis should be)) – <can there be a reversed thought in the background: you are afraid that you will be left with nothing in your hands if you quit -> it does not feel like that ((first a stretch off denial, then a reflective denial alongside which she is exploring her feelings.)) 22.9.09

In describing the patient’s response to my interpretation, I first use a paraphrase (‘it does not feel like that’), after which I move into categorical descriptions of two consecutive denials.

The notes shown above suggest that my work on reception of interpretations informs my way of organising my recollections of the sessions in my clinical notes: I am perceiving my interpretations as actions that invoke a response from the patient. In my clinical work, I categorise the patient’s responses in a rather similar way as I have categorised them in my CA research.

Yet another practice discussed in my CA work, showing up in my notes (and also in my recollections) involves the analyst designing the interpretative utterance in specific ways that increase the plausibility of the linkages between spheres of experience that the interpretation proposes are connected (see Peräkylä, 2004). Thus, for example, when my patient described, in subdued complaining tone, that an upcoming annual January event in her workplace will nail down her life once again into the old repetitive pattern, and she will know exactly ‘the course of life until next January’, I suggest to
her that she might be feeling that the analysis also is in a repetitive pattern, and she knows exactly ‘the course of analysis until next January’. Circulation of the description ‘knowing the course of X until next January’ demonstrates for the patient the linkages between the two spheres of experience (working life and analysis), and serves as a means to draw the patient’s attention to a feeling of stagnation in the analytic relation.

So, in designing my interpretative utterance, I find myself interacting with my patient in ways that I have first encountered in my CA work on psychoanalysis. However, in my CA work, I have also discussed a number of practices pertaining to interpretations that do not show up in my clinical notes. Regarding these practices, my research work has not left traces on my way to organise my recollection as a clinician. One of them, most extensively discussed by Vehviläinen (2003; see also Peräkylä, 2004), involves the invocation of a puzzle in the interaction that eventually leads up to the interpretation. My notes very seldom, if ever, show such ‘projects’ (see Schegloff, 2007) in which the analyst’s responses to patient’s talk are geared to prepare the ground for an interpretation to come. Second, the notes do not show the patients designing their elaborations of interpretation (which, by their face value, show agreement and understanding of the interpretation) in ways that make the elaborations selective vis-à-vis the interpretation, thereby facilitating covert resistance towards the interpretation (see Peräkylä, 2005). And third, my CA work suggests that an important facet of the interpretative work takes place in ‘third position’, that is, in analysts’ utterances that come after the patients’ responses to interpretations (Peräkylä, 2010). My clinical notes do not show any traces of such third-position interpretative work.

Why might it be that these practices that I have found by investigating psychoanalytic practice through CA do not show up in my notes on my own practice? One possibility is, of course, that my own practice is different from that of the analysts whose work I have been investigating. In principle, it is possible that I just don’t do those things. That could also apply to my patients: they could be different as well, as they don’t do such selective elaborations as the patients in my CA tapes do. The other possibility is that in writing up my notes, I am not able to reach these aspects of interaction. They go unnoticed while they occur, and I do not have access to them afterwards, either. Should this be the case, a further question would arise: Why is it, then, that I do have access to the basic sequential structure of interpretation (the adjacency pair interpretation and response) and I do perceive the patient’s responses broadly along the same lines as I have analysed them in my conversation analytical work? And that I do perceive myself designing some of my interpretative utterance by circulating the words that the patient has used? Can it be the case that some interactional phenomena – perhaps the more robust ones – are available

in situ to the practitioner, while others – perhaps the more complex and delicate ones – are not available, even if the practitioner is, like I am, highly experienced in accessing these phenomena in the role of a CA researcher?

I have no definite answers to offer, and I am ready to live without one. As a conversation analyst, I can continue my research work along the lines suggested by Sacks (1992, p. 11), by just trying ‘to come to terms with how it is that that the thing comes off’. Practitioners’ awareness, not even my own practitioner’s awareness, is not needed as an evidence for an organisation of interaction to be there. And as a psychoanalyst, I will continue my clinical work, with the understanding that much of what I do – but not all of what I do – remains outside the scope of my reflective awareness.

Part 2 Clinical practices which prompt theoretical rethinking in CA

Understanding mind in interaction

Whereas the first part of the chapter explored the ways in which my experience as a conversation analyst has influenced my work as a psychoanalyst, this second part of the chapter will focus on the influence in the opposite direction. I will be asking how the psychoanalytic practice has influenced my conversation-analytical ideas.

We are not talking about direct and distinct consequences of clinical practice upon my conversation-analytical thinking. The influences are vague and certainly indirect. Having said this, it does appear to me that being involved in clinical training and clinical work has pushed me towards rethinking and re-explication of my own understandings regarding some central ideas of Conversation Analysis. The relation between interaction and mind is at the centre of this rethinking.

There are two contradicting positions on mind and interaction, both of which I find unsatisfactory. I will explain both positions in simplified terms. The traditional psychoanalytic thinking represents a position than can be characterised as mentalist (see Watson and Coultet, 2008, p. 1). Traditional psychoanalysis, alongside other mentalist (and ‘cognitivist’ and ‘psychologist’, Watson and Coultet, 2008, p. 1) approaches, considers human minds as entities that are linked to, but still separate from, their social environment (for a more recent psychoanalytic criticism of such positions, see, for example, Mitchell, 2000). Such entities exhibit their specific internal processes, having to do with cognition, affect, motivation or the like. Traditional psychoanalysis disagrees with, for example, cognitive psychology regarding how these processes within mind are organised, but the two approaches agree about the very distinctiveness of the individual minds. People respond
to their social and other environment in ways that arise from their affects, cognitions, motivations and so on. Therefore, what people do can be explained with reference to their mental processes.

As contrast to this kind of understanding, ethnomethodologists and discursive psychologists have argued for understanding human minds as socially constructed. The object of EM and DP studies are the ways in which mental states or processes are referred to in social interaction. According to this view, any references to thinking, knowing, feeling, or the like, should be understood as public actions: as constituents of interactional processes, whereby the participants do things such as justifying, blaming, narrating or the like (see, for example, Coulter, 1989; McHoul and Rapley, 2003; Potter, 2006; Watson and Coulter, 2008). There is a strong criticism towards ‘mentalism’ involved in this position: internal experience, or mental processes, are considered as lay understandings, and the task of the researcher is to show how these understandings are constructed and made use of in interactions, rather than to share and use them as explanations him- or herself. Regarding one key mental concept, ‘motivation’, Watson and Coulter (2008, p. 12) recently wrote: ‘The root phenomenon is how members (not analysts) attribute motive in making cultural sense of action, how members treat motives as “expressed” (i.e. avowed, exhibited) ... in real scenes of communicative interaction.’ This position, shared by many ethnomethodologists, discursive psychologists and analytic philosophers, might be called ‘anti-mentalism’.

Searching for a third way

Basically, my position as a conversation analyst who is involved in clinical practice of psychoanalysis has prompted me to reconsider this dichotomy between mentalism and anti-mentalism. First of all, being a conversation analyst is hardly compatible with positions that make a strong demarcation between ‘inner’ and ‘outer’ reality (mind and social interaction), and treat the individual mind as a free standing field. Seeing, through the eyes of a conversation analyst, the thoroughly dialogical character of any expressions of mental states – be they verbal descriptions or non-verbal displays – makes it impossible to justify any strong distinction between the outer and the inner. They appear as parts of the same process. Therefore, the mentalist position of traditional psychoanalysis seems to me as impossible to accept.

Let me take an example from everyday interactions. From a mentalist perspective, facial expressions are a paradigmatic case of how the internal affective states of humans shape their interactive behaviour: basic emotions (such as joy, sadness, anger or fear) have each their distinct expression in human face (see Ekman and Friesen, 2003). The face is an outlet of the mind (and the physiological emotion processes). To understand facial expression, we have to trace it back to what is happening in the inner self of the individual.

Johanna Ruusuvuori and I have in recent years examined facial expressions in everyday interactions (see Peräkylä and Ruusuvuori, 2006; Ruusuvuori and Peräkylä 2009). Basically, we show how the timing and shape of the facial expressions is thoroughly embedded in the sequential organisation of interaction. There are particular places and consequences of such expressions. Rather than being spontaneous outlets of the internal emotional state of humans, in our data facial expressions appear as interactional resources, the use of which is thoroughly interwoven with that of other such resources (word choice, syntax, prosody, gaze, gesture).

While my conversation-analytical experience alienates me from any mentalistic positions, being involved in psychoanalytic processes makes it impossible for me to sustain the claims of anti-mentalism. The EM and DP approach to mind suggests that avowal and ascription of mental predicates is a process that should be investigated in ways that are detached from any presuppositions regarding inner realities. Psychoanalysis is a practice in which the client and the analyst explore their inner experiences, and step by step either recognise dimensions of affect and cognition that appear for them as ones that have always been there but have not been perceived with clarity before, or achieve new dimensions of affect and cognition that are real but have not been possible to be experienced before the psychoanalytic process. In short, feelings, thoughts, hopes, desires appear as real phenomena in psychoanalytic practice – not merely as artefacts or projections produced by linguistic and interactive processes in the consultation room or elsewhere.

Hence, as a conversation analyst who is doing psychoanalysis, I have searched for an approach that would not compromise the understanding of mental phenomena as thoroughly social, but at the same time, would still accommodate the very reality of mental processes.

There are two recent conceptual developments in interaction studies that have helped me in the search for such a ‘third way’ between mentalism and anti-mentalism. One comes from the recent work of Enfield and Levinson (1996; Levinson, 1996a, b) and the other from the work on mother-baby interaction by Beebe and Lachman (2002; for a more extended review of these approaches, see Peräkylä, 2009). In what follows I give a sketch of those two approaches, to suggest to the reader how it is that we might begin to bridge the supposedly unbridgeable chasm between realism and social constructionism, at least as a working principle in therapy.

Mental simulation in psychotherapy

Levinson and his co-workers have brought together a key contemporary discussion in psychology on theory of mind, and the findings of Conversation Analysis. In result, they propose that the basic practices of social interaction
involve a process of mutual ‘reading’ of the mental states of the co-interactants. According to Levinson and Enfield (2006, p. 1), the interactants take part in ‘shared mental world’. This shared mental world involves the interactants’ detailed expectations concerning each others’ behaviour and their understandings regarding each other’s cognitions, intentions and motives. It is a world that is shaped and maintained in and through sequentially organised action.

Theory of mind is a corner-stone of conceptualisation by Levinson and Enfield. It is not a ‘researcher’s theory’, but a basic competence in understanding the social world, shared by normally developed humans. It involves an ability to attribute to other persons a world of inner experience that is independent from the outer world and the observer’s own experience – a world consisting of states such as beliefs, desires and intentions (Premack, 1976).

According to Levinson and Enfield, theory of mind is in incessant use in social interaction. The use of theory of mind is normally automatized and non-reflective. The interactants read each others’ communicative intentions and respond to these (Levinson and Enfield, 2006, p. 5; Levinson, 2006a, p. 45). Interactants do not respond to others’ behaviour as such. Interaction requires interpretation of other’s behaviour: ‘mapping intentions or goals onto behaviour’ (Levinson, 2006a, p. 45), whereby behaviour gets understood as intentional action. This process of interpretation, according to Levinson (p. 45), involves ‘some kind of simulation of the other’s mental world’.

Levinson (2006a, 2006b) and Enfield (Enfield and Levinson 2006), and the contributors to their recent collection (especially Schegloff, 2006) show how the practices identified by Conversation Analysis – adjacency pairs, pre-sequences, recipient design, repair – involve reciprocal and reflexive simulation of the mental states of the participants. From here arises a new way to conceptualize psychotherapeutic interaction. Psychotherapy involves an effort to examine, recognise and modify the patient’s ways of experiencing and relating to his or her experience. The mutual simulation of each other’s mental world by participants to an interaction appears be a generic property of interaction that is taken into a special use in psychotherapy.

As colleagues and I proposed in the introductory article to a recent collection of CA papers on psychotherapy, ‘[a]ny action by the therapist ... expresses an understanding of the patient’s experience’ (Peräkylä et al., 2008, p. 16). Because the actions of the participants are tied together by sequential implicativeness, ‘the participants inevitably have to orient to and work with the understandings that they each bring about through their actions’. The conceptualisation by Levinson provides a theoretical backing and specification for this proposal of ours. The therapist is involved in simulation of the patient’s experience, and tries to be as aware as possible of this process. The therapist’s actions convey to the patient how the therapist simulates the patient’s experience, and the patient’s actions convey to the therapist how (s)he simulates the therapist’s experience. The therapist’s actions, be they formulations (see, for example, Antaki, 2008), recognitions (Voutilainen, Peräkylä and Ruusuvuori, 2010), interpretations (Peräkylä, 2005. and 2008; Bercelli, Rossano and Viaro, 2008) involve movement in this mutual simulation.

Through the integration of Conversation Analysis and the research tradition on theory of mind suggested by Levinson and Enfield, we can thus arrive at a conceptualisation of interaction which preserves the conversation-analytical findings, and yet does not call into question the relevancy of mental processes. Another such integrative conceptual development comes from the recent work on infant-caretaker interaction by Beebe and Lachman.

Self- and interactional regulation as a system

In the past decade, much psychological research has focused on regulation of emotion: ‘the process by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions’ (Gross, 1998, p. 275; see also Vandekerckhove et al., 2008). While most research on regulation of emotions focuses on this process within individual minds, Beebe and Lachman (2002) offer a perspective which integrates interactional and psychological processes of emotion regulation. They propose that there is ‘an intimate connection between self and interaction regulation’ (p. 22). The same behaviours that entail self-regulation also serve in interactive regulation.

A key example comes from research on baby-caretaker interaction. When playing with her mother, a baby sometimes turns her head away from the mother. In interactional terms, that entails withdrawal from mutual engagement. In a study by Field (1981), cited by Beebe and Lachman (2002, pp. 158–9), it was shown that the heart rate of babies is unusually high just prior to this withdrawal, and that it returns to normal after it, before the babies turn their heads back to their mothers. So, the turning away of gaze regulated interaction (disengagement) and at the same time, it regulated the internal state of the baby (arousal as indicated by the heart rate).

A similar connection can be found in facial expressions. Research conducted by Ruusuvuori and myself, among many other studies, indicates that the face has an important task in the regulation of interaction: the face is visually available to the other participants and has consequences for their facial expressions, talk and other behaviours (see also Goodwin, 1980; Dimberg, 1982). On the other hand, there is plenty of evidence about the impact of
Changes the way I practice as a psychotherapist. There are applications of Conversation Analysis that demonstrably result in changes in professional practice – the work of Heritage and colleagues (2007) on closing questions in medical encounters is a great example, well documented in Heritage and Robinson’s chapter in this volume – but my personal explorations between psychoanalysis and Conversation Analysis are not among them. What CA has offered to me, as a practising psychotherapist, is means for conceptualising some of the things that I find myself doing with my patients. Besides, it has offered an understanding that much of what I do is beyond my reflexive awareness, yet ordered at all points (Sacks, 1992, p. 484) and as interactional practice, accessible to the methods of CA research.

Leaving aside my own practice, I would like to suggest that in psychotherapy, direct behavioural interventions from CA to clinical practice – for example, recommendations for practitioners to use a particular utterance design and to avoid another – may not be feasible. Apart from the fact that therapists’ minutiae of behaviours are pre-reflected, this non-feasibility of direct behavioural interventions may arise from the great variability of interactions in psychotherapy. Unlike, for example, medical encounters, psychotherapy sessions (at least in psychodynamic therapies) are not organised into institutionally ascribed phases. On turn-by-turn level, the practitioners’ actions are adapted to the variable actions of the individual patients. On the level of therapy processes, each patient brings in particular themes and problems, understanding of which characterises of the therapists’ choices of action. Stiles, reflecting upon the lack of correlation between specific therapist behaviours and the outcome of treatment, points out that the behaviours of the therapist are (or should be) responsive to the ‘emerging context, particularly including client requirements’ (1999, p.6). For this reason, in psychotherapy there might not be particular clinician actions or behaviours that are beneficial for the outcome across different clients and different phases of the treatment. With each client, and at each moment, the therapist may have to assemble a particular way to proceed.

The future agenda of applied CA research on psychotherapy, therefore, probably does not involve search for distinct clinician behaviours that might be therapeutically effective, but, instead, the search for increased understanding of the means of responsiveness – that is, alignment, affiliation, as well as therapeutically meaningful non-alignment and non-affiliation – in the therapeutic interaction (cf. Voutilainen et al., 2010).

Conversation Analysis is a strong tradition and its findings are robust. It need not protect itself from other research traditions and professional practices. Being engaged in linkages like those that I have discussed in this chapter requires Conversation Analysis – and the conversation analyst to – accept
methodological impurity and theoretical challenges. The reward is in the
possibility of renewed understanding of the fields that get linked – and in the
social, and even personal, relevance of one’s work.

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