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Conversation Analysis and Psychotherapy

Introduction – a brief look at the literature on CA and doctor–patient interactions

As Conversation Analysis (CA) is an approach which is slowly beginning to be used as a method of research for psychotherapy, I also looked at some research involving doctor–patient interactions and made some comparisons (Scheglof, 1963; ten Have, 1991; Mellinger, 1995; Garafanga and Britten, 2004; Heritage and Maynard, 2006; Antaki, 2011; Heritage and Robinson, 2011; Gill and Roberts, 2013). Doctor–patient consultations, such as might be found in a G.P. surgery or psychiatric unit are analogous to psychotherapist–client interactions as both are of an institutional nature where the trained professional offers a helping service to a patient or client in need. Most of the research carried out using CA on doctor–patient consultations found that both participants orient themselves to a specific structure or expectation about how the consultation will proceed. As would be expected in a professional–client consultation the asymmetrical relationship affects the turn-taking procedures, which are designed in a particular format where the doctor asks the questions and the patient answers until a diagnosis is reached. However, using doctor–patient interviews as a basis for studying psychotherapist–client interviews may not do justice to the practice of psychotherapy as some of the more intimate and powerful aspects of therapy may be overlooked. Hak and de Boer (1996) found that in a medical first encounter interview, formulations were non-existent. The question–answer format, coupled with the notable absence of formulations (reflecting back techniques) provided an indication of how the doctor is able to impose a particular type of order on to the conversation, that is reflecting back techniques were absent (ibid.). In a doctor–patient psychiatric interview only gist
formulations, which summarize what the client has said and as described by Heritage and Watson (1979), were used and were employed as devices for checking on information so that professional assessments could be conducted (1979). Hak and de Boer (1996) concluded that the absence of *upshot* formulations, where the professional draws out some relevant implication from what the patient/client says (adding something to the reflecting back technique) forms the main difference between a doctor–patient psychiatric interview and a psychotherapeutic one.

What one can say however is that all practitioners adopt a specific agenda and use this agenda with all patients and clients. Patients and clients on the other hand adjust their talk to those agendas (Antaki, 2011).

Mellinger (1995) investigates talk-in-interaction in a psychiatric interview where the patient is being assessed concerning their suitability for psychotherapy. However, the interaction is examined from the point of view of dominance which may be too strong a word in the psychotherapeutic encounter. Mellinger (1995) sees the power relationship in the interaction as very asymmetrical and sees the psychiatrist’s talk, where all the questions asked are indications of control with the patient offering little resistance. Heritage and Robinson (2011) suggest that patients may sometimes withhold concerns if they are secondary to what they see as their main concern unless the practitioner pins a patient down with specific questions, for example, ‘is there anything else we need to take care of today’ (p., 11). Garafanga and Britten (2004), who see the doctor–patient relationship pointing more towards mutuality, found that patients in a medical consultation did resist suggestions made by the doctor and did not just accept the doctor’s preferences. Ten Have (1991), who looked at how doctors and patients achieve asymmetry through the details of their situated interactions, found that the participants choose to act in accordance with what is expected of them by the institution and that both participants could try to influence the course of conversation. As doctor–patient interactions work mainly around a diagnosis and how the patient can be treated, the elements of influence followed by client resistance are much less subtle than one would find in psychotherapy – at least in short-term therapy where one expects to be helped in a short space of time.

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Much of the literature to date on CA and psychotherapy focuses on a thorough description of how psychotherapists accomplish their tasks.