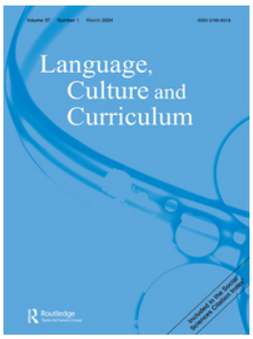

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Interactional Competence for professional communication in intercultural contexts: Epistemology, analytic framework and pedagogy

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ABSTRACT

In the twenty-first-century working professionals need to possess strong Interactional Competence to handle professional communication in intercultural contexts (PCIC). However, the relationship among the three PCIC constituents – culture, workplace and interaction – is undertheorized in current research. This leaves PCIC practitioners oftentimes uncertain of how to better define and develop their communication skills. This article seeks to address the gap by first analysing the two dominant PCIC epistemologies: the inference-based, psychological-positivist approach and the practice-based, interactional-constructivist approach. I then propose an analytical PCIC framework to differentiate the *inference* we make about one another and the *practice* we observe in each other. Using authentic PCIC training materials analysed through Sequential-Categorial Analysis (combining Conversation Analysis and Membership Categorization Analysis), I argue the concept of Interactional Competence can bridge inference and practice, offering a route to assisting researchers in analysing PCIC, educators in developing PCIC training materials, and practitioners in refining their PCIC skills. Pedagogical applications of the PCIC framework are also presented. I conclude the paper with theoretical, methodological and practical implications for PCIC, where we constantly see grounds for inclusion and exclusion articulated around notions of culture and professional identities.

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Professional communication; Workplace communication; Intercultural communication; Interactional Competence; Membership categorization analysis; Conversation analysis

What is professional communication in intercultural contexts?

Let me start addressing this question with a vignette: imagine a female Anglo dentist, born and trained in the US, is treating a female patient who was originally from China and speaks limited English. The patient reports having bleeding gums. The dentist insists on the cause of the patient's symptom being bacteria in her mouth while the patient wants the dentist to prescribe Chinese herbal medicine that restores the balance of *qi* 'life force' in her. For the patient, the unbalance of *qi*, a traditional

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Chinese medicine concept, is what provoked her gums to bleed. The dentist wonders why the patient is not listening to her science-based explanation, which has always worked so well with patients from her own cultural background. The patient equally feels frustrated about how the dentist does not acknowledge her health beliefs, categorizing the dentist as dismissive, unsympathetic, unprofessional and worse still, racist.

The above vignette describes one episode of Professional Communication in Intercultural Contexts (PCIC), where communication takes place in professional workplace contexts amongst interactants of different cultural backgrounds.[1] Although any form of communication carries stakes, PCIC constitutes a particular site of high-stakes communication because of its culture and workplace constituents. In the vignette, the dentist may extrapolate similar experiences and form essentialized notions of how Chinese patients think, talk and behave, creating 'hard boundaries' (Zhu et al., 2022, p. 316) between Chinese and non-Chinese patients. On the other hand, the Chinese patient can feel wrongly treated by the dentist and decide to lodge a complaint. These inferences the two protagonists make about one another, predicated on notions of culture, workplace and interpersonal interaction, can happen not only in healthcare communication but also in other arenas of PCIC such as corporate, political and legal communication.

To understand PCIC and mitigate, if not avoid the fallout of failed PCIC as captured in the vignette, I argue a fruitful starting point is to investigate PCIC's three main constituents – culture, workplace and interaction. This is due to (1) the failure of PCIC is often attributed to interactants' divergent cultural backgrounds, (2) the stakes of PCIC are best reflected by its professional nature where job security and career progression can be placed in jeopardy and (3) interaction is where culture meets workplace and where the intricacies of PCIC need to be managed on a moment-by-moment, turn-by-turn basis. Figure 1 presents the relationships among the three, with the dashed lines between culture and workplace indicating the porous nature between the two and the ones around interaction implying the mediating role of interaction between culture and workplace.

The interrelatedness of culture, workplace and interaction in PCIC requires a componential analysis of each individual constituent and at the same time, a combined, holistic

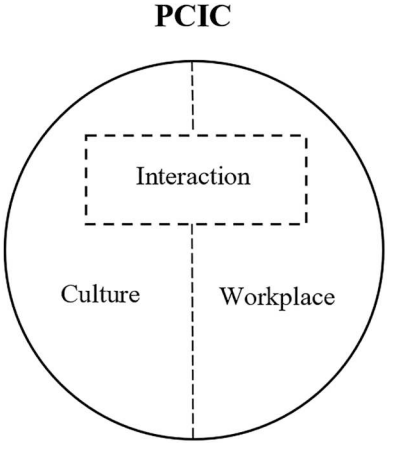

Figure 1. PCIC and its constituents.

evaluation of all three. More specifically, this paper contends that a distinction between *inference* and *practice* is conducive to understanding how PCIC operates. Inference is the judgement we make based on what we observe in our and our interactants' conduct in PCIC while practice refers to the conduct itself. The difference between inference and practice is rooted in the two epistemologies in the study of culture and workplace, namely the psychological-positivist and the interactional-constructivist approach. To reconcile the gap between inference and practice and promote more effective PCIC teaching and learning, I argue that PCIC researchers and practitioners need to (1) develop PCIC interactants' Interactional Competence in managing interaction and (2) utilize the *bracketing* technique to resist evoking essentialist notions of culture and workplace as explanations. Interactional Competence is a speaker's ability to mobilize interactional resources for interaction (Hall & Pekarek Doehler, 2011) and mediate the inferences predicated on interaction (Dai, 2024). Bracketing is an analytic principle in ethnomethodology that requires speakers to set aside etic, pre-determined considerations in explaining practice (Garfinkel & Sacks, 2005). An example of bracketing from the previous vignette is the patient bracketing the notion of race and refraining from thinking 'it is because the dentist is *white* that she said this to me'. The concept of Interactional Competence and the principle of bracketing will be further explicated in subsequent sections.

This paper is structured by first, an explication of the inference-based, psychological-positivist approach and the practice-based, interactional-constructivist approach to culture, followed by an analysis of the workplace along the same two lines. I then present a discussion on interaction, Interactional Competence, and a PCIC framework that can serve as a conceptual and practical template for PCIC research and training. Finally, I use two worked examples to illustrate my argument, followed by a pedagogical demonstration of how the PCIC framework can be put to PCIC education. This paper concludes with theoretical, methodological and pedagogical implications of the PCIC framework.

Culture

What we infer: the psychological-positivist approach

Culture, as one constituent of PCIC, holds a paramount position given how frequently it is used as an explanation for tension or breakdown in PCIC. If we go back to the dentist-patient vignette, it is not unimaginable for the dentist to casually talk to her Western colleagues after the previous incident about how patients from Chinese cultural backgrounds can present certain challenges. Similarly, we can reasonably expect the patient to seek sympathy and understanding from her family and friends who share the same Chinese culture. The logic behind this type of behaviour is premised on the *inference* we make about our interactants. We perceive, infer and construct patterns in how we and others communicate, forming bounded notions of definable cultural groups. A large body of work following this logic centres on the influential model developed by Hofstede (2011). Its six dimensions – power distance, individualism, masculinity, uncertainty avoidance, long-term orientation and indulgence – solidify the inferences we make about interactants from other *named* cultures. Using Hofstedean models we can draw inferences not just about other people's interactional styles but also their values and beliefs towards

interaction (Spencer-Oatey & Wang, 2020). The appeal of such models is that they reduce culture, a slippery and fuzzy concept, into measures that are describable and articulable. However, as Ladegaard and Jenks (2015, p. 402) argue, such approaches run the danger of treating culture as 'a set of coagulated cognitive and psychological traits', or 'a causal *a priori*'. By focusing on differences in cultural practices and explaining such differences using *a priori* psychological traits predicated on the process of inferencing, attempts to resolve tension in PCIC can unintentionally reinforce the perception of differences and maintain boundaries articulated around race, gender, class and/or ethnicity. This can lead to acts of symbolic violence (Bourdieu, 1991) where differences perceived through casual inferencing, grouped under the name of culture, become grounds for exclusion, fetishization and subordination (Simpson & O'Regan, 2021).

Here I term this approach to culture as psychological-positivist in its epistemology, which focuses on drawing categorizable inferences based on perceived differences. The enduring popularity of this approach, whether in PCIC training (Trompenaars & Hampden-Turner, 2012) or everyday mundane PCIC sense-making (c.f. the above-mentioned dentist–patient vignette), rests in humans' fundamental need to essentialize and categorize. When we grow up and socialize in our own community, or later move to a new country and socialize into a different community, we invariably try to make sense of the interactional practices employed by people around us (see Li, 2023 for a parallel argument on how one deveops the ability to think). The initial stage of such sense-making is largely unconscious while we become familiar and comfortable with practices that we have been repeatedly exposed to. As we start to engage in the practices we observe, these become sedimented, routinized and essentialized. When encountering interactants in PCIC settings, we become acutely aware of how similar or different their practices are, which leads to inferences being made about the other person. Dai (2024) details a large-scale empirical study where 36 first-language Chinese participants viewed and commented on 198 recordings of a wide range of intercultural encounters between first-language Chinese speakers and speakers of Chinese as an additional language. The study was designed to understand what inferences everyday members of a speech community develop when differences in interactional practices become pronounced. Thematic analysis of participant comments revealed that everyday members of a speech community routinely orient to (1) whether speakers in intercultural encounters are being friendly or not (inference about emotion), (2) reasonable or not (inference about logic) and (3) credible or not (inference about morality). Figure 2 illustrates how this inference process takes place from an etic, psychological-positivist perspective.

Although it is human nature to make inferences based on what we perceive, it is problematic to explain our inferences via *a priori* categories of culture. This is when culture as a constructed, notional concept is employed as both a sensemaking and explaining tool, allowing us to validate and justify our positions when we create a binary relationship of my *culture* versus the other *culture*, whether the other cultures are the Chinese culture, teen culture, public-school culture, our-parents'-generation culture, Muslim culture or economically-depressed-suburb culture. These cultural categories are purposefully manufactured for specific interactional contexts as no two members in any such category are identical in every interactional practice they employ, nor do they overlap

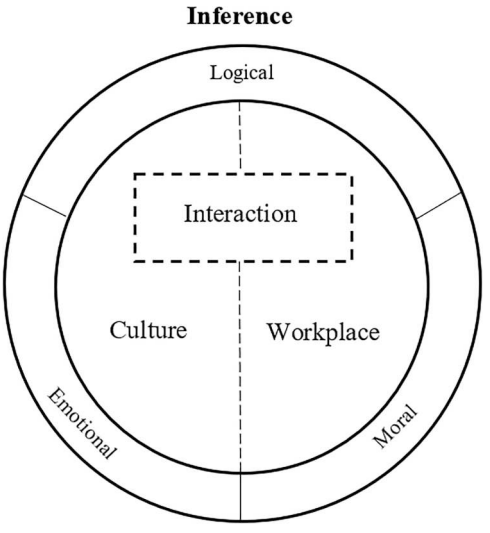

Figure 2. Inferences about PCIC.

completely in all the other categories to which they simultaneously belong. This is the main limitation of the inference-based, psychological-positivist thinking to culture in PCIC. Although it is natural for humans to draw inferences from their genuine sense-making experiences, it becomes problematic when we start to proffer *casually formulated*, but *causally expressed* explanations for our inferences based on cultural categories (e.g. the patient was being uncooperative because she was Chinese, because she was not from here, or because she was a middle-aged female). Another limitation of the psychological-positivist approach is that it lacks an acknowledgement of the dynamic nature of human cognition and interaction, where cultural categories are constantly refined and redefined by interactants. This leads us to the other mainstream approach to culture: the interactional-constructivist.

What we do: the interactional-constructivist approach

Noting the essentialist, reductionist danger in the psychological-positivist view on culture, we can draw on constructivist and discursive perspectives (Edwards & Potter, 1992) to analyse culture, which emphasize what interactants *do*, rather than what *we think* they do in PCIC. In this paper, I term it the interactional-constructivist approach, which sees culture as fluid, flexible and dynamic, mediated through language and discourse. Instead of relying on presupposed *a priori* cultural categories as does the psychological-positivist approach, the interactional-constructivist approach starts with discourse where cultural categories are brought into interaction, made relevant, negotiated and contested. There are many methodologies that fall under the banner of interactional-constructivist (Stubbe et al., 2003), with the bulk of research so far being conducted using interactional sociolinguistics (Holmes, 2018; Holmes et al., 2020; Vine et al., 2022). Among these analytic methods are Conversation Analysis and Membership Categorization Analysis, which Dai (2024) collectively termed

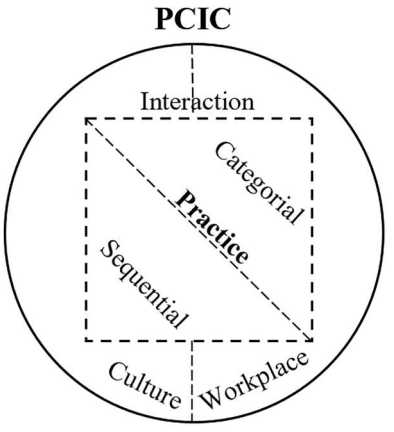

Figure 3. Practices within PCIC.

Sequential-Categorial Analysis (SCA). In this paper, I explicate how SCA and its concomitant *bracketing* analytic principle can contribute unique insight into the conceptualization and teaching of PCIC.

First developed by Sacks (1992), SCA adopts the *bracketing* technique in ethnomethodology (Garfinkel & Sacks, 2005), focusing the analyst's attention solely on interactants' emic *practice* (what they do) in interaction without recourse to analyst's etic *inference* of what is happening in the interaction (what we think they do). In particular, the sequential aspect in SCA refers to using the analytic apparatus in Conversation Analysis (ten Have, 2007) to understand the temporal unfolding of interaction, while the categorial aspect relates to the employment of Membership Categorization Analysis to unpack the socio-relational aspect of interaction (Dai & Davey, 2023; Stokoe, 2012). Figure 3 depicts how this interactional-constructivist approach puts a premium on actual interactional practices (both sequential and categorial) that take place within interaction, without evoking etic inferences outside the PCIC circle as does Figure 2.

There are distinctive advantages in using SCA and its bracketing analytic procedure to unpack culture in PCIC: by suspending pre-established notions of culture, SCA forces us to rely our understanding of PCIC solely on interactants' actual practice in interaction. The analytic focus here is on interactants' orientation to culture through their use of culturally-resonant descriptions, or their display of conduct in interaction that is culturally recognizable (Roever & Dai, 2021; Stokoe, 2012). In this way, we can empirically ground claims of culture or cultural practices in interactants' actual conduct. For example, through observing how Chinese-background patients and Anglo-background dentists orient to each other's interaction, we can either confirm or challenge our pre-existing notions of cultures. Some such notions can be one cultural group (a) is more individualist, (b) shows more orientation to power difference, or (c) tends to avoid uncertainty more compared to another. A body of research adopting the SCA principle, though mostly using Conversation Analysis instead of Membership Categorization Analysis or a combination of the two, has generated more nuanced understandings of culture as interactional practices where essentialized cultural categories are challenged (see Brandt & Jenks, 2011 for an example).

Irreconcilability or possibility for unification?

I have so far analysed the two ends of the spectrum of approaches to culture in PCIC: at one end the psychological-positivist approach essentializes and quantifies culture as a collection of inferences while at the other end, the interactional-constructivist approach acknowledges and embraces the fluid, co-constructed, context-shaped and context-shaping nature of culture as practice, drawing on discourse analysis of moments when culture becomes a focal point in interaction. The reality of culture, as with most things in life, is far more complex and resists dualistic thinking.

Proponents of the interactional-constructivist approach can reasonably argue that the psychological-positivist tradition reduces complex human experiences and identities to simplistic and ethnocentric inferences that reify differences, distinctions and barriers. On the other hand, supporters of the psychological-positivist thinking can reference people's everyday experience of sense-making, inferencing and categorizing, which, to staunch interactional-constructivist partisans' dismay, does suggest recognizable differences in people's interactional practices that can be mis/categorized as culture. Kecskes (2014) posits that to propose a linear connection between culture and interactional patterns (c.f. the psychological-positivist thinking) is just as erroneous as to maintain that culture does not impose any characteristics on communicative behaviour *a priori* (c.f. the interactional-constructivist thinking).[2] Here I opine that to understand culture in PCIC, we need to establish an analytic framework that accommodates the distinctions people can recognise and infer in their own and others' interactional practices, but at the same time, acknowledges the performative and emergent nature of such practices in cultural identification and cultural becoming. Take the dentist-patient vignette as an example, we cannot deny that there are certain recognizable features, patterns and interactional practices about the dentist and patient that invite them to infer and categorize one another as *dentist* and *patient*, *American* and *Chinese*. At the same time, however, we need to recognize and analyse how they become *dentist* and *patient*, *American* and *Chinese*. They do not come into PCIC with such categories; instead, they produce and reproduce *dentist*, *patient*, *American* and *Chinese* through interactional practices. The unique contribution of SCA is that we bracket our pre-existing notions of such cultural categories and the inferences we make of the interactants. We instead examine how the interactants themselves take on these categories and talk the categories into existence using sequential and categorial interactional practices. Before I present a unified PCIC framework that reconciles the inference-based psychological-positivist and practice-based interactional-constructivist epistemologies, I shall first turn to the other side of the coin of PCIC: the workplace.

Workplace

A defining feature of PCIC is that it takes place in professional contexts such as healthcare, legal and corporate communication. Although miscommunication in either professional or mundane/everyday communication is undesirable, affronting a neighbour carries relatively lower consequences than misdiagnosing a patient, misrepresenting one's client in court, or mismanaging one's relationship with their manager. Not getting it right in

professional communication can have dire consequences for a person's job security and general well-being.

Just like with culture, workplace as a constituent of PCIC can be analysed through an inference-based, psychological-positivist approach, or a practice-based, interactional-constructivist approach. The psychological-positivist approach to workplace draws upon pre-determined categories – country, gender, profession, seniority – to arrive at generalizable inferences about workplace communication. The influence of the essentialist, Hofstedean, psychological-positivist approach is observable in popular business communication training materials. Hernandez (2013) recounts one such example where English-speaking PCIC practitioners are provided with this advice on how to give a business presentation in Russia: one should be as clear and specific as possible, not to the extent that English speakers normally would do, but also not be too vague or general. Here we see how inferences about workplace practices, formulated along the lines of nationality, are solidified as guidelines for PCIC training. Although such advice gives PCIC practitioners a sense of direction by appealing to humans' fundamental cognitive process of inferring and categorizing, it can be challenging to implement this advice in real-world PCIC. If we extend the example in Hernandez (2013) and have an English-speaking, Chinese-background businessman who has lived in Russia for work for one year. What if during the Q&A session, the people in the audience asking questions to the businessman are from companies in Vietnam, India or Chile? Does this businessman need to acquire an encyclopaedic knowledge of different professional communication practices in all countries to function successfully? Furthermore, if we observe modern-day workplaces, we see businesspeople Zooming in meetings in different countries and time zones, health professionals with prior work experiences in various countries and clinical contexts collaborating to provide patient care, and lawyers seeing a Chinese-background client today but a Vietnamese-background one the next day. PCIC curricula developed with a strictly inference-based, psychological-positivist mindset do not account for the complexity and reality of modern-day workplaces.

Similar to the practice-based, interactional-constructivist approach to culture, professional communication can also be investigated via the lens where workplace norms are considered emergent, flexible, context-shaped and context-shaping practices. The interactional-constructivist approach does not see professionals as having static, *a priori* categories such as dentist, American, middle-class, white, or Christian. Instead, they become, take on, reject and edit these categories in the workplace vis-a-vis their interlocutor (Angouri & Humonen, 2023; Dai et al., 2024; Debray & Spencer-Oatey, 2022; Holmes, 2006). SCA as an analytical procedure can similarly be applied to the study of workplace communication as it does with culture. Following the bracketing principle in ethnomethodology, any claims of workplace norms or interactional patterns are not treated as relevant until they are oriented to as such by interactants in interaction.

Although an interactional-constructivist orientation to workplace communication can address limitations in the psychological-positivist approach, strict adherence to an interactional-constructivist perspective poses the same epistemological and practical challenges as it does with culture. Firstly, there is a lack of account of the inference-based, sense-making nature of human cognition that involves recognition, categorization and differentiation of interactional practices. A disregard for these differences that

professionals can genuinely notice and palpably feel invalidates their very real sense-making experience. A practical and comprehensive framework of PCIC therefore needs to account for this dimension of PCIC. Secondly, discourse analysis that adopts the interactional-constructivist epistemology can generate useful insight into the interactional practices of PCIC, but in terms of translating findings to practical resources for PCIC practitioners, existing research tends to conclude with a call for sensitivity, awareness and tolerance. Although such principles are clearly worth advocating, it will be useful to provide a working PCIC framework that provides a practical toolkit for practitioners to understand how they can successfully sail across the many perils of PCIC. To address these conceptual and methodological challenges, in the next Section I present an analytic PCIC framework, focusing on interaction and Interactional Competence, that accommodates the tension in the psychological-positivist and the interactional-constructivist approaches to culture and workplace, but at the same time operates as a useful template for PCIC practitioners and researchers alike.

Interaction and Interactional Competence

In the preceding sections, I analysed the two epistemologies undergirding our established thinking of culture and workplace, namely the psychological-positivist and interactional-constructivist approaches. I also called for a framework that has the capacity to reconcile the two and suggested that a comprehensive PCIC framework has the potential to offer a best-of-both-worlds solution here. In this section, I explain why a focus on interaction in PCIC can not only unite the two epistemologies but also generate insight for praxis.

Despite the multiple layers of cultural and workplace norms, practices and beliefs expounded previously, at the heart of PCIC is interaction where culture intersects with workplace. The use of the word interaction, instead of communication is purposeful as interaction highlights the contingent, moment-by-moment nature of interpersonal communication. Compared to other conceptualizations of communicative abilities, the ability to interact, or Interactional Competence, puts a premium on the turn-by-turn management of both sequential and categorial practices to make a speaker's social action recognizable to their interactant. Concurrently, Interactional Competence emphasizes the inferential nature of social interaction: effective communication requires the speakers to remain reflective of the emotional, logical and moral inferences their communication style opens themselves up to (Dai, 2024; Tai & Dai, 2023).

Demonstrating strong Interactional Competence in PCIC is particularly challenging as PCIC simultaneously traverses the cultural dimension (e.g. race, nationality, religion, socio-economic status) and the workplace dimension (e.g. occupation, organizational level, institutional knowledge) of communication. Interaction is the site where all the previously discussed categories and their associated inferences collide, submerge, transform and reincarnate. Therefore, one of the crucial aims of PCIC curricula is to develop practitioners' Interactional Competence in handling real-time PCIC.

In Figure 4 I present a holistic PCIC framework that captures the intricacies of culture, workplace, interaction and Interactional Competence, and at the same time, accommodates the two epistemological approaches to culture and workplace communication. Through two concentric circles, Figure 4 connects the inference-based approach in

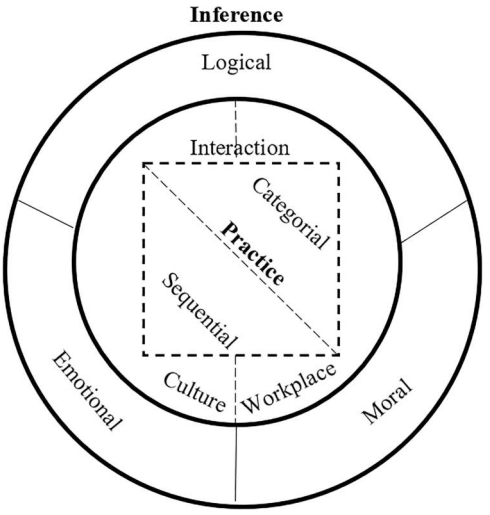

Figure 4. A conceptual and analytical framework of PCIC.

Figure 2 and the practice-based approach in Figure 3. At the heart of the inner circle is interaction, represented via a square box, consisting of both sequential and categorial practices. Sequential practices refer to the use of semiotic resources (e.g. words, sentence structures, gaze, spatial arrangement) to manage interaction sequentially (e.g. turn-taking, preference organization and repair). Conversation Analysis in SCA is a suitable methodology for the analysis of this side of interaction (Hall & Pekarek Doehler, 2011). Categorial practices pertain to the employment of the same semiotic resources to mediate the socio-categorial nature of interaction, such as how to enact speakers' social roles, how to establish social relations in interaction, how to articulate group memberships and how to talk into existence notions of communities, objects and institutions. The word categorial implies that these are social categories we bring to interaction. Membership Categorization Analysis in SCA, as the name suggests, is a fitting methodology to unpack the categorial nature of Interactional Competence (Dai & Davey, 2023). When semiotic resources are used for sequential practices, they are referred to as sequential resources, and if the other, categorial resources.

How interactants employ sequential and categorial resources for interaction can be understood by how each interactant regulates their internal, individual lifeworld, a world they have constructed through repeated interaction with the outside world since infancy. When infants grow up and start interacting with others and their surroundings in familial, educational and vocational contexts, they begin to formulate notions of how social actions are managed (when dad *sets the table* it means everyone needs to *go to the dining room for dinner*) and how social roles are enacted (*teachers* instruct *students* to behave in class). Repeated exposure to similar interactional practices leads to sedimentation and routinization of contextualization cues (Gumperz, 1982), which are concurrently sequential and categorial.

The sequential and categorial resources and the learned practices in how to deploy these resources undergird the inferences we make about one another in the outer circle in Figure 4. Interactants from the same group – categorizable in terms such as

nationality, race, suburb, socioeconomic status, gender, company and profession – see greater similarity in the interactional practices of members in the 'same' (constructed) group. When an interactant encounters another from a categoriably different group, they may notice differences in sequential and categorial practices and attribute such differences to the named category, whether the category is nationality, race or profession. Both regularity and haphazardness exist in this process of sense-making, inferring and categorizing: the probability of a correct inference when inferring a woman to be a child's 'mother' after hearing the child calling the woman mum is very high (although this could be a roleplay scenario, or the child has mistaken another woman for their mother). On the other hand, when we see a nurse from Pakistan taking a nap in the staff room during lunch break in a British hospital, how confidently can we attribute it to the nurse being a 'Pakistani', 'woman', from a certain 'educational background', a member of a previous 'workplace', from a certain 'age group', or simply to the nurse 'being tired'? Here we can already see how biases and stereotypes in PCIC can easily stem from erroneous inferencing and categorizing.

When two interactants interact, we see two lifeworlds coming into contact, with both interactants' sequential and categorial interactional resources activated in their respective lifeworld. During the process, the two interactants can orient to their shared human sociality in the two lifeworlds in relation to interactional patterns and resources (Stivers et al., 2009). Contemporaneously, as every single lifeworld is unique due to the sui generis nature of every person's life journey in terms of family upbringing, communal socialization, educational experience, work history, national ideology and societal values, the two interactants also invariably attend to differences in how their interactional resources are deployed both sequentially and categorially.

The outer circle in Figure 4 captures the inferences interactants routinely make about one another, classified under the emotional, logical and moral dimensions, which correspond to the three Aristotelian artistic proofs. When interactants make sense of each other's sequential and categorial interactional practices, they make value judgments about the interactants: they consider how others engage with them affectively through attempts to build rapport or control conflict (emotional, pathos), how others display rationality when structuring information or providing explanations for their actions (logical, logos), and how others project their personae – a dentist, a patient – and manage the display of personae-predicated qualities – for example doing being a 'helpful' dentist and a 'collaborative' patient (moral, ethos). The two concentric circles connect an interactant's inner lifeworld, which consists of sequential and categorial interactional practices, and the outer social lifeworld, where interactants make inferences about one another at the emotional, logical and moral levels. Our notions of culture and workplace sit between these two circles, two worlds, mediated by practice and inference. Our command of PCIC lies in our Interactional Competence (1) to employ sequential and categorial resources for practice and (2) to manage the inferences our interaction engenders.

Connecting practice and inference in this PCIC framework opens avenues for criticality and reflexivity: instead of using casual inferencing to hastily match certain interactional practices with a convenient category (e.g. an 'overseas trained dentist', an 'ignorant patient'), this PCIC framework prompts us to ponder what the other person and ourselves are trying to achieve in PCIC and how we are going about doing it – which is *practice*: is

the dentist trying to build rapport by spending so much time chitchatting? Is the patient attempting to make sense of her own condition in her own way? Is my hygienist colleague deliberately being rude by taking a nap in the middle of the staff room or could there be other explanations? Interactants will not be able to make sense of every interactional practice *here* and *now* in interaction insomuch that no interactant will have complete knowledge of another interactant's lifeworld. In fact, none of us can make complete sense of our own lifeworld either as our interactional practices are routinized and our interactional resources sedimented below the conscious level (for a similar argument about the acquisition of pragmatic conventions, see Yates, 2004). The focus of this PCIC framework, instead, is to give us a practical template to make *inference* of what we and our interactants are doing or trying to do through *practice* in interaction while bracketing convenient but oftentimes erroneous cultural and workplace categories used for explaining either inference or practice.

Through specifying the routinized sequential and categorial interactional practices in an interactant's lifeworld, this PCIC framework allows us to unite the two epistemologies in PCIC. The psychological-positivist thinking focuses on defining the sedimented patterns in interactants' interactional resources and inferring emotional, logical and moral qualities from these practices. As for the interactional-constructivist approach, the PCIC framework equally has the capacity to account for the dynamic, emergent and performative nature of interaction. Since this PCIC framework is rooted in the ethnomethodological understanding of social interaction, an important feature of it, as introduced previously, is the concept of bracketing (Garfinkel & Sacks, 2005). Bracketing, employed by researchers working with SCA, can serve as a practical principle that everyday-life social members can utilize when engaging in PCIC. Although it is inevitable that interactants will notice differences in each other's interactional practices, instead of explaining such recognizable differences using essentialized terms like 'Chineseness in patients', and 'unprofessional doctors trained overseas', it can be helpful to bracket such generalizations and focus on interactants' observable practices in interaction.

Following this PCIC framework, we now have a practical template to critically reflect on our/our interactants' practice, the inferences we make/our interactants make of us and the potential misuse of pre-existing categories to explain practice and inference. Interaction is the site where boundaries created by categories can be reified, reinforced, negotiated and broken down. In other words, interaction creates *a third lifeworld* that gives us the opportunity to critically examine how we employ sequential and categorial resources in our own lifeworlds to do the emotional, logical and moral work in interaction, which is our Interactional Competence. Concurrently we have the analytic point of reference to reflect with curiosity on how the other person does their interactional work and displays their Interactional Competence. This holistic PCIC framework, therefore, allows us to not only describe PCIC in terms of its three constituents, its inferences and practices, but also where the aim of effective PCIC curricula lies: to develop practitioners' Interactional Competence in mediating culture and workplace between the two concentric circles.

Worked examples and pedagogical demonstration

Having analysed the three constituents of PCIC – culture, workplace and interaction, and having presented a unified PCIC framework, in this section, I use two worked examples to

illustrate how this PCIC framework can serve as an analytic framework for PCIC researchers and practitioners, and translate to more effective PCIC curricula.

The examples are two contrastive excerpts of PCIC in the clinical context. The excerpts are from two training videos from a university-level dentistry training programme on intercultural communication in healthcare. The original videos have descriptors 'bad communication' for Excerpt 1 and 'good communication' for Excerpt 2, which demonstrate how the video creators oriented to the quality of dentist-patient communication in the videos.

The context for the interaction is that two patients come to see a dentist because they have bleeding gums. Both patients have recognizable Asian physical features, appear to be in their 50–60s, produce speech that can be conventionally characterized as additional-language-speaker speech in terms of syntactic structures and pronunciation, and self-identify as from China in the interaction. In terms of healthcare beliefs, both patients talk about their established practices of seeking relief from traditional Chinese medicine, attributing bleeding gums to heat and imbalance of *qi* (life force) in their bodies. The only major point of difference between the two patients is that the patient in the bad communication Excerpt 1 is female while the one in the good communication Excerpt 2 is male. The dentists in both videos are Caucasian-looking females in their late 20s. They speak a variety of English that can be characterized as educated native Northern-American English.

What happened prior to the two excerpts is that the patients explained to the dentists why they thought they were having bleeding gums, which they attributed to an imbalance in their bodily functioning caused by too much heat in their bodies. They described they would have taken certain Chinese herbs to cool down the heat if they were in China. The two excerpts were transcribed in the Jefferson conventions.

Excerpt 1: Bad Communication 4:29 - 5:19

```
01  DEN   I don't know very much about this(0.2)
02        but here in this country (0.1)
03        um when people have bleeding gums=
04        =we have treatment, very specific treatments
05        for that, that we know (0.3) will work
06        based on scientific evidence (0.2)
07        and um that's something that I would
08        make some recommendations to ↑you
09        .h hm I don't really know very much about all this
10        hm the Chinese medicine (0.4)
11        and the balance and all of that
12        but (0.5) hm I think that we can treat your bleeding gums
13        and [hm xxxx          ]
14  PT        [but xxxx huangqi] is ↑GOOD (0.3)
15  DEN   WELL .hhh you know there's really not a lot of (0.9)
16        scientific evidence to support that=
17        =and here in America we
18        that's how we base our treatments=
19        =and we have lots of success (0.3)
20        all my patients they respond very well to my treatment (0.5)
21        and hm we do that we clean the teeth=
22        =and we get the bacteria off the teeth
23        and that's [xxxx
24  PT               [do you think some bacteria in my teeth?
```

Excerpt 2: Good Communication 4:23 - 5:09

```
01  PT   too much heat in the liver=
02  DEN  =.hh k so there's some ↑herbs you can take[that            ]
03  PT                                              [yeah to cool down]
04  PT   cool down the hea[t]
05  DEN                  [o]h to cool down the [heat     ]
06  PT                                         [heat yes ]=
07  DEN  =ok .h ok ah I think I ↑understand hm (0.5)what's going on here=
08  PT   =yes=
09  DEN  =and we have a very similar way of looking at
10       what causes the gums to bleed=
11  PT   =hm?=
12  DEN  =hm <HEAT>, we call it <inflammation> (0.3)
13  PT   ah °inflammation°=
14  DEN  =inflammation=
15  PT   =yes=
16  DEN  =and sometimes when when food is left behind on the teeth=
17  PT   =uhm?=
18  DEN  =a:nd also sometimes germs in the mouth=
19  PT   =uhm?=
20  DEN  =hm it will cau[se. ]
21  PT                  [ah::]
22  DEN  it will make the=
23       =hm?=
24       =↑hea:t in the gums ↑too
25       and maybe there's something that I have that can help you=
26  PT   =hm=
27  DEN  =with the herbs that you are using (0.4)hm to make your gums
         better
```

Now I demonstrate how the PCIC framework in Figure 4 can serve as a practical resource for PCIC researchers and practitioners. We start with the bracketing principle, which means that although we recognize categorizable cultural and workplace features about the interactants such as their race, age, language background, cultural affiliation and occupation, we bracket such inferred knowledge and refrain from using it to explain participants' interactional conduct. Instead, we focus solely on how interactants orient to one another in interaction. As this framework integrates the psychological-positivist and interactional-constructivist approaches to PCIC, we need to approach the analysis in a two-step process, covering both inference and practice. A recommended starting point is to use SCA to look at practice following the interactional-constructivist tradition.

Starting from the inner Interaction square box in Figure 4, we first analyse the sequential patterning in the excerpts using Conversation Analysis in SCA. Based on turn-by-turn transcription of interaction, Conversation Analysis allows us to observe the sequential features of interaction, such as pauses, gaps and overlaps (ten Have, 2007). Here we can find noteworthy differences: Excerpt 1 presents the dentist doing most of the speaking in a monologic manner with the patient only inserting two lines through interruptions in lines 14 and 24. Excerpt 2 displays a different turn-taking pattern with the turns in general equally distributed between the dentist and the patient with frequent overlaps (e.g. lines 4 and 5), listener responses (e.g. line 21), collaborative completions (e.g. lines 2 and 3) and latching (e.g. lines 8–27).

Having examined the sequential patterns of the two excerpts, we now move on to categorial resources interactants evoke in interaction. As discussed in the section on

the interactional-constructivist approach, Membership Categorization Analysis in SCA is an appropriate method to uncover how speakers' social categories, speakers' relational obligations and responsibilities (predicates), social relations and group memberships are talked into existence (Stokoe, 2012). In Excerpt 1 we see the dentist categorizing a group of people, including herself, as 'people in this country' in line 2. When having bleeding gums, people in this category look for 'specific treatments' (line 4), which is a predicate associated with the category 'people in this country'. This country is confirmed in line 17 as North America. This categorization work by the dentist creates, from the onset of this excerpt, a relational pair, an act of distinction between (a) 'the dentist' and 'the patient' and (b) 'people in this country' and 'people not from this country'. The dentist further establishes a membership categorization device (MCD) in line 10 for 'Chinese medicine' where notional categories such as 'balance' and other 'all of that' concepts (line 11) are stored. An MCD, a Membership Categorization Analysis terminology, is a collection of categories that members from the same speech community consider as belonging together (Hester & Eglin, 1997). In this case, the 'Chinese medicine' MCD is created in direct response to the storytelling from the patient before line 1 where the patient painstakingly recounts her understanding of her bleeding gums based on traditional Chinese medicine: an imbalance in the body caused by too much heat, treatable through the use of Chinese herbs. The dentist's elaboration of her understanding of her own lifeworld and the one of the patient, however, does not seem to receive any engagement from the patient: there are no acknowledgement tokens, display of backchanneling, or supply of alignment devices from the patient. The only response the patient provides is in line 24 where she repairs the dentist's notional category 'bacteria' in the dentist's Western medicine MCD, displaying the patient's non-acceptance of the dentist's categorial explanation.

Moving on to Excerpt 2, we see a similar distinction being made by the dentist between her lifeworld and the patient's from line 7 to line 12, although the interactional upshot differs drastically from Excerpt 1. In Excerpt 2, the dentist first epistemically aligns with the patient in line 7 by claiming that she has gained better insight into the patient's lifeworld: the patient's Chinese medicine MCD. What is noteworthy is that the dentist then establishes a connection between the two lifeworlds in line 9 by focusing on shared common ground in the Chinese medicine MCD and the Western medicine MCD through the category 'heat'. In line 12, the dentist further recategorizes 'heat', a category from the Chinese medicine MCD to 'inflammation', a category in the Western medicine MCD. We see this delicate categorical work by the dentist paying off in the ensuing dialogue, where the patient proffers a change-of-stake token ah in line 13, and an acceptance token yes in line 15. This paves the way for subsequent talk where the dentist expounds more categories in her Western medicine MCD such as 'food on the teeth' in line 16 and 'germs' in line 18, with constant evocations of categories in the patient's Chinese medicine MCD such as 'heat' in line 24 and 'herbs' in line 27. The dentist in Excerpt 2 therefore proactively builds a third lifeworld where the dentist's and patient's respective lifeworlds connect and merge, translating into better patient engagement, evidenced by the patient's latched speeches, overlaps and supply of acknowledge and acceptance tokens throughout lines 19–26. We therefore see a clear difference in Interactional Competence between the two dentists in terms of how they employ interactional resources for practice.

So far we have analysed the sequential and categorial resources employed by interactants in the two excerpts from an emic perspective following the interactional-constructivist tradition. The focus was on what speakers do, which is *practice* in the inner circle in the PCIC framework. The analysis above underscores the emergent, co-constructed nature of culture and workplace in PCIC, which is a strength of the interactional-constructivist approach. Now we turn to how these interactional resources lead us to make etic evaluations about the interactants at the emotional, logical and moral levels. This is aligned with the psychological-positivist tradition where we examine how our natural sense-making of interactional practices prompts us to make judgements of speakers. The focus here is on what we think speakers are doing, which is *inference* in the outer circle in the framework. A key analytic principle is to continue employing the bracketing technique to resist the temptation of using cultural or workplace categories such as race or occupation as explanations for our inferences.

The psychological-positivist analysis starts at the emotional level. We see the dentist in Excerpt 1 dominating the conversation and displaying little interest in eliciting the patient's perspective, while the dentist in Excerpt 2 purposefully creates opportunities for engagement between two lifeworlds and encourages the patient to talk. At a logical level, both dentists in Excerpt 1 and Excerpt 2 present cogent arguments on the causes of the bleeding gum although the dentist in Excerpt 1 focuses primarily on the scientific process in her understanding while the one in Excerpt 2 establishes a logical connection between her explanation and the one from the patient. At a moral level, we can formulate notions of the dentist in Excerpt 1 being 'knowledgeable' and 'capable' based on her claims of successful past experiences treating patients, but her interactional practices can, however, also attract moral inferences of her being 'rude' and 'insensitive'. The dentist in Excerpt 2 on the other hand, based on her use of sequential and categorial resources, can be morally categorized as being 'approachable', 'patient-centred' and 'encouraging patients to talk'. It should be noted the inferences we formulate are influenced by our values and beliefs, which are shaped by repeated exposure to interactional practices throughout our lifespan, as discussed previously. Different people can develop divergent inferences when viewing the same interactional episode (one person's 'considerate' can be another's 'condescending'). Intercultural dialogue around such differences can open up the reflective space to interrogate one's own values and beliefs.

Having discussed the sequential and categorial interactional *practices* we notice through emic SCA and the etic emotional, logical and moral *inferences* we make of the interactants in the two excerpts based on their *practices*, let us now revisit the distinction between inference and practice. As explicated earlier, it is human nature to sense-make, infer and categorize noticeable interactional patterns. Based on the dentists' differing use of sequential and categorial resources we may find the dentist in Excerpt 1 'domineering', 'monopolizing the consultation' or 'does not let the patient talk', and the one in Excerpt 2 'approachable', 'encouraging the patient to talk' and 'eliciting the patient's perspective'. These inferences are natural and need to be accounted for in a framework of PCIC, but the danger lies in using pre-established cultural and workplace categories to explain such inferences. It is problematic when we casually link, for example, the dentist's perceived 'aggressiveness' or 'patient-centredness' to her being 'a female', 'a white person', or 'a dentist educated in the West'. This is why it is crucial to consistently

apply the bracketing technique in our analysis of PCIC, whether we are looking at practice following the interactional-constructivist approach or inference following the psychological-positivist approach.

The PCIC framework in Figure 4 therefore allows us to differentiate between the inference we make and the practice we see in others and ourselves. Simultaneously the framework reminds us to stay vigilant of formulating cultural and workplace stereotypes: while we acknowledge the common-sensical inferences we make based on the practice we observe, we bracket convenient, pre-established cultural and workplace categories and avoid using them as explanations. Instead, we focus our attention on what is actually taking place in the interaction: interactants' Interactional Competence in managing PCIC. The aim of PCIC training is therefore to develop practitioners' competence in utilizing sequential and categorial *practices* to mediate the inferences they open their conducts to. PCIC educators should explore with learners what interactional practices they think can lead to the inference of the dentist in Excerpt 1 being 'aggressive' (and how to avoid it) and what practices make them think of the one in Excerpt 2 being 'approachable' and 'patient-oriented' (and how to achieve the display of these inferred qualities).

As a pedagogical demonstration here I explain two methods that I have used over the years in developing PCIC training materials based on the framework presented. The first one relies on roleplay scenarios. PCIC trainers can create semi-structured roleplay cards where some lines in the dialogue are scripted for the participants (see Youn, 2013 and Dai, 2024 for examples). Drawing on the worked examples above, trainers can group PCIC learners in pairs, one roleplaying the dentist and the other the patient. On the dentist roleplay card, the trainer can specify that the learner roleplaying the dentist will say something like 'here in this country when people have bleeding gums they seek specific treatment' (lines 2–4 in Excerpt 1). When the roleplay finishes, the trainer invites the learners to reflect on what they think they communicated when they used phrases such as 'this country', who the 'people' they were referring to, how the interaction flowed, how the learner roleplaying the patient responded, and what impression of the dentist both parties formulated. These discussions on practice and inference prompt PCIC learners to reflect on how interaction shapes the way we engage with one another and how we can improve our Interactional Competence.

The second method is to present conversation-analytically transcribed PCIC interaction to learners. Similar to Excerpts 1 and 2, trainers can display PCIC interaction in a line-by-line fashion. Trainers can stop at certain critical points, for example, line 15 in Excerpt 2, and ask learners who roleplay the dentist what they will say next now that the dentist has introduced the concept of inflammation. After eliciting learner responses, trainers can prompt the learners to reflect on what they said and how they said it (practice), and how they think the patient would feel (inference) in response to what the learners came up with. Trainers can also play the following lines 17–24 and ask learners to evaluate the dentist's use of sequential and categorial resources, and the emotional, logical and moral inferences the learners make of the dentist. Similar approaches have been reported in other PCIC training contexts such as mediation services (see Stokoe, 2013, 2014).

Overall, my experience as a PCIC researcher and trainer has informed me that learners find it useful to have the opportunity to reflect on the connection between practice and inference through studying other speakers' interaction and reflecting on their own. These

insights then feed into their learning and real-time PCIC, which generates more reflection guided by the framework. It is through this iterative process one develops their Interactional Competence. To make PCIC training effective for busy practitioners, the PCIC framework presented here can serve as a practical template for trainers to structure their teaching. PCIC learners and practitioners can also use the framework to continue their observation, reflection and application when they engage in self-directed learning or real-world PCIC work.

Concluding remarks

PCIC is a complex site of interpersonal communication where its constituents – culture, workplace and interaction – are in constant interplay. Contemporary appreciation of the fluid nature of cultural and workplace identities further increases the complexity of analysing and understanding PCIC. Establishing PCIC as a focused area of study therefore is of paramount importance, especially when we consider the biases, discriminatory practices and acts of symbolic violence frequently observed in PCIC.

This paper promotes PCIC as a distinctive area of study in three directions. Theoretically, I proposed a conceptual and analytical PCIC framework that connects inference and practice in PCIC, corresponding to the psychological-positivist and the interactional-constructivist epistemologies we see in culture and workplace studies. I argue that it is human nature to make inferences based on the interactional practices we observe in ourselves and others, but it is problematic when we *casually* link inferences to pre-conceived cultural and workplace categories that are evoked as *causal* determinants. An understanding of the relationship between inference and practice, how this relationship shapes our notions of culture and workplace, and the role interaction plays in this process, is the first step towards unpacking the complexities of PCIC.

Methodologically, the paper argues for the use of SCA to analyse interaction in PCIC. SCA allows us to unpick at a micro level how our use of sequential and categorial resources influences the inferences we make at a macro level about culture and workplace. One important advantage of SCA is its ethnomethodological principle of bracketing, which encourages researchers and practitioners to suspend preconceived notions of culture and workplace when analysing PCIC. When we approach our and our interactants' management of PCIC, we focus on interactional practices and acknowledge the inferences we invariably make about one another at the emotional, logical and moral levels. However, we refuse to use convenient, casually-evoked cultural and workplace categories as tools to explain the practices we observe and the inferences we make. Instead, we try to uncover how the connection between practice and inference is established, for example, which sequential and categorial practices from the dentists made us think of them as 'approachable' or 'dismissive'.

Finally, in terms of the pedagogical contributions of this paper, I advocate for the teaching of Interactional Competence for PCIC in practitioner training in diverse fields where PCIC is a regular occurrence, such as dentistry, healthcare and police work. Since interaction is the mediating constituent between culture and workplace, practice and inference, it is crucial to develop PCIC practitioners' ability to manage the moment-by-moment complexities of PCIC, which is their Interactional Competence. We can use SCA to make explicit how our use of sequential and categorial resources shapes

interaction and develop PCIC practitioners' competence in managing these interactional resources. We can also develop practitioners' awareness of how their Interactional Competence in PCIC affects the emotional, logical and moral inferences their interactants may make about them and how they can shape the inferences being made through their command of sequential and categorial practices. Combining the theoretical PCIC framework and the SCA methodology, PCIC trainers and practitioners can now investigate how to refine their Interactional Competence for PCIC in a century where we are all cultural and professional nomads who constantly engage in complex PCIC episodes.

Although the framework in this paper is developed for professional communication in intercultural encounters, its analytic procedure can also be applied to mundane/non-professional/everyday intercultural experiences. Future research can investigate how the framework in this paper can be adapted to general intercultural communication training, where practice and inference co-exist, where the principle of bracketing may also prove useful, and where the development of Interactional Competence is ever more crucial to allow us to navigate our everyday intercultural life journey.

Notes

1. It is worth highlighting at this point that the vignette purposefully evokes essentialist notions of culture, for example, a 'Chinese' patient and a 'US' dentist, to present the type of problematic storytelling and sense-making we commonly observe. The logic undergirding such sense-making processes will be unpacked and critiqued in subsequent sections.
2. Drawing on Baynham's notion of identities, Gray and Morton (2018) offer a parallel discussion on identities that are *brought about* and identities are *brought along* in interaction. From this perspective in the case of the paper speakers' American-ness and Chinese-ness are both brought along and brought about.

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