On how to include psychotherapists in research on psychotherapies[1]

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Abstract

In this paper I examine three broadly ethnomethodological projects on organisation of psychotherapeutic practices (Fitzgerald and Leudar 2010; Leudar, Sharrock, et al. 2008; and Davies, Thomas and Leudar 1999). Psychotherapists participated in the research in all these projects; the purpose of the current examination is to ascertain how they contributed to the projects and whether their contributions were necessary. The expectation was that the therapists provided background information, which helped the ethnomethodologists to understand the therapy talk, not just as conversations but also *as therapeutic practices*. One conclusion of the present examination is that conversation analysis of psychotherapy indeed needs to be enriched by background ethnographic information in general; the actual participation of the psychotherapists ensures that it is used in a relevant and occasioned way. The second is that the work on 'mentalisation' in psychotherapy presupposes understanding of how therapists and clients contextualize their talk. The third is that psychotherapy does not happen just in the 'consulting room' but extends into the life beyond—this further points to the relevance of 'ethnograpical augmentation'.

INTRODUCTION

I shall try to persuade you that one must involve psychotherapists in research on psychotherapy. But why should one try doing this? Surely we are scientists, and, natural sciences study matter, which is without agency. Talking about matter as participating in, say, an experiment, sounds distinctly odd. The matter is a *subject* to rather than a *participant* in investigations.[2] This perspective is not unique to natural sciences. Even visual artists *depict* landscapes, rather than allowing them

[1] This paper was presented to the meeting of ICCAP, held in Berlin, at the International Psychoanalytic University between 20-23 of June 2019. The text has been revised after the talk, partly in reactions to the discussion.

[2] Of course psychologists nowadays do not call the participants 'subjects' but the participation is very constrained.

to participate in painting, except perhaps for a few misguided ecological artists, who do.[3] So, should one always investigate psychotherapists and the way they do things as if they were chemicals, or atomic particles, or plants, 'objectively' so to speak?

There are good arguments against doing this, and for, at least sometimes, practicing *participant* research (including 'joint analysis'). There are a variety of phenomena studied in different sciences—e.g. atoms, cells, stars, social groups—and hence research practices should differ too (cf. Collingwood 1936; Feyerabend 1975; Leudar 2009). There might be very good reasons to pay attention to *methodological pluralism* and consider carefully what the best ways to research psychotherapies might be if we are to do them justice (cf. Kaplan 2001). One does not want to use a method of investigation, which obscures the phenomenon studied, re-formulates it out of recognition and impoverishes our understanding of it.[4]

Methodological pluralism often means one of two things. First, several methods can be used to investigate a phenomenon in a complementary way, without setting the methods into competition, so as to converge on a richer understanding of the phenomenon. Second, a method most appropriate to study a phenomenon can be developed and used, and further developed in being used.[5]

So how can we apply these considerations to the study of psychotherapy? First, there are good reasons for including case studies in researching complex social interactions, despite the regularly pointed out problems with generalising their findings. In our area—investigating talking cures—the advantage of case studies is that they afford synthesis—insight into how different conversational devices are used purposefully in concert. And, moreover, case studies allow us to capture some of the uniqueness claimed for any good course of psychotherapy. We do not want to ignore such uniqueness, even though trying to capture the uniqueness could be maligned as 'stamp collecting'. But, still, what about the problem of generalizing from case studies? I have argued that case studies are typically joined together in long-term projects through 'practical historical work', and can be combined (in projects) with cross-sectional studies through dependence on common analytical methods and past findings.

But, surely, all of this can be done without psychotherapists participating in research as researchers, thus safeguarding (scientific) objectivity. Yes, but what about analysing recorded therapy sessions, and transcripts and making sense of them? I will argue that this certainly is one place where the psychotherapists need to be involved. I will *not* argue that Conversation Analysis (CA) as it is usually done (see e.g. Schegloff 2007; Sidnell 2012; Peräkylä 2012) must be done

[3] See the link to Experimental Visual Art at www.leudar.com (accessed 31 July 2019).

[4] Experiments in psychology, for instance, are not considered social situations, even though they clearly are. They are, though, a very particular kind of a social situation, and this biases findings especially if the experiments investigate higher psychological functions.

[5] One can of course talk about a family of methods as a method.

differently. The argument will instead be that such CA 'proper' needs to be supported by ethnographical analysis to get at the senses of psychotherapeutic practices. And we shall see that is cannot consist just of academics making use of background information, because its relevance at any point in therapy is a practical and episodic matter rather than a logical one. This is of course not an innocuous argument—it means that when CA investigates psychotherapy, it can't do it by itself!

So I will consider why we should involve psychotherapists, with their knowledge, skills and insights in the research on psychotherapy. Let me indicate my conclusion. Conversation analytical investigations of psychotherapeutic interactions clarified both the process and the outcome of psychotherapeutic interventions (e.g. Perakyla et al. 2008; Fitzgerald 2013). Such studies were, however, more effective where they used background information so as to understand both the institutional and broadly-occasioned *sense* of the interactions. This is especially so where long interaction sequences are concerned—therapy *emerges* in these and therapists orient to such emergence. Now, this is in principle not just my conclusion. Aaron Cicourel (1992), for example, has argued the following.

1. Cicourel on the use of ethnography in analysing practices

> The context of conversation or discourse material can be made rather transparent when we use brief, formal or informal exchanges among people we do not know, who interact in settings described in a limited way, or when we use casual, mundane everyday conversations among friends during informal exchanges. When the research analyst is working in her or his own society, and the reader is expected to be from the same society, it is especially convenient to use brief, formal or informal mundane conversations. The investigator's ability to comprehend these exchanges is assumed to be self-evident and is seldom if ever an aspect of the analysis. *But if a fuller analysis of participants' conversation and ethnographic understandings about activities, objects and ideas is desired, and that understanding presupposes prior social experience, and/or technical, scientific, or professional training, then other strategies besides a completely local analysis must be employed.* (Cicourel 1992: 294, my emphasis)

There is, however another reason for combining ethnography with conversation analysis in studies of psychotherapy. Ole Dreier argued cogently that therapy does not necessarily happen in the consulting room, but *also* elsewhere—see (2).

2. Dreier (2008) on combining ethnography and CA

> The practice of therapy is seen as occurring *exclusively* inside an isolated situation: the session. Although sessions actually are particular parts of clients' lives elsewhere

> and of therapists' institutional work practices, the conduct of sessions is assumed independent thereof ... the actual contextuality of the social practice of therapy then goes unnoticed. (Dreier 2008: 5, my emphasis)

> It should be of great concern how clients include their therapy into their lives in other places in order to deal with their everyday troubles. That is what therapy is there for. (Dreier 2008: 12)

What this means is that one needs methods that record and analyse something that is distributed across occasions separated in time and space, and are of distinct character. Methodological pluralism rather than dogmatism is indeed required.

This argument can be developed in an abstract way by analysing the focus and the methods of conversation analytic studies, and considering to what extent an analysis of 'psychotherapy talk' is *in principle* possible without background ethnographic information pertinent to a therapeutic practice, which is only available from practitioners and perhaps clients. How thick a description of psychotherapy can one produce in this way? I tried this elsewhere without much effect (Leudar et al. 2008a).

There is, however, no need restrict ourselves to an abstract argument—psychotherapists do in fact participate in many research projects on psychotherapy. So one can analyse *empirically* how psychotherapists have participated in such research—what did they contribute and how would the work have been impoverished if they did not participate? A general theoretical problem can be turned into a practical one, as Sharrock advises. The advice is clearly consistent with the Kuhnian method of researching history of science through the analyses of paradigmatic studies (cf. Sharrock and Read 2002).

I shall be focusing on three projects in which I worked jointly with psychotherapists. The first was on person-centred, solution-focused therapy. The second project was on an intervention by psychoanalytic psychotherapist to help children to enter school. The third was on a psychiatric intervention to help a voice hearer to deal with command voices. This set of projects is hopefully varied enough to provide a good range of manners in which psychotherapists may participate in research. I shall analyse such participation by examining the pertinent accounts in publications of these three projects. For each of them I shall present and analyse excerpts relevant to the therapists participation in the projects—these constitute the empirical data I shall use—22 texts in all.

It is crucial to understand that my aim is *not* to re-analyse these materials used in these three projects but instead to examine the published analyses, as well as any available supplementary materials, and see how the team's interpretations of what was happening in the therapy were derived and warranted. *The question is, do some interpretations and warrants for them come from the participating*

therapists, reflect their professional knowledge and personal experience, and become necessary for understanding the sense of the interactions?

The expectation is not that *every* step in *every* analysis has to be warranted ethnographically—only that some of the analysis is so warranted and needs to be. I shall try to work out at which points typically CA sequential analysis needs to be helped through ethnography.

PROJECT 1: WORKING WITH A PERSON-CENTRED, SOLUTION-FOCUSED THERAPIST ON HELPING PEOPLE TO COPE AT WORK (FITZGERALD AND LEUDAR 2010; FITZGERALD 2013)

The first project I shall consider was an investigation of person-centred, solution-focused therapy.

Pamela Fitzgerald (PF) is an experienced, person-centred, solution-focused therapist who was at the time based in Ireland where she supervised other therapists, but also practiced in Germany. Some of her clients come to her directly; their employers refer others. She came to Manchester to do her PhD with me and learned her CA there. Wes Sharrock was her advisor. Over the four years, our academic collaboration moved from working on her PhD in the usual roles, to producing joint publications. She then turned her PhD into a monograph, with some help from me. So PF is not just a psychotherapist participating in a research project on psychotherapy, but also a postgraduate student and a researcher.[6]

The research itself was on interventions, which she herself carried out. From a CA point of view, we worked on formulations, continuers and therapist disclosure, and how these were used in PF's kind of therapy. Now, most of the PhD supervisions were recorded by PF. In principle these could be interrogated to establish how the joint interpretations of transcripts of therapy sessions were accomplished. I shall not do this in this paper though. Instead, I shall take a look at our joint publication in the *Journal of Pragmatics*, which was on how person centred, solution-focused therapists use response tokens, and continuers in particular. The question was, do they do it in some way consistent with their avowed therapeutic orientation (person-centred, non-directive, solution focused in this case) or as anybody might in everyday talk, or perhaps both? The text (3) comes from the introduction to the paper in question. Note first, that in introducing the study we described the kind of therapeutic practice investigated and the problems dealt with in the sessions.

[6] Most of analytical sessions were recorded but cannot be used here, for a variety of reasons. They would however be exactly the kind of materials useful for our purposes. In fact, a certain amount of the analysis was done in graduate groups including psychotherapists of various callings.

3. Fitzgerald and Leudar (2010)

> Our data comes from a corpus of 50 sessions occurring between a person-centred, solution-focused therapist and seven clients, each of whom attended for between 4 and 8 sessions spread over up to 10 weeks. The therapeutic practice is influenced by the ideas put forward by the Irish Association of Holistic Psychotherapy. The clients presented an array of difficulties ranging from mild depression, eating disorders, relationship problems and bereavement to interactional difficulties at work. (Fitzgerald and Leudar 2010: 3190)

This identification of the therapeutic style could have been provided as general background information, for its own sake but irrelevant to the analysis of the talk; we shall see it was in fact consequential in the analysis.

The work was on the use of continuers, but from the start we formulated it as flowing in two interacting currents. First, continuers were presented as aspects of mundane listening, and second as aspects of therapeutic technique. In both cases, listening is implicitly not an invisible mental activity, but a conduct—it is *dialogised*. Note also that in (4) below, the two are joined by 'however' so the two are not necessarily the same. We shall see that the mundane use is seen as basic and understanding it enables the analysis of therapy talk. The converse is not the case—therapeutic uses are not seen as particularly enlightening us about the mundane uses.

4. Fitzgerald and Leudar (2010)

> This paper will treat continuers as interactional devices used by a therapist to listen to the client's account in the same way as one might listen to a person's story in *ordinary conversation. However, they will also be examined as therapeutic listening techniques used by the therapist to enact the business of psychotherapy*. (Fitzgerald and Leudar 2010: 3188, my italics)

Consistently with this, still in the introduction, CA work on the functions of response-tokens and continuers is summarised, as are its application in research on psychotherapy. The summary of the latter work indicates that we expected the use of continuers to be contingent on therapeutic orientations of practitioners—see (5).

5. Fitzgerald and Leudar (2010)

> Müller and Frank-Ernst (1996) who investigated the use of tokens in a phone counselling encounter found that the use of continuers indicated that the listener was taking sides by claiming agreement. In person-centred therapy, solution-focused

> therapy claiming agreement would interfere with the non-judgmental attitude expected of the therapist. It needs to be acknowledged that some therapists may disclaim the use of such devices as they may come across as judgemental, or may be seen as interfering with the transference and therefore compromise the neutral stance adopted by the therapist. (Leudar and Fitzgerald 2010: 3189)

In fact, the expectations of what we might or might not find in the analysis are *partly* formulated against the background of the therapeutic orientation in question—non-directive, person centred, solution focused; see (6). This was contributed to the analysis by PF as it became relevant.

6. *Fitzgerald and Leudar (2010)*

> We shall see that in solution-focused therapy the continuers act as *a form of management to keep the client on track until the problem is defined and the solution emerges*. In person-centred therapy one would expect that continuers would be used as listening devices to indicate that the therapist is following the client's lead as well as subtly directing them to say more if the therapist feels the client could have more to tell. *The therapeutic process is directed by what the therapist believes is the best move in the sequence. Our expectation is that the location of the continuers, as well as being part of the turn-taking system, reflects the therapists support for clients as they tell their stories which can also encourage or direct the client to continue on talking rather than make an intervention*. By examining their location one may learn something about where the therapists put their focus. (Fitzgerald and Leudar 2010: 3189, my italics)

In (6) we anticipate and summarize our results. 'Keeping on track' means that therapeutic orientation reveals itself in long sequences rather than in any particular continuer. In (6), psychotherapy is being done in long sequences and *emerges* from *focused* use of continuers, (amongst other things of course). But, and this is important, how does an analyst of psychotherapy know what kind of extended sequences to look for? So the analysis *here* requires both the knowledge of what I called elsewhere 'therapeutic orientation' and the knowledge of continuers revealed by CA. The former was provided by PF, the latter *jointly* by PF and IL.

So what did we actually find? There were three kinds of continuers: classical, emphatic and channelling ones. *It was the differential use of these, which revealed how therapeutic orientation entered psychotherapy and needed to be borne in mind*.

The empathic continuers were used to 'support' the client narrating their problems, most likely in an emotion-laden manner, as in complaints. The continuers displayed the therapist's 'empathic' understanding, one without judging or directing.

7. Emphatic continuers

> Person-centred, solution-focused therapy is first and foremost Rogerian in its approach. Empathic continuers are a normative feature of this therapy and it would be expected that the therapist would first and foremost display empathic understanding when the client is revealing feelings. Empathy according to Rogers (1980:142), 'involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that he or she is experiencing'. Accurate empathy according to Miller and Rollnick, 'involves skilful reflective listening that clarifies and amplifies the person's own experiencing and meaning, without imposing the counsellor's own material'. (Miller and Rollnick 2002: 7, quoted in Fitzgerald and Leudar 2010: 3197)

The channelling continuers are different and follow from the second focus of the therapy on finding solutions: 'Solution-focused therapy emphasizes the importance of listening out for the client's strengths, skills and resources'.

8. Channelling continuers

> These channelling continuers orient to the client's speech, which contains something positive, and their use indicates that the therapist is engaging in solution-focused therapy. They resonate with the speaker's positive expressions in the prior turn, which express something positive about themselves—their strengths, skills or resources and/or contain positive steps or developments towards the solution. The therapist uses a loud volume continuer, which can be louder or the same volume as the surrounding speech. At times they can be quite directive in the way they channel and nudge the talk in a particular direction. These continuers have an assessment or evaluative quality and the pauses surrounding them tend to be short or non-existent—indicating that they may be claiming understanding of the client's prior utterance as well as functioning to keep the client talking in a particular way. (Fitzgerald and Leudar 2010: 3196)

So the channelling continuers are used selectively, when the client expresses something positive, here about their work. They are not used when the client lists problems and complaints. Then the classical or empathic ones might display emphatic listening. The channelling continuers, on the other hand, are subtly directive. This, by the way, means that our analysis, according to PF made explicit a contradiction in this approach to psychotherapy—it is supposed to be non-directive rather than directive, but in subtle ways it is both.

Our analysis of continuers paid attention both to what individual continuers were in form and how they were placed in talk—see (7) and (8) above. We also

analysed how they were used systematically to produce solution-oriented long sequences. Therapist PF provided information pertinent to how they were used systematically and produced extended sequences. Some of this information was quite specific and involved episodic details of past sessions. What would have happened without her contribution?

9. Weiste and Peräkylä (2014)

> In order to study the prosodic aspects of the therapists´ empathic responses, we first needed to find 'empathic sequences' in our data. To find such sequences, we focused on utterances in which the client expresses an emotional experience. In those utterances the clients express 'here and now' emotions (i.e. by crying), or they describe how they feel about somebody or something. Thus, the selection of the sequences was first based on the content of the client´s utterances. When we examined the therapist's´ responses to the client´s emotional experience, we found that the therapists recurrently formulated the clients´ emotions i.e. showed understanding of the client's previous turn by proposing a version of it. (Weiste and Peräkylä 2014: 11)

Weiste and Peräkylä are both experienced therapists. The text (9) implies, however, that in their research they set aside their therapeutic expertise and acted solely as conversation analysts. The identification of sequences is said to have depended solely on what the clients and therapists did *in transcripts,* so to speak. This would not have worked in our case where the varied continuers were used strategically, with the strategy depending on the therapy being both client oriented and solution-focused. It is in fact arguable, if not necessarily true, that in selecting their corpus Weiste and Peräkylä used tacit knowledge of what are 'empathic sequences' and this background knowledge is not mundane but of a generic therapeutic kind.

So in this first project the psychotherapist was both a practitioner and a researcher involved in the analysis of transcripts. It is clearly the case that she provided relevant background knowledge we needed to understand what was happening in her psychotherapy. Such background knowledge was of two kinds: that pertinent to her therapeutic orientation, and that pertinent to actual cases in therapy. Both knowledges were essential, in addition to using CA analytical skills, if one were to understand why the extended sequences were as they were—why she encouraged some but not other talk in this case—one would have to realize that the therapist was trying to support the client emotionally in an emphatic and non-directive way, and yet at the same time, nudging their thoughts towards solutions and towards being 'solution-focused'. The therapeutic approach should enable the clients to live with difficult conditions at work.

Interestingly a disagreement developed between me and PF about her way of doing psychotherapy. She did not encourage clients to complain about their work, even though they seemed to me justified. Being a life-long trade unionist, I have

done many personal cases, helping colleagues who had problems with the management. In doing this, one tries both to enable the colleague to deal with the circumstances (rather than just cope with them passively), but the union volunteers also try to change the circumstances by intervening and representing the client with management if necessary. The warning here is that the collaborations between psychotherapists and researchers are not always a straightforward matter of using their professional knowledge as a royal road to valid analysis. Moreover, the divergence in perspectives may have consequences for the analysis—it certainly made it more difficult for me to imagine and note the intentionality of PF's actions—how the constellation of sympathetic and encouraging listening worked.[7]

What did PF as a therapist get out of the collaboration? She concluded that CA was a useful teaching tool and put it to use. She also came to agree with Anssi Peräkylä—psychotherapists do not always do as they think they do or say they do, and one can use CA to show and even remedy this lack of awareness. We can, however, also see that the psychotherapists can help to analyse therapy talk, correct misconceptions and stimulate imagination. This is even more obvious in the next project we shall analyse, where the background psychological assumptions of the therapists departed somewhat further from common sense.

PROJECT 2: WORKING WITH PSYCHOANALYTICAL CHILD PSYCHOANALYSTS (LEUDAR ET AL, 2008A; LEUDAR ET AL, 2008B)

In this project Wes Sharrock (WS) and I (IL) worked with psychotherapists from Birmingham centre for psychoanalytical child psychotherapy and Shirley Truckle (ST) in particular. They carried out an early intervention study to help children from economically deprived neighbourhoods to help with their distress on entering school. The therapists worked with small groups of children, meeting each group on four occasions in a classroom. All of the children in the reception class were included. This early intervention was a new departure for the therapists—they did not usually work with groups, so it was improvised rather than a routine, at least to begin with.

The psychotherapists video-recorded all the sessions, and approached us to help design a way to document their practice and its outcomes. They were not happy with using statistical methods, chiefly because doing this would contradict their emphasis on variety of problems and solutions for the individual children. In statistics such varieties are subsumed in the error term and become random noise. They wanted their intervention presented in a way consistent with the aims and methods of the psychoanalytical psychotherapy as they practiced it. And what did we want from the interactions? We were fascinated by the therapists and their

[7] PF and IL for instance had a discussion about why the therapist did not use 'discontinuers', so to speak, to discourage complaints.

project and agreed that it would be possible to analyse the interventions so as to demonstrate the variety of problems children encountered and the ways they were dealt with in the group. We thought we could show how at least some children's conduct changed over the sessions, arguably as a consequence of the interactions. If successful, such demonstrations would have contributed to both the process and the outcome research on psychotherapy.

The results of the work were published in two papers and presented at several conferences (see Leudar et al, 2008a,b). *I do not want to re-describe the practices again here*. What I do want to do is to analyse *how* our descriptions and interpretations were arrived at and warranted. What did not show clearly enough in the published papers was how we used, and sometimes misused, our prior background knowledge of Kleinian psychoanalytical psychotherapy, and how the psychotherapists participated in the analyses of session recordings and corrected us.

To anticipate, it turns out that we could have done some of the analysis ourselves, without the therapists' input; elsewhere psychotherapists' contribution was essential, especially as concerned with the therapists' therapeutic aims and the course of the sessions (referred to elsewhere as 'extended sequences' or 'trajectories'). Even in the former case, however, we inevitably used a variety of background assumptions in our analysis.

So what background assumptions did we ourselves bring into the project? Both of us knew about psychoanalysis as an academic discipline. IL taught a course about history of madness at Manchester University, which included parts on Ronald Fairburn and Melanie Klein, using Klein's 'Narrative of child analysis' amongst other sources (Leudar and Antaki, 1997). So the idea of using play as a means of expression in psychotherapy was familiar (10), as were the problems children may have when starting school (11).

10. Klein (1975)

Fourteenth Session (Tuesday)

> Mrs K. had brought the toys and put them on the table. Richard was interested and at once began to play. He first picked up the two little swings, put them side by side, made them swing, and then laid them beside each other, saying: 'They are having fun.' He filled one track of the train which he called 'goods train' with small figures, and said 'the children' were off on a pleasure trip to Dover. He added a slightly larger toy woman in a pink dress, whom he at once called Mummy. Mrs K. interpreted that the swings represented his parents; laying them down side by side and saying they were having fun meant their being in bed together, and the movement of swings together indicated their sexual relations. [...] Richard was extremely impressed by Mrs K.'s interpretation. He expressed his surprise that his thoughts and feelings could be shown in his play.' (Klein 1975: 63-64)

11. Leudar et al, 2008a

> Let us briefly consider what Melanie Klein had to say about starting school, when children are separated from their parents and have to interact with strangers in unfamiliar circumstances: 'In the life of a child school means that a new reality is encountered, which is often apprehended as very stern. The way in which he adapts himself to these demands is usually typical of his attitude towards the tasks of life in general.' (Klein 1988: 59, quoted in Leudar et al, 2008a: 155)

So we knew that according to Klein, any child will have problems when leaving family and entering school, including those in Birmingham then. So how did we apply this background assumption in the project? Wes Sharrock and I formulated the following 'background maxims'.[8]

12. Leudar et al, 2008a

> We can formulate three Kleinian therapeutic 'background maxims' (i) 'new environments and separation are sources of anxiety,' (ii) 'children express the anxieties symbolically but without necessarily knowing that they do so,' and (iii) 'all children are different in how they cope and what they have to cope with.' (Leudar et al, 2008a: 155)

As with Gricean maxims (see Grice, 1965) we assumed that these would be in the phenomenological background, resourcing the interactions and making them understandable. What we came to realize fairly quickly, however, was the following:

13. Leudar et al, 2008a

> The next question is, though, when and how do the therapists use therapeutic maxims in concrete circumstances? As policies in politics, so these maxims cannot be applied dogmatically. *It is very unlikely that our experienced psychotherapists would act as novices and follow therapeutic maxims like recipes (cf. Dreyfus and Dreyfus, 1985)*. Their participation in the group is intended to be responsive to what the children's behaviour reveals, rather than vigorously to pursue conceptions of what kinds of experience the children *must* be having. *In their words, therapeutic maxims are somewhat like evolving maps of an unknown country*' (cf. Leudar and Costall, 1996, on acting with flexible plans).' (Leudar et al, 2008a: 156, my italics)

[8] This was actually more of my fault than Wes Sharrock's.

But how did we come to recognize that such maxims could easily lead us to underestimate the therapists' experience and flexibility?—through discussing our analyses with the therapists. The text (13) is in fact a revision of what we came to call the 'first pass analysis'. This is obvious in the text. The first italicised sentence followed an 'intense' discussion of IL's first draft of Leudar et al (2008a). Notice also the phrase 'in their words'—what was 'in their words' was not always quite what was in pragmatic maxims—the notion was much more dynamic and open-ended and it was only broadly Kleinian. It became quickly obvious that we could not always depend too much and on our background knowledge of Klenian psychoanalysis to grasp what the therapists were doing in general or at any point in therapeutic interactions.

The published texts (11-13) then have a complex genealogy—it is a product both of our initial EMCA based analysis *and* of its subsequent discussion with the therapists. In the event we proceeded as follows. We first analysed the interactions ourselves in an ethnomethodological fashion. Then we critically considered our first pass analyses in joint meetings with ST (see 14).

14. Leudar et al, 2008a

> […] the 'first pass analyses' of the video recordings have been discussed with the authors who acted as therapists. These discussions pinpointed misunderstandings, omissions, and errors, and made it possible to correct and extend the initial analysis and highlight the real differences of opinion among the authors as to what may be happening. We use transcripts of these discussions below to detail the issues that arise in using theories in the analysis of concrete therapeutic interactions—this turns out to be by no means straightforward. (Leudar et al, 2008a: 152)

As I intimated, there were long sequences characteristic of the therapeutic practice in general. We noted three problems the psychotherapists addressed with each group. One was to transform a classroom into a setting in which psychotherapeutic work could be done. The second was how to convert spontaneous play into something therapeutically expressive, to both therapists *and* the children (somewhat as in the Klein's example above). The third was to deal with the trauma of separation resulting from the therapy ending. These three always occurred in this sequence (rather than in a 'series', cf. Schegloff, 2007). This long sequence extends over four therapy sessions and it is held together by logic of its pragmatics. Establishing a therapeutic situation and relationship is a pre-requisite for using play therapeutically, and the possibility of separation trauma depends on the advent of therapeutic engagement. This is a different 'glue' than that which held together the extended therapeutic listening noted in the previous project.

I shall, however, focus here on our analysis of the first two problems. Therapists started each group by establishing the nature of the occasion. How the classroom became a sort of consulting room was fairly transparent to us (15).

15. Transforming the situation

> It is less than 2 min into the first session and yet the proffered transformation of the school classroom into a place in which aspects of psychoanalytic psychotherapy can happen is well on the way. The 'here-and-now' of the school is being transformed towards the 'here-and-now' which affords at least an approximation to a fully fledged therapeutic encounter. The therapists are producing a setting for therapeutic immediacy. *So far they have created the spatial arrangements for the occasion, structured the group into adults and children and indicated that the occasion is one where the children can show things about themselves to the adults who will listen.* (Leudar et al, 2008b: 875, my italics)

ST did not pick up on this part of the analysis; she accepted it as obvious. The transformation was clear, as was the need for it. *We first analysed how it was done without ST's contribution*. This does not mean that we did not need to use *our own* background knowledge to note and understand the transformation. We needed to use our knowledge of schools and classrooms—children started by all sitting fairly still and paying attention to the therapists but eventually becoming far less inhibited—some got very noisy. The interesting point was that the therapists did not separate sharply the occasion of therapy from school. They also topicalized the continuities between the two, which were relevant to what they were doing. One continuity between the two situations was that both were traumatic for the small children—they were meeting strangers in unfamiliar settings. This could possibly be understood on the basis of knowledge of Kleinian psychoanalysis. Nevertheless in the event the point was confirmed by ST, and needed to be.

The second transformation was to endow the children's play with therapeutic meaning. Through their play children could show the problems they had on entering school. What problems though? (See 16.)

16. Transforming play

> The problems she mentions include feeling small, not wanting to do new things, having to be big, having to be a good girl, having to sit still, etc. Note how ST does the formulation—she does not simply factually list the problems. Instead she puts herself into the position of a child and speaks as a child—the display of understanding is empathic and again offers a warm emotional bond. The formulation is also dramatic—ST is playful and invites the children into the play, having already established that doing things with playdough can be telling things. Here ST delimits what

> the children may want to tell and in doing this offers an engagement with specific emotional and imaginational qualities. She expresses the effects of these impositions on the child as 'being squished' (15–16). *So the squishing can now refer to moulding of playdough but in these proto-psychotherapeutic settings also to the effects of school on a child.* 'Squishing' becomes changing of a child by force to fit it in the school, and this can now be expressed through play. (Leudar et al, 2008b: 880, my italics)

We analysed and documented systematically and in detail three things. One was how the therapists introduced meanings of play actions relevant to the problems children encounter on entering school. The other was how different children took to these additional meanings—i.e. the uptake. The third one was how they interleaved working with individual children and the group (because that is what they did). Again, we went through the analysis jointly with the therapists.

The problem relevant here was that we (the ethnomethodologists) sometimes misinterpreted what was happening between the psychotherapists and the children. The example I will use here is that of Abu, a very noisy boy of Asian extraction. Abu made a monster mask from plasticine, used it to hide his face, and then roared like a lion. Eventually he broke the mask. So how did we understand this sequence—making of the mask, hiding behind it, roaring, and breaking it—and the therapists' role in the sequence? As a novice you could think that the mask was a means of defence against Kleinian situation-specific traumas, a defence that became unnecessary as a consequence of the psychotherapy. This actually was not the case, as became clear in the joint analysis (see 17).

17. Breaking the mask

> What is Th1's reaction to the breaking of the mask? It is not to comment on his accomplishment, it is more constructive—the breaking the mask allows him to try something else. Going over the analysis with Th1 subsequently, she commented as follows: 'I want these kids to have the freedom to have fun in school. To enjoy it. Yeah? yeah I want them to have the freedom of choice to sit down and concentrate or to be little buggers. Abu, at the point where he was being the monster, didn't have freedom of choice right '. What Th1 asserted was that Abu was terrified and acted under compulsion. *She explained that she was not trying to stop Abu from ever acting as a monster (there may be in his life situations where this is appropriate) but her aim was to enable him to stop and think if being a monster is necessary. The concept of compulsion is then important in understanding what Th1 is doing vis-à-vis Abu; but that she is using it, and how she is using it, is situation and child specific.*
>
> …

> Note that Th1 does not assume that Abu's problem that turns him into a monster is gone. The problem is not with adopting the monster character, but with doing so as a compulsive reaction when it is unnecessary in the situation and not a good way of coping with new situations in general. (Leudar et al, 2008a: 164, my italics)

There are two things on which we were set straight by ST. The first was that she was not trying to stop Abu from roaring on disciplinary grounds, but instead to allow him to participate in the psychotherapy. The second thing we could not easily understand was the nature of the trauma that she diagnosed—it was not Kleinian but rather stemming from racism—Abu was of Pakistani extraction and lived in a deprived part of Birmingham (18).

18. ST contribution—breaking the mask

> … there is no background maxim in the therapists' school that would draw their attention to skin colour. Yet the therapists are not only conscious of, but motivated by the fact that they are working in a socially disadvantaged neighbourhood, where class and ethnicity are live issues. Th1 revealed the following in the discussion of the first pass analysis:
>
> WS: no, you put it in, yeah? Is it for him to pick up? For them all to pick up?
>
> TH1: It was for him. That was my gift to him. Because I have an Asian daughter, and know what an issue it was for her at this age, I gave that to him quite deliberately. And as I remember I got eye contact. (Leudar et al, 2008a)

What ST made a use of in the session was her personal experience, not Kleinian theory. Without her participation in the analysis we would have inevitably missed this. So the participation of the psychotherapist may be essential to analysing correctly the *sense* of therapeutic interactions, especially where they are based on therapists' unique life experiences and expertise.

PROJECT 3: WORKING WITH A RADICAL PSYCHIATRIST ON COMPULSIVE VOICES (DAVIES, THOMAS AND LEUDAR, 1999; LEUDAR AND THOMAS, 2000, CH. 7)

The third project was somewhat different from the previous two. The practitioner was a psychiatrist. His client was involved more directly in the project, as we shall see. And we are not studying how an established therapeutic practice is delivered, but documenting a project in which a practice is designed anew.

Phil Thomas (PT) is a radical psychiatrist, who does not think of himself as a psychotherapist and at the time worked with the Hearing Voices Network. This

network consists of individuals subject to hearing voices, and their 'allies'; it stresses self and mutual help as opposed to medication and internment. Peg Davies (PD) was a headmistress who heard voices. One of them commanded her to smother old people, her aging mother included. Another urged her to steal Catholic sacraments. She knew this was wrong, but on a few occasions she acted impulsively on the voices' commands (fortunately without success in the former case). She was horrified, evolved coping strategies but found it a struggle to resist. She was diagnosed as suffering from schizophrenia and hospitalized. Despite long-term neuroleptic medication (depixol in particular) she continued to hear the imperative-in-form and compulsive voices. PT, moreover, was seriously concerned about the possible side effects of extended drug use, such as tardive dyskinesia, and discussed this with her.

We therefore tried to think about a way that would strip the voices of their compulsiveness. The aim here is to analyse how PT, PD and I cooperated in designing an intervention to help, carrying it out, and reporting the case in two publications and understanding what happened in the 'intervention' (PD was the first author in one of them).

First, the therapeutic consultations between PT and PD could not be recorded, so what we had available were PT's reports of consultations rather than transcripts. This is how he summarized the initial stages of the encounter in Davies, Thomas and Leudar (1999).

19. PT's case description

> The first six months of out-patient contact between Peg and PT dealt more or less exclusively with these issues: the problem of responsibility for Peg's actions in response to her voices, and the problems of long-term neuroleptic medication. [...] At the end of this initial period, Peg's attitude to her experiences began to change. She wanted to start reducing her medication, but was rightly concerned about the possibility that she might find it more difficult to cope with her voices. Because of this it became important for her to find other ways of coping with her experiences, and to do this we agreed that it would be necessary to achieve a greater understanding of the meaning of her voices. The approach used in this task was much influenced by the work of Romme and Escher (1989, 1991, 1994), who were using the Maastricht interview to clarify the meaning of a subject's voices, in the context of the person's life narrative. So Peg chose to produce her own narrative by writing out her life story in longhand. (Leudar and Thomas 2000: 132)

Note that he does not just report what has transpired, but also situates his work with PD using a brief summary of Romme and Escher's work on voices actuated in the Hearing Voices Network. The intervention and the case study report are not something idiosyncratic and singular but tied to an on-going project—the case

study has a past. The main continuity is the stress on the meaning that the voices have for 'clients' and the stress on guided self-help.

But what was my contribution? Our joint past work on voices tried to shift the perspective from voices being seen as matters of perception to matters of language. PT is not just a clinician, he is also an accomplished medical researcher. The information revealed by questionnaire data and PD's biographical narrative revealed a clear pragmatic organisation of her voices. We concluded that there was no reason she should not be able to resist the voices, provided that she was able to stop when she heard a voice command, and rather than trying to do as the voices commanded, refuse it in words and deeds. *The problem was how to allow her reactions to voice commands to be mediated rather than immediate*. Our aim was to provide her with a technique, which would allow her to do just that by providing a moral mediation. PT suggested she would keep a voice-diary, a practice inherited from the Hearing voices network. The diary would allow us to pinpoint situations where she heard the voices, as well as record her reactions and coping. Moreover, she could use her diary to imagine possible reactions to commanding voices and practice refusal. Two points need to be made about this. One is that that PT and IL collaborated in designing the intervention using their respective skills, expertise and experiences. PT formulated the practice using his experiences as a radical psychiatrist; IL provided a theoretical basis for it, drawing on pragmatics, socio-cultural psychology and object-relations theory (e.g. Fairburn 1994). IL designed the pragmatic interview. So here research on practice and the design of the practice inter-leave and are not easily separable.

And note: the therapy had to also happen when PD heard the command voices. This supports Dreier's argument that the therapy cannot happen just in the 'consulting room' (there wasn't one anyway in this case), but also in the problematic situations themselves. PD was to be empowered to help herself when she most needed the help most.

So how did all this work? As you might expect, not as we hoped. The following, (20), is a pertinent page from her diary.

20. Peg's journal

> I was a bit stressed out in the night but I was awake so I know I did not do anything untoward except that a new voice has joined the happy band reassuring me that I would be all right. Telling me that my Guardian Angel will not destroy me. I have called it my Holy Angel, but I think it is the voice of Peg.
>
> Does that make sense? I told it eventually to go away I must sleep and it did. Voice of my Holy Angel 'You are going to be all right. You will come through this. Your Guardian Angel is not going to destroy you. Don't be afraid of me. I am your friend'.
> It was like Peg speaking. I am going to leave behind now my GA and my LD and

> have my new voice. (My response.) I call it my Holy Angel. But it is Peg. Constantly reassuring me positive comments—you are going to win through this time. When it first came a couple of days ago I thought I must be imagining things but I am not. I told it to let me go to sleep— now 4 a.m. it is a kind warm voice not cold and clinical. (Leudar and Thomas, 2000: 136)

In fact she started experiencing another voice, HA. This voice re-assured her and mediated between her and command voices (21).

21. A new voice, 'Holy angel'

> After the 1st session in which she explored her voices she felt very stressed, and she awoke in the early hours hearing *a new voice* telling her that the GA would not destroy her. She wrote in her journal that: 'I have called it (the new voice) my *holy angel*, but I think it is the voice of Peg'. The holy angel (HA) told her that she would be all right and that the other voices would not destroy her. (Davies, Thomas and Leudar 1999: p. 131)
>
> [...]
>
> This new voice was '. . . like Peg speaking . . .', and although she called it her holy angel, it was Peg's voice. We are not using a metaphor. Peg heard a new voice, sounding like her own, but she was not speaking to herself. This voice shared pragmatic qualities in common with Sheila and P.T., because like them, it reassured and supported her, and enhanced her self-esteem.' (Davies, Thomas and Leudar 1999: p. 137)
>
> [...]
>
> Eight weeks later, she found herself in difficult situations in which her old voices usually appeared. They visited Sheila's ageing mother, who was physically ill. During the visit the GA spoke to Peg, suggesting that she could ease the old lady's suffering, but the HA appeared immediately, telling the other voice to leave Peg alone, which it did. This was immensely reassuring for Peg, who felt sure that had the new voice not intervened she would have acted on the GA's suggestion. (Davies, Thomas and Leudar 1999: 140)

The Hearing Voices Network, as it was then, stressed connections between voices and traumas, as well as users' self and mutual help over professional interventions. It was possible to understand the first two voices, GA and LD, in that way and the Hearing Voices Network perspective made relevant by PT. The third voice, HA, however was not a direct consequence of trauma but instead, we

thought, a defence against the command voices. I suggested it was a personalised synthesis of those helping PD. Personalised because it sounded like her, and of helpers because she experienced aspects of her companion Sheila and her psychiatrist PT in the voice. Our understanding owed a debt to socio-cultural psychology and Ronald Fairbairn, both of which occupied IL at the time.

This project was then not simply a qualitative investigation of an existing practice. And the method of intervention and the interpretation of its consequences would not have been possible without the collaboration of all the three parties. But PT was not just a therapist; he was also a researcher and a mental health activist. *And these aspects of him were not dissociated in our project*. He was essential to the research since he informed and framed the interventions, their reports and analysis. The client PD was a highly competent individual able to make the suggested ways for dealing with the voices her own.

There was no fine-grained analysis of PD's interactions with the voices, except via the pragmatic interview designed by IL (Leudar et al. 1997) and through her diary. Some of it was transparent and anyone could understand and analyse it; much had to be understood with the help of PT's clinical case notes. The outcome—the new voice—was also interpreted using sociocultural psychology work on internalisation and work on dissociation. We presented the work as a continuation of our own long-term project on voices as language with pragmatics. The important point is that therapy was distributed throughout PD's life and solutions and relapses emerged in it.

CONCLUSIONS

1. It is our suspicion that therapeutic effects are not typically localised in any particular phrase or a short sequence of talk but instead emerge in 'long sequences' of therapeutic dialogues, which are sometimes distributed across sessions.
2. Background ethnographic information has to be used in the analysis especially where long sequences[9] specific to the kind of therapy are concerned to identify them.
3. But since the long sequences supervene on shorter conversation sequences, traditional CA which focuses on locally organized sequential context is also essential.
4. Background ethnographic information cannot be always be gained from, for example, books, and applied by the conversation analyst. The participation of the therapist is needed to ensure the relevance of the background ethnographic knowledge at any point of the therapy talk analysed.

[9] Extended sequences, trajectories in other names.

5. Some relevant background knowledge cannot be learned from books—it is personal and unique to the therapist and only can be gleaned through their participation.

BEYOND CONCLUSIONS

In a paper one asks questions and should end with answers, as I have just done. But one can also end with better questions, which she or he does not have to answer in any 'final' way. So let me try this.

1. What can psychotherapists, conversation analysts and ethnomethodologists learn from each other?

It should be something that would allow them to develop a mode of collaboration, which would do justice to situated therapeutic interactions. So what did I learn from the three collaborations? From ST I learned how difficult being an accomplished therapist is. The accomplished therapist cannot depend cosily on therapeutic orientation and training but has to improvise in good will always anew. From PT I learned about the importance of user movements and the way the experts should be situated in these—with a dose of humility, that is. And the interaction with PF brought home to me, amongst other things, that psychotherapy is a political matter.

2. Where does the therapy happen?

Clearly the answer is, not just in the consulting room. Dreier put is as follows:

22. Dreier, 2008

> According to a technical rationality, a theory offers practitioners direct answers to their questions about what to do in concrete cases and situations. […] *Yet, the conduct and outcome of* therapy is not up to him alone. The conduct and outcome *are a distributed effect of what everyone who is somehow involved does and think*. (Dreier 2008: 4, my italics)

This was arguably so in all the three cases even though the balance of researcher/therapist/client contributions was different. In PD's case the therapy had to happen when she was on her own with her voices. And it happened also when she wrote her diary and practiced reactions to voice commands. In the case of PF's clients, the solution-focused therapy provided an analogue of 'zone of proximal development' but it was up to clients to extend what they learned in the consulting room to deal with new problems in their life at large. In the therapy with children,

the problem was again to extend the therapeutic influence well beyond the sessions. I suspect that many children would deal with the problems at school such as being separated from their parents and 'squished', *with ST as penumbra of their experiences*. In all the three cases, the experience of therapy, if it is worth anything, should not fade away when the door is shut but work as a resource for living.

3. What is the relationship between contextualizing and mentalizing?

George Miller (1991) once defined psychology as the 'science of mental life'. Consistent with this, psychotherapeutic interventions tend to be thought of as concerned with mental processes and their dysfunctions. Psychotherapy is made possible by everyday intentional stance to other people and what they do—it presupposes 'language of intentionality'. The three studies above were however concerned not with 'mentalizing' but with 'contextualizing', as it happens in psychotherapy. This does not mean that the account is irrelevant to research on psychotherapy. It is a truism in Pragmatics that people attend to the *sense* of what is said (rather than its literal meaning) and that sense is a function of context. If we perceive or infer intentionality of another person we do this on the basis of its sense—what they say or do *in context*. In this sense, study of contextualizing takes a precedence over study of 'mentalizing'. Our observation is that participants in psychotherapy construct the situation through their activities so that their inner life can be directly apprehended, without complex inferential work. Wes Sharrock and I tried to capture this in the concept of 'structured immediacy' (Leudar, Sharrock et al. 2008b).

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