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THE INHERENT DIALOGICALITY OF THE CLINICAL EXCHANGE INTRODUCTION TO THE SPECIAL ISSUE

Sergio Salvatore Alessandro Gennaro
Università del Salento (Italy)

ABSTRACT. The dialogical theory is a contender to become a general theory of the psychotherapy process. In this perspective, it is important to clarify the specificity of the dialogical clinical standpoint within the more general domain of the relational paradigm. To this end, the authors propose to consider the constitutive nature of otherness for the self as the basic tenet grounding and qualifying the dialogical standpoint. Moreover, they provide a reading of some clinical theories as more or less radical interpretations of such a tenet. Finally, they raise the issue of the quality of otherness (a dialectic counterpart versus an organic complement) as a relevant issue that, due to its methodological and clinical implications, dialogical clinical theory is asked to address in its endeavour to develop itself as a comprehensive framework for clinical thinking.

Introduction

The necessity of a general theory of the psychotherapy process

Research on the psychotherapy process has produced a growing amount of empirical findings for the last three decades (Hill & Lambert, 2004). This mass of data has shed light on several aspects of the clinical exchange – e.g. the role of the therapeutic alliance (e.g. Horvath, 2011), the relationship between defence mechanisms and change (e.g. Perry, Beck, Costantinides, Foley, 2009), the transformation of narratives through clinical dialogue (e.g. Angus & McLeod, 2004), and the dynamics of the process (Salvatore, Lauro-Grotto, Gennaro & Gelo, 2009; Tschacher, Scheier & Grawe; 1998). Nevertheless, it has not yet led to the definition of a general, comprehensive vision of the process – namely a theory defining *what the psychotherapy process is* and what its *basic way of functioning* is.

A theory of this kind precedes and grounds the various models of psychotherapy provided by the clinical schools (psychodynamic, cognitive, humanistic, and the like); it must be considered a strategic priority for psychotherapy research. Two theoretical and clinical issues can only be addressed through a general theory. On the one hand, so far many findings have been accumulated concerning the role played by many aspects of the clinical exchange. Yet we need a general theory of the process in order to deepen

AUTHORS' NOTE. Please address correspondence regarding this article to Sergio Salvatore, Università del Salento -Dipartimento di Scienze Psicologiche Pedagogiche e Didattiche, via stampacchia 18, 73100 (Italy). Email: sergio.salvatore@unisalento.it

the understanding of such results, namely to understand *why* they work - and often why they work under certain conditions. For instance, we know that the therapeutic alliance is an important success factor. Moreover, we know that it is not the level of therapeutic alliance per se that is relevant, but how it develops through time – in terms of rupture and reconstruction (Colli & Lingiardi, 2009; Safran & Murray, 2000). Yet, this knowledge does not close, but opens the issue, raising the fundamental question of why, owing to what basic mechanisms, the dynamics of the therapeutic alliance brings about (or however is associated with) clinical change. To say this in more abstract terms, if X is the process factor that the research has identified as affecting the clinical exchange (C), the general theory of the process is the model aimed at conceptualizing the dynamics due to which X affects C. On the other hand, we are in the paradoxical situation of being faced with as many psychotherapy processes as there are different clinical schools – namely, there is the process as defined by psychodynamic theory (or better: processes as defined by psychodynamic theories), cognitive theory, narrative theory, gestalt theory, and so forth - each of them holding their own particular vision of how and why the clinical exchange works. And these different visions of the psychotherapy process run in parallel, without it being possible either to reduce one to the others (as was done at the beginning of the history of psychoanalysis, in terms of the idea of the bronze of psychotherapy deriving from the gold of psychoanalysis), or to put them into a hierarchy of efficacy – a possibility prevented by the Dodo bird's verdict that the various kinds of psychotherapies are all equally efficacious (Luborsky, 1975, Wampold, 2001). Thus, we are left with only two options: either we accept the idea that there are as many processes as clinical school theories or we begin to think of the various school theories of the process as local instantiations of a unique, basic general process model. The first strategy is clearly easier, because it eliminates the problem, rather than addressing it. And, not by chance, this seems the solution adopted by mainstream research. Nevertheless, it raises a very critical scientific and socio-political issue – it gives no protection from the proliferation of process theories and therefore from the deterioration of the specificity of psychotherapy caused by the spread of other more or less similar forms of social and professional practices (i.e. philosophical counsellor, social worker…). In other words, if the definition of the psychotherapy process and of its way of functioning is held within the single clinical school theory, then where can one place the border between what has to be considered "psychotherapy" and what has to be marked as "not-psychotherapy"? It is evident that if one wants to keep the difference between psychotherapy and, say, philosophical counselling – but also flower-therapy, pet therapy, sail-therapy and so forth - one needs theoretical criteria by which to distinguish psychotherapy from the alternatives. And it is clear as well that such criteria have to be of a higher order than the level of the specific clinical theory, the latter being the level where the alternatives are practiced. If these criteria are not defined, the distinction between psychotherapy and alternatives

can be only a matter of socio-institutional labelling, reflecting the distribution of power between professional lobbies.

It is worth explicitly specifying the epistemological assumption grounding the above considerations. We do not think that the development of clinical theory in terms of integration is only a matter of empirical validation. Needless to say, the empirical test of theories plays a major role in the development of the clinical field – not unlike what happens in other areas of the psychological and social sciences (Looren de Jong, 2010). Yet the empirical level works within every theoretical domain, favouring its development but however within the constraints defined by the basic assumption grounding the domain itself. Thus, one can empirically test a statement, or place two statements in competition, but in any case this is done in accordance with and within the assumptions defining the theoretical domain such statements (and the method of empirically testing) belong to. Therefore, theoretical integration is only marginally a matter of empirical testing. Rather it is a theoretical endeavour, aimed at defining a super-ordered conceptual framework according to which the single theories can be discussed and understood in more abstract terms, namely as local versions - instantiations - of more general statements (Salvatore & Valsiner, 2011). Incidentally, this is not an alternative strategy compared to the empirical one. Rather, as it increases the commensurability among theories, in the final analysis it enables the possibilities of empirical investigation to expand.

Dialogism as the grounds of a general clinical theory

Our basic thesis is that dialogical theory can be the grounds of the general clinical theory we are looking for. Seeing the clinical exchange in dialogical terms means looking at it as an engagement between subjects who are reciprocally Other-for-the-other. Psychotherapy, in this sense, comes to be seen as that specific form of human encounter where the practice of otherness is expressly aimed at changing the client's form of subjectivity (Salvatore, Gelo, Gennaro, Manzo & Al-Radaideh, 2010).

The special issue this paper introduces is designed to contribute to the development of the dialogical clinical theory as a general framework providing a common ground to the school models. The works it collects vary as concerns the aspects they address as well as the conceptual and methodological approaches they propose; yet they share the basic assumption of dialogism: the *constitutive nature of otherness for the self.* This assumption is what roots the dialogical view within the more general relational paradigm, which claims the intersubjective nature of the clinical exchange (Luborsky & Crits-Cristoph, 1990; Mitchel & Aron, 1999; Storolow, Atwood & Brandchaft, 1994) and more in general of the mind (Bruner, 2004; Harre & Gilet, 1994). At the same time, the assumption of its constitutiveness makes dialogism a specific and deeper interpretation of the relational paradigm. Indeed, compared to the other relational approaches, dialogism provides a vision of the subject which is not only

open to engagement with what is outside it, but which is the product of such an encounter.

The following pages of this work examine this vision in greater depth, in order to justify our intention of considering the specificity of dialogism - what grounds and marks the dialogical approach as a peculiar interpretation entailing the theoretical and methodological implications of the inherently relational nature of the mind.

We consider this a propaedeutical task for developing a dialogical clinical model. Indeed, within the relational paradigms the boundaries of the various models are not clearly defined: the differences among the approaches often remain in the background, compared to the similarities – namely the common criticism of the unipersonal approach of mainstream psychology. As a result, relational concepts appear to be quite polysemic: they lend themselves to be interpreted in different ways, according to a range of assumptions. The use of notions like "relation", "dialogue", "intersubjectivity", "negotiation" "co-construction" and so forth, therefore risks suffering from a kind of "Pentecost effect", namely a situation in which everyone speaks their own language, while thinking they are being understood by - and understand - interlocutors. To avoid such a risk it is therefore necessary to make it clear what conceptual context the relational terms are used in. By doing so, it becomes possible to develop the dialogical clinical framework and appreciate the contribution it can offer to the enhancement of theory, analysis and practice in the clinical field.

The specificity of dialogism: The tenet of constitutiveness

Broadly speaking, clinical relational thinking can be seen as a way of viewing the psychotherapy process as a dynamics produced not only by the subject(s), but also depending on what is beyond it (them) – namely, what is *other*.

The relational models, however, differ among them as regards the way this otherness is conceived, and consequently the role it plays in the clinical exchange. We propose to synthetically conceptualize such pluralism in terms of a basic dichotomy: functionality - constitutiveness. Accordingly, otherness can be conceived of as a *function* of the subject's way of working/development or as a *constitutive* dimension of subjectivity.

The other as a function

A set of relational interpretations of otherness shares the basic idea of the original autonomy of the subject. According to this idea, the other is a necessary condition and a device for the subject's development and more in general for its life, but not a constitutive element of it.

Henceforth we refer to two versions of this interpretation. Firstly, the idea of otherness as entailed in all those theories that regard the encounter with difference as

triggering the psychological functioning. Piaget's theory of cognitive decentering is emblematic of this line of thought. The subject finds in what is outside itself the constraints of its own way of functioning and thus is compelled to decenter and reorganize itself at a more developed level. The neo-Piagetian authors have further underlined the social nature of this process, highlighting how otherness is in any case an experience concerning the interpersonal world (Perret Clermont, 1993). The other, in this perspective, is the *perturbing limit* of the self. Another instance of this interpretation is Vygotsky's notion of Zone of Proximal Development (ZPD), which sees the role of otherness as the device triggering the subject's competence. In this case the other is not a dialectic counterpart of the subject, but a supportive scaffold of its functioning. And yet it remains an external resource that the subject encounters and with which it interacts simply because both exist before and independently of their encounter, as two separate and autonomous entities. In sum, the subject is made *by* the encounter with the other, but it is not made *of* this encounter – otherness is like the weights for the body-builder: a necessary devices for the sake of the subject's functioning and development, but not for that a constitutive part of it.

A further version of this approach is provided by those authors that use it as a way of interpreting the meaning-making process in terms of co-construction and negotiation of significance (Angus & Mc Leod 2004; Hoffman, 1998). The logic of this interpretation is no different from the previous one: the other is seen as the source of a semiotic (rather than functional/cognitive) conflict allowing the subject to move from a given position (as expressed by speech, narrative form, form of discourse or of action) to another, so as to reconstruct the desired (or however required) equilibrium of the interaction. In sum, also in this case the co-construction, the negotiation of meaning and positions, is a dynamics grounded on the subject's agency, rather than a process constituting such agency (even though, obviously, the product of that dynamics affects the form and quality of the agency).

The constitutiveness of the other

Conceiving otherness as an inherent constitutive dimension of subjectivity means that even the basic aspects of psychological life are sustained by and through the presence of the other. Which means that there is no subject prior to and independent of its relationship with the other – the subject is made up of such a relation. One can find different - more or less radical - versions of this conception.

One interpretation is provided by those theories that assume the subject's psychological states are inherently intentional, namely always and in any case concerning the experience of something. From this perspective, the other plays its constitutive role as the *reference* of the subject's experience: subjectivity is (the experience of) *what* the person relates with and *how*. The Dialogical Self Theory's idea of the mind as a society of selves (Hermans, & Hermans-Konopka, 2010, Hermans &

Dimaggio, 2004) provides a version of this interpretation: any position that articulates the multiplicity of the Self reflects a model of relationship with a specific form of otherness. Klein's Object Relation Theory is another example of this vision. According to that theory, the individual mind is the precipitate of the representations of the early experience of relationship (i.e. inner objects); the subject experiences the present reality by assimilating it to the movements of this archaic internalised relationship. Broadly speaking, one could say that according to this interpretation the subject is inherently relational because it is constituted of the desire *for* the other: the subject lives on and in terms of the other that is experienced.

An extension of this interpretation is provided by the vision of language and more in general of meaning-making as acts that are always shaped by their inherent addressivity (Bakthin, 1981; Linell, 2009). The subject feels, thinks and speaks *of* the experience of the other person and *in terms* of such experience, but also addresses such acts to the other – its psychological activity is directed at and shaped *by engagement with the other person*. This means that the other enters into defining the very way the subject addresses it - how and what the subject thinks, feels and speaks reflects how it anticipates the response of the other person to whom its are addressed (Rommetveit, 1992). In sum, this interpretation adds to the previous one the idea of the other person (the anticipation of its answer) as the feed-forward regulative device in the constitution of the subject.

A further interpretation of constitutiveness lies in the idea that psychological life is shaped by forms (categories, signs, tools, symbolic resources) that persons find in the social space. The theory of symbolic mediation (Vygotsky, 1986; Valsiner, 2007; Zittoun, 2009) is an instance of this way of looking at the constitutiveness of the other person. One can also refers to Lacan's notions of Symbolic order as the place of the other's signifier, inhabited by the subject (Muller, 1996). What these notions propose is the vision of the social world as shaping the subjectivity in its constitutive elements – the way of thinking and feeling, the very structure of the subjectivity and its dynamics is sustained, regulated and nourished by the discourse of the other (culture, symbolic resources). From the standpoint of this interpretation, the subject constitutes itself *through* the (signs of the) other. This can be seen as a more radical interpretation of constitutiveness, because otherness is regarded not only as the reference and the measure of the subject, but as its very sustain, what provides the stuff of which the subject is made.

Finally, one can distinguish a further, pragmatic variant of the latter interpretation, considering those semiotic theories that focus on how the other contributes actively to building the subject's experience. According to this view, any subject's condition is not a self-contained state, but it is the precipitate of the combination of the subject's act and the other's response. In this sense, subjectivity is constituted of the other's *answer*. This vision is expressed by Peirce's triadic semiotic

model. According to this author, meaning is not contained in the sign; rather, it is the interpretant (another sign) in terms of which somebody interprets the sign. Thus, the meaning is not in what the subject says, acts and feels, but in how all this *is interpreted by somebody* – the meaning has a backward dynamics – it is what follows in the gaze of the other (Salvatore, in press). An interpretation of this kind leads definitively to decoupling subject and individual - the subject is extended and concerns not the individual, but the constitutive work of otherness on it. The subject is inherently an *intersubject*.

Some implications

We propose to consider only the former type of theory (i.e. the ones grounding the tenet of the constitutiveness of the otherness) dialogical as distinguished from the latter (i.e. the other as a function), which we propose to consider *interactional* (Grossen, 2009). Not taking this into account can lead to misunderstandings, both at a theoretical and clinical level.

From a theoretical point of view, the difference between the two approaches can be expressed through the model of causality (Emmeche, Koppe, Stjernfelt, 2000) in terms of which the role of otherness is interpreted. In the case of the dialogical interpretation of the relational nature of subjectivity, otherness is conceived of in terms of *material causality* – namely in terms of the immanent properties of the explanandum's elements (i.e. causality as defined by expression as in: the subject is made of the experience of the other), and/or *formal causality* – namely, in terms of the explanandum's structure and/or modality of functioning (i.e. see the backward mechanism of meaning mentioned above). The other entailed in the interactional theories is instead conceived of in terms of *final causality* – namely as referring to the function played by the explanandum (i.e. the other as performing the function of decentering, of scaffolding).

These different logics of causality have important implications at the methodological level. The relational analysis of the subject is not the same if one takes an interactional standpoint or a dialogical one (Salvatore et al., 2010) – and if one adopts a more or less radical version of dialogicality. Choices like the unit of analysis, the temporal window of observation, the role played by the subject's point of view, the aim itself of the analysis, to refer to just a few points, vary dramatically in terms of the way of looking at otherness. And this is clearly shown by the papers collected in this special issue, whose methodological pluralism reflects the different ways of interpreting the dialogical view. We will come back on this point below.

Finally, it is also evident that the different interpretations mentioned above are reflected in the clinical approach to psychotherapy. According to our view, a major issue of the theory of clinical technique strictly associated with the dialog-interaction distinction (in the sense used here) concerns the way of looking at the connection

between *technical* (i.e. broadly speaking the set of values, operative criteria and objectives sustaining the activity of the clinician) and *relational* dimensions of the setting (i.e. the dynamic field determined by the encounter of therapist and patient within which the subjectivity of both participants is embedded). Technique concerns the therapist's agency, the sphere of her capability of directing her own subjectivity (i.e. her thought, feelings, attitudes, choices) in a strategic way, namely for a purpose (for a discussion on the aim of psychotherapy, though limited to the psychodynamic field, see Sandler & Dreher, 1996). Therefore, if the clinician adopts an interactional approach, and thus maintains at least a relative autonomy for the subject in engaging with the other, then she can consider the technique quite an autonomous domain at least. Consequently, she will be allowed to consider the relational field of the clinical exchange as a separate dimension, interacting and affecting the exercise of the technique, but not constituting it. In other words, take the patient that produces an act (A) (e.g. she tells the therapist about an unpleasant event that happened the day before). Imagine now that in accordance with the therapist's clinical model (CM), the act A has to be addressed in terms of a given clinical procedure (P) (e.g. in terms of the analysis of dialogical positioning). Well, insofar as the clinical model CM is sufficiently autonomous from the situated relational condition in which it is applied, this means that the procedure P is considered and validated as deriving from the clinical model CM, namely as a *technical choice*, only marginally influenced (if at all) by the relational condition in which it is carried out. Now, this is not so if the clinician assumes the dialogical standpoint. As has already been said, such an assumption depicts the subject as constituted by otherness – which means that the subject is not an autonomous, separate entity prior to the relationship in which it is embedded. And this leads to conclude as well that the technical domain is not autonomous from the relationship. Therefore, any clinician's intervention, regardless of its level of technical consistency and quality, is always and in any case a relational phenomenon, the reflection of the participation of the clinician in the relational field, and therefore, in the final analysis, the reflection of the capacity of the patient's otherness in constituting the therapist's subjectivity. Think again of the patient producing the act A and getting the answer P from the therapist. Well, the dialogical standpoint leads to recognizing that in its turn the procedure P is the reflection of the constitutive impact of the act A on the relation (R) between patient and therapist and therefore, in the final analysis, on the subjectivity of the therapist. Thus, if in the case of the interactional standpoint, the procedure P is a function of the clinical CM – P=f(CM) - in the case of the dialogical standpoint one is compelled to recognize that the procedure P is a function of the clinical CM but also of the relational field R – A=f(CM,R). In more concrete terms, from the dialogical standpoint the state of the therapist's subjectivity that leads her to act in one way or another - say, to explicitly specify the position characterizing the narration of the patient or to interpret it as the emergence of novelty, and so forth - is in any case always what has been construed by the intersubjective dynamics of the therapist-patient exchange.

This special issue

This special issue collects contributions highlighting a multiplicity of facets of the constitutive nature of otherness in the clinical field. It brings together proposals concerning both clinical and methodological issues. Moreover, it complements them with commentaries so as to endow the text with an initial level of dialogical discussion.

The first section focuses on clinical topics. Grounded in Dialogical Self Theory (DST), Salvatore, Carcione, Dimaggio (2012) propose a relational interpretation of Narcissistic Personality Disorder highlighting the centrality of the self-object linkage as constitutive of this psychopathological condition. Their analysis is particularly interesting because they provide a dialogical interpretation of a clinical condition that is generally seen as the marker of the auto-referentiality of the Self. Van Doorn and van Nijnatten (2012) discuss a development of a dialogical clinical strategy (the Self Confrontation Method; Hermans & Hermans-Jansen, 1995) for the intervention with pre-school children (Van Doorn & Louwe, 2005, 2006), aimed at adapting it to patients with severe emotional and behavioural problems. This kind of child presents developmental constraints, in particular in terms of "not fully developed capacities to reflect on an organized repertoire of I-positions of the self" (p. 77). This led the authors to a shift in the clinical strategy, making the goal of the intervention the improvement of the children's capacity to recognise and differentiate positions sustaining their sense of self. And it is clear that the dialogical standpoint is the most suitable framework for addressing a theoretical-clinical task of this kind; indeed, the very idea that the therapist works to promote a child's very basic competence – i.e. the differentiation and recognition of inner states – entails conceiving of the therapist-patient relationship as a constitutive dimension of the self – something that enables the basic developmental steps of the self, rather than something that follows such development.

In their commentary on these two papers Freda and De Luca Picione (2012) provide a reading of the notion of I-position from a psychodynamic standpoint, highlighting its relational, pragmatic and affective nature. In so doing, they show that the dialogical framework can operate as a common ground for the clinical school models enabling them to interact in the perspective of a general integrative model of the psychotherapy process – and more in general of sensemaking.

The second section addresses methodological topics concerning the analysis of the clinical exchange in dialogical terms. Avdi (2012) proposes to integrate the Dialogical Self Theory with the socio-constructivist notion of subjective positioning, as an analytic tool for the study of the psychotherapy process in dialogical terms. Gonçalves and Ribeiro (2012) focus on the process of change, which they analyze in terms of the Innovative Moment model (Gonçalves, Ribeiro, Matos, Santos & Mendes, 2010). They show that clinical change, an event which is obviously observed at the individual level (i.e. at the level of the patient's narrative), must in any case be

conceptualized as the product of a dialogical dynamics of meta-positioning. Dialogical Sequence Analysis (DSA, Leiman, 2012) is instead directly focused on the dialogical dynamics sustaining the clinical exchange. DSA is based on Bakhtin's teaching, integrated within a joint cognitive and psychodynamic framework, and it is designed to model the linkage between the inner psychological processes and the interpersonal discursive dynamics, in terms of sequence of patterns of positioning and counter-positioning. Also the Dialogical Discursive Analysis (DDA) proposed by Martínez, Tomicic and Medina (2012) is a method concerning the micro-dynamics of the therapeutic dialogue. DDA integrates a level of analysis focusing on the interpersonal regulation of patient-therapist communication - performed in terms of conversational analysis - and a level focusing on the intrapersonal sphere, addressed in terms of the discursive markers of the subject's positioning articulating the semantic and pragmatic dimensions of the text.

Four commentaries enrich the section with several cues that open innovative perspectives of development of the dialogical clinical standpoint. Auletta (2012) highlights how both intrapsychic and intersubjective dimensions should be considered as equally meaningful in analyzing the process of psychotherapy from a dialogical perspective. Moreover, he underlines the necessity that psychotherapy process research develops strategies of analysis being able to grasp the processual dimension of the dialogical dynamics. Georgaca (2012) shows that the dialogical approach needs to be integrated with a semiotic view of the therapist-patient relationship – namely, the clinical exchange as sensemaking - and needs to take into account both the micro-dynamics of the interpersonal regulation of communication and the socio-cultural context within which such regulation is performed. Lepper (2012) underlines the fact that the dialogical approach requires both intrapersonal and inter-personal levels of analysis to be jointly taken into account; moreover, she believes that students of clinical dialogue have to take into account the valence of actions of any communication event. In this perspective, pragmatics represents a theoretical and methodological tradition that lends itself to integration within the dialogical standpoint. Finally, Traversa (2012) maintains the necessity of developing the dialogical notion of the self by considering the embodied dimension of the I-Other encounter - "the carnal Self", to use the term adopted by the author.

In sum, taken as a whole, the papers collected in the special issue witness how the dialogical clinical theory is a field in rapid development, open to innovative topics (e.g. theory of psychopathology, technical modifications due to new kinds of client), addressed through innovative methodological strategies (e.g. sequence analysis, conversational analysis, analysis of discourse) enabling a plurality of levels of analysis to be encompassed (interpersonal and intrapersonal, pragmatics and semantics, micro-dynamics and socio-cultural domain) as well as clinical schools (humanistic, cognitive, psychodynamics).

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