Running Head: DIALOGIC COGNITIVE THERAPY?

Considering the dialogic potentials of cognitive therapy

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Abstract

We have been encouraged by continued developments within cognitive behavioural therapy (CBT) and offer 'our' dialogic and discursive (i.e., social constructionist) ideas as resources for where CBT might yet develop. We show how these ideas might further critical examination of CBT should it be narrowly practised in monologic or ideological ways that obscure client preferences and resourcefulness. We also turn a discourse analytic lens on therapeutic dialogue itself to consider ways CBT could be practised in ways that are collaborative and generative. For us, CBT takes place in dialogues that discursive insights can help to optimize.

The possibility of dialogue has not been ended by those who plan continually for monologue to be followed by cheers of acceptance. (p.109, Michael Billig, 1996)

Cognitive therapy, along with so many other recent cultural developments, has been a site of diversity and hybridity. More a family of theoretically affiliated approaches to therapy than a singular method (e.g., Dobson, 2001), what has been hybrid about cognitive behavioural therapy (CBT) is its evolving inclusion of new theoretical and clinical ideas, such as Ellis' (1993) integration of constructivist ideas. We consider CBT a dialogic practise where language use in clinical conversation is its focal activity, and we bring a discourse analysis and social constructionist view to CBT. We share our concerns for non-dialogic variants of practise, and in particular for technologizing CBT into a cultural prescription, and will examine conversational practices that show some of CBT's therapeutic aims being met.

We write from a preference for a collaboratively practiced CBT that conversationally mobilizes the expertise and resourcefulness of both clients and therapists. For us, therapy is a dialogue occurring at the nexus of many dialogues in which clients and therapists are already engaged. This extends to how we regard "cognition" since we see it as inseparable from these dialogues (Billig, 1996). Consistent with these different dialogues in which we find ourselves are different ways of understanding and orienting to experience, and to each other. CBT is one such dialogue, one in which client and therapist could refract meanings and other ways of talking in which they are also engaged and could beneficially talk from.

Given our preference for dialogue we are concerned about where CBT has been and could be taken. CBT, practised monologically, could be seen as an ideological instrument for holding others to particular understandings of reality or particular ways of engaging with it (c.f., Bakhtin, 1984; Eagleton, 1991). Variations on this theme come up when practise is reduced to scripts for therapists and clients, or to cultural prescriptions for self-conduct (Layard, 2005). It also comes up in ways CBT might be used

with clients: "administered", "implemented" – as if therapy was about doing something to a merely receptive client. Closer to our dialogic views are practices within the CBT literature that speak to actively engaging clients in *co*-developing preferred and viable ways of understanding and acting.

We will say more about how we position ourselves within CBT's therapeutic approaches in ways we think are useful for the continued development and hybridization of CBT. We elaborate on what we mean by "dialogical" practise, relating this to the meaning-making of both clients and therapists, particularly in how they make sense of and respond to each other in clinical interviews. Seeing cognition, discourse and dialogue as related, we share how relationships between them can generatively inform the practise of CBT. In the other direction, we further articulate our concerns and objections with reducing the practise of CBT to narrow cultural and therapeutic prescriptions. We aim to add to CBT's discussions with our focus on resourceful and collaborative dialogues with clients.
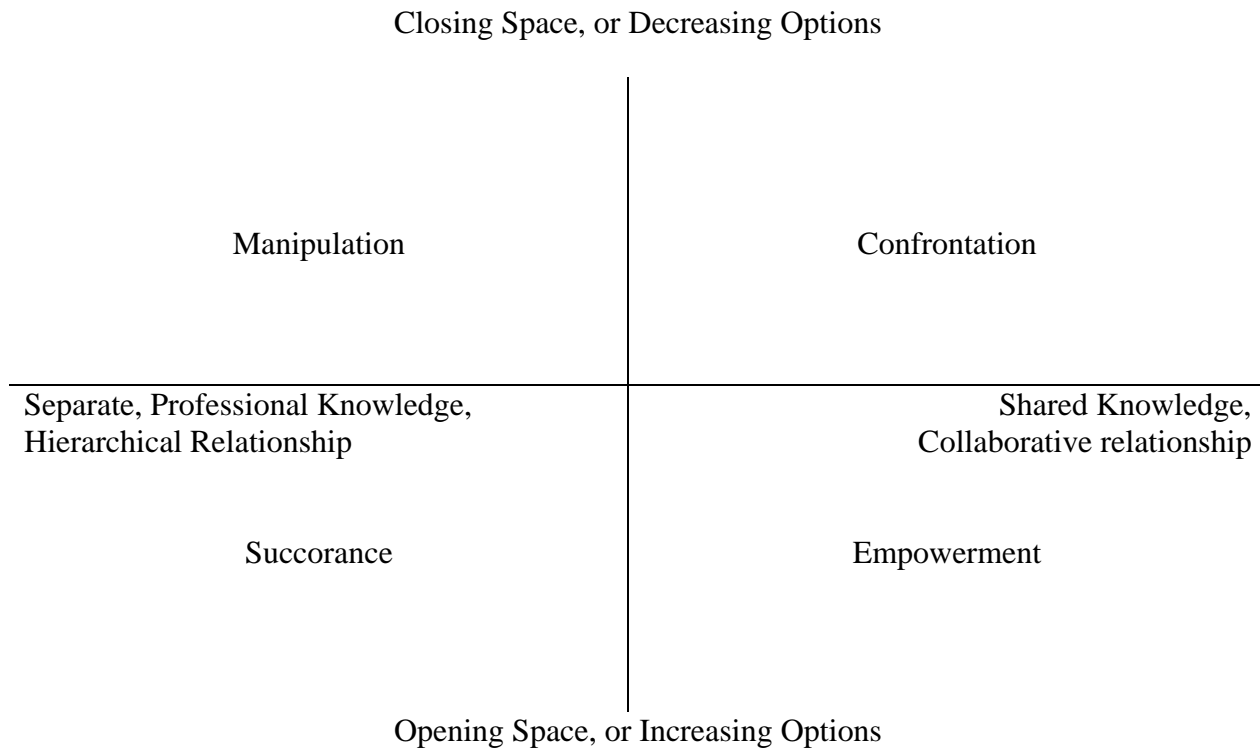
Positioning ourselves and CBT

We can't use our minds at full capacity unless we have some idea of how much what we

think we're thinking is really thought, and how much is familiar words running along

their own familiar tracks. Nearly everyone does enough talking, at least, to become fairly

fluent in his own language, and at that point there's always the danger of automatic

fluency, turning on a tap and letting a lot of platitudinous bumble emerge. The best check

on this so far discovered is some knowledge of other languages, where at least the

bumble has to fit into a different set of grammatical grooves. (p. 50, Northrop Frye, 1962)

Our position with respect to CBT is that it involves particular kinds of conversations, the kinds that develop 'their own familiar tracks' as Frye suggests above. So, we will link our intentions to some possibly unfamiliar tracks for readers and relate these to the conversations we aim to have with clients. Each of us has been fortunate to work with the renowned family therapist, Karl Tomm. Tomm (as cited

in Godard, 2006) has conceptualized such conversations in terms of the intentions held by therapists as

they work with clients, interactions he classifies in four ethical quadrants as seen below in Figure 1.

Figure 1. Karl Tomm's grid of ethical postures as delineated by two continua (axes).

Closing Space, or Decreasing Options

Manipulation	Confrontation
Separate, Professional Knowledge, Hierarchical Relationship	Shared Knowledge, Collaborative relationship
Succorance	Empowerment

Opening Space, or Increasing Options

The figure above is delineated by two continua. The vertical axis refers to the degree to

which therapists promote options of practise that restrict or increase client options on the matter

of clinical interest. This extends to how therapists might hold clients to their particular

therapeutic initiatives or conceptualizations or, conversely, "open space for" client initiatives and

conceptualizations. The horizontal access reflects the degree to which therapists make their

knowledge shared, transparent and contestable; and the degree to which decisions about

therapy's goals, procedures and interventions are shared or expertly prescribed by the therapist.

Tomm's quadrants thus make explicit choices therapists can make in how they 'position'

themselves with clients in terms of their use of professional knowledge within therapeutic

conversations. We locate our approach to CBT primarily in the lower "Empowerment" quadrant

and see our expertise as focused on collaboratively eliciting and mobilizing clients' expertise in addressing their presenting concerns (Anderson, 1997; Strong, 2002). We focus our expertise on hosting generative therapeutic conversations where decisions about the interview's conduct and progress are made transparently and mutually.

CBT practised from this 'position' requires improvising skill by responsive therapists who open themselves and the therapeutic process to client direction. In our dialogic and constructionist view of CBT, the interview is a construction (or deconstruction) zone collaboratively constructed and maintained (Strong, 2004). CBT's primary focus, the meanings and ways of thinking clients bring to therapy find their inadequacies or fit in this construction zone. For us, however, thinking and meaning are linked to language as the primary means by which people not only represent their experiences, but influence them as well. We borrow from Wittgenstein (1958) for whom the aptness of language was a paramount concern, and from narrative therapists for whom there can be 'better' discourses or stories for experience (Freedman & Combs, 1996; White & Epston, 1990). CBT, as we envision it, is a collaborative and critically informed search – not for better thinking – but for more viable language (in clients' eyes) to articulate ways forward where clients have been experiencing concerns.

Thought as dialogue and discourse

We agree with writers who see thoughts as extensions of dialogue (Beck, 1978; Edwards, 1996; Maranhão, 1986) and find it odd that thoughts could be seen as being apart from dialogue when they are discussed as a part *of* dialogue. We agree with writers such as Vygotsky (1978) that any "intra"-mental representation or activity begins "inter"-mentally – between people. Cognition in this sense is a representational activity sustained in dialogue. But, there is another dimension brought out by writers such as Michael Billig (1996, 1999) for whom this activity

remains rhetorical, not merely representational. By this we refer to how thoughts are partly developed in anticipation of how they might be received in the interactions where they might be put to use. Billig (1999) used the example of repression to illustrate how a repressive style of talking or interacting parallels the internal dynamics (i.e., way of thinking) associated with that style of talking. This is a significant shift away from locating maladaptive thinking in particular constructs or evaluations made by the individual. Rhetorically, the same style of participating in dialogue that preceded a particular thought or way of thinking could sustain it in later dialogues. For us, therefore, how conversations occur are as important, if not more important, for therapeutic dialogue than what gets discussed in such dialogues.

What therapy can offer is a dialogue outside the hurly-burly of habitual, everyday conversation – a break from the kinds of conversations where others hold us to particular accounts and ways of interacting (Shotter, 1993). Therapists can offer proxy dialogues for those where therapy's outcomes can hopefully be talked into being, while exploring possibilities seemingly unavailable to clients in their everyday conversing. Practised this way, therapy hinges on a question: how can we have a dialogue different from the ones you have been having with yourself and others, on the matter which brought you to therapy? A therapeutic conversation that occurs in new ways, ways different from one's prior internal and external dialogues, affords possibilities for new mental connections (Wittgenstein, 1958), and new ways of thinking at the same time. Therapy can help clients overcome their stalled projects in dialogue, where lines of talk or inquiry lack a satisfactory resolution until helpful dialogue facilitates this occurring. Not surprisingly, internal dialogue can sometimes be seen as unspeakable dilemmas (Griffith & Griffith, 1994), unspeakable for how what gets said is expected to be received by others. Our

CBT reverses Vygotsky's inter- to intra-mental trajectory, by eliciting the not-yet-said aloud, or by welcoming efforts to talk beyond prior dialogic impasses that got similarly stuck internally.

We are of course not alone in seeing cognition as inner dialogue. However, such inner dialogues are often portrayed as eccentric projects hived off from real world interaction. That doesn't square with our sense of dialogue, or how individuals create and convey understandings via the discourses accessible to them. Emotional life thus finds its meanings and performances in particular discourses, "language games" (Wittgenstein, 1958) or in what Harré, (1986) termed "emotionologies". The notion that a construct or schema could be extricated, collaboratively evaluated or re-construed, to 'therapeutically' be placed back in unchanged patterns or dialogues in clients' lives comes up short for us. Thoughts are contextually linked to the inner and outer dialogues where they find their currency. Thus, therapy is a dialogue to transform such contexts.

Moving from Monologic to Dialogic Interaction in CBT

There is little doubt that CBT's attention to inner "talk" and careful use of questions assists clients to construct useful knowledges and actions for making differences in their lives. How this talking occurs merits consideration. Meichenbaum (1996) distinguishes "rationalist" and "constructive" perspectives taken up within CBT (Ellis, 1993; Wessler, 1992). Bruner (1990) highlights these differences by contrasting computational knowledges and narrative knowledges. Therapy focused on thought as rationally computed positions both client and therapist differently from therapy focused on client story-making. Sampson's (1981) concerns relate to the former stance: cognitive psychology has tended toward subjectivism in granting "primacy to the structures and processes of the knowing subject" (p.730) and individualism for centering on the individual knower apart from relationship. Such a view of cognition breaks it into discrete components and mechanisms located *in* individuals. Instead, Sampson (1993)

highlighted a relational and social character to human knowing that arises in and from

interactions between persons in social and cultural contexts, culminating in an emergence of

individuals' unique perspectives or "*voices*" (Bruner, 1990, p. 77).

Monologue and Dialogue

Bakhtin's (1984, 1986; Lysack, 2002) distinction between monologue and dialogue has

helped us distinguish differences between *hierarchical* and *collaborative* forms of therapeutic

interaction. Bakhtin (1984) outlined the main characteristics of a monologic orientation:

Monologue manages without the other, and therefore to some degree materializes all reality

…[and] pretends to be the ultimate word. (pp. 293-294) However, in relationships oriented by

dialogue, human consciousness, life and relationships combine to construct a shared dialogic

space: "The single adequate form for *verbally expressing* authentic human life is the *open-ended*

dialogue. Life by its very nature is dialogic. To live means to participate in dialogue" (p. 293;

emphasis in original). Bakhtin's (1984) distinction between monologue and dialogue relates to

an accompanying ethics. It is "one thing to be in relation to a dead thing, to voiceless material

that can be molded and formed as one wishes, and another thing to be active *in relation to*

someone else's living, autonomous consciousness" (p. 285; emphasis in original). Consistent

with a view that knowledge is relational and transactional, he also wrote, "Truth is not born nor

is it to be found inside the head of an individual person, it is born *between people* collectively

searching for truth, in the process of their dialogic interaction" (p. 110; emphasis in original). For

Bakhtin, dialogue is where and how a person is "constructed."

Dialogic Relationship and Emergence of Voice

A dialogical perspective also entails an awareness of the co-presence of voices within

language and conversation. This occurs between people and within the inner speech of one's

consciousness which points to other voices, and to other consciousnesses. For Bakhtin these voices are not content simply to co-exist alongside of one another, but gravitate to an intense interanimation with one another in what he calls a "microdialogue" where "They hear each other constantly, call back and forth to each other, and are reflected in one another" (p. 75).

Like others (Hermans, H., Kempen, H., & van Loon, R., 1992; Hermans, H., & Kempen, H., 1993; Pare & Lysack, 2004), Penn and Frankfurt (1994) explored therapeutic possibilities of clients shifting from monologue to dialogue in their inner conversations:

> Frequently, clients…tell their first stories as though they were monologues: single-voiced, absolute and closed.… Unlike the monologue, dialogical conversation is many-voiced. It listens to others and is open, inviting, relative, and endless because it is future-oriented. It awaits an answer (p. 223).

We have also found that clients can be dominated by negative inner "voices", initially experiencing these voices to the exclusion of others. Penn and Frankfurt suggest that in struggling with problems we construct,

> an internal monologue that is often experienced as a negative, self-accusing voice: 'You're hopeless, you've failed, you're incompetent, unlovable,' and so on. However, given the ability to reply to ourselves, we can create a balance of power, so to speak, through the discovery or invention of our other voices – more positive, confident, even ecstatic voices – that can converse with our negative monologue (p. 218).

Similarly, Meichenbaum (1996) found that clients suffering PTSD from the effects of abuse described themselves as "spoiled goods", "damaged property" or "useless." He suggests a client "may inadvertently reproduce the 'voice' of the perpetrator, as in the case of victims of domestic

violence. She needs to develop her own voice" (p. 135). For Penn and Frankfurt (1994), this is where a beneficial plurality of voices can come into contact and engage with each other interactively, in what might be called a "dialogic space" (p. 222).

Such ideas inform our participation in therapy as a dialogic interaction which can generate multiple perspectives while expanding on existing meanings with other possible meanings through responsive dialogue between client and therapist (Lysack, 2005; Pare and Lysack, 2004, Strong, 2003). Therapy can enact a polyphony of voices that Bakhtin saw as crucial to a dialogic orientation. We share Meichenbaum's (1996) view when he suggested that therapists working with clients, "…should not do the thinking for them, nor put words in their mouths" (p. 140).

Cognitive Modification as Dialogical Accomplishment

One of the significant contributions of CBT has been its focus on 'commonsense psychology' or on people's attempts to define their problems in their own terms (Beck, 1976; Ellis, 1962; Meichenbaum, 1977). Proponents of behaviorist or bio-psychiatric approaches too often dismissed as irrelevant the value of exploring clients' judgments and understandings of their problems. CBT practitioners made people's routine meaning-making a primary target of investigation and intervention. But, many CBT practitioners adopt a correspondence theory of truth and evaluate clients' appraisals of events and experiences by comparing them to their purportedly, objectively known reality (Lyddon, 1995). Such therapists assessed and challenged "incorrect meanings" implicit in clients' reports (Beck, 1976, p. 95).

In contrast to an 'objectivist' approach, social constructionists (Berger & Luckmann, 1967; Gergen, 1999) focus on meaning as it arises in social interaction. Similarly, discursive psychologists (Edwards, 1994, 1995; Edwards & Potter, 1992) regard meanings as accounts

introduced by clients in accomplishing situated interactional work (e.g., such as a question being answered). Discursive psychologists argue that such meanings or accounts evolve over time and change according to the contexts in which they are occasioned. Different therapists or even the same therapist on a different occasion is likely to elicit (or co-articulate) a different accounts of the client's problem or experience.[1] Hence, discursive and constructionist psychologists maintain that clients' thoughts, attitudes, memories, or even identities are not private events but are communicative accomplishments (Edwards & Potter, 1992; Gergen, 1999). What matters is how participants (therapists and clients) produce their descriptions. The *function* of a client's evaluative or experiential report in interacting with a therapist, as well as the *context* of its production, shapes the precise nature of the report.

Constructionist and critical movements in psychology focus on how socio-cultural, familial, and (inter)personal circumstances occasion particular meanings (cognitions) and how prior meaning shapes such circumstances (Gergen, 1999; Prilleltensky & Nelson, 2002). Some CBT writers also warn against considering cognition, affect, and behavior apart from contexts that shape and sustain them (Alexander, Jameson, Newell, Gunderson, 1996; Baucom, Epstein, Raskin, & Burnett, 1996; Linehan, 1993; Neimeyer & Cabanillas, 2004; Safran & Segal, 1990). Critically-oriented CBT practitioners attend to factors that shape (or constrain) how clients come to cognize themselves and their life situations, aiming to minimize power differentials in the therapeutic relationship (Doherty, 1995; Dunst, Trivette, & Deal, 1988; McWhirter, 1994; Safran & Muran, 2000). Instead they promote a dialogic context where clients' problematic meanings and experiences are welcomed then collaboratively formulated, evaluated, and modified.

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[1] For example, rearchers who study discourse of couples therapy demonstrate how systemic therapists deploy specific linguistic devices to transform couples' 'individualist' accounts of their predicaments (he is too distant; she is too critical) into systemic or relational terms (Buttny, 1996; Edwards, 1994).

Consistent with some approaches to CBT (e.g., Meichenbaum, 1977), constructionists propose that peoples' cognition is derived, created and maintained in and through interpersonal processes across the lifespan. A common assumption among CBT practitioners is that clients' experiences and appraisals of them are private and relatively stable. Social constructionists 'externalize' clients' "internal communication system" (Beck, 1976, p. 26), maintaining that clients' rationality is not internally 'pre-packaged'. Instead, the reality clients utter has many discursive articulations for understanding and describing that reality, some being formulated and unpacked in the back-and-forth of clients' communication with others, including therapists.

Viewing clients' voiced cognitions as emergent in and through interactions of therapist and the client challenges traditional conceptions of the therapist as a neutral and objective elicitor and describer of intrapsychic reality. From our perspective, therapists co-articulate clients' cognitive material and neither can objectively "discover" that material (Guidano & Liotti, 1983; Lyddon, 1995; Mahoney, 1988; Safran & Segal, 1990). While clients are conceived as active and purposeful interpreters of events and circumstances, their constructions of reality will overlap in some ways and differ in others from those of the therapist (Neimeyer, 1993). Collaborative and dialogically-oriented CB therapists are often pragmatists who recognize that the value and utility of the client's cognitions are established and evaluated conjointly by the client and therapist as they talk (Neimeyer, 2002). They propose to view cognitive-behavioral intervention as a relational act (Safran & Muran, 2000; Safran & Segal, 1990) of meaning construction and negotiation. They join clients in their unique ways of construing their lives and experiences and expand collaboratively on those ways by encouraging clients step into, or 'try on,' alternative meanings and experiential descriptions (Strong, 2000).

CBT as ideology?

Human beings have largely conquered nature, but they have to still conquer themselves.

(Richard Layard, 2006, p. 9)

It may seem a heavy-handed criticism but some see therapists as being ideological in how their notions and ways of practice can become complicit with dominant cultural aims and norms (Foucault, 1990, Rose, 1990). Typically one associates therapy with expanding one's possibilities for freedom and happiness, not hitching these to some restrictive practise of ideas. Feminists (Brown, 1994; Miller, 1976) and "radical" psychiatrists (Laing, 1967; Szasz, 1970) have long taken issue with therapy 'helping' clients adjust to unjust realities. Linking such realities to practised ideologies however is a move that makes some uncomfortable and others suggesting activism (Gergen, 2000). Quite a literature has developed examining therapists' power vis-à-vis that of the client (e.g., Proctor, 2002), particularly in how therapy's dialogues often tilt asymmetrically toward therapist control of the interview and its content (e.g., Antaki, 2001; Davis, 1984). But, the reality-ideology critique, extended to the practise of therapy, has some important implications for the practise of CBT.

In his popular book, "Happiness", Richard Layard (2006), an economist, invites readers to find their happiness internally. He also argues that depression is of greater concern than poverty (p. 181) and that CBT holds potential to enhance inner control for overcoming moodiness and attaining happiness. Two streams of critique converge for us here (Foucault, 1990; House, 2003; Newman & Holzman, 1997) because therapy can – intentionally or inadvertently - become a quintessential activity in upholding particular moral and cultural orders. CBT's 'realist' approaches can position therapists as expert "arbiters of correct subjectivity" (Rose, 1990) as if there were correct ways of understanding reality or conducting oneself in it. Our other concern is with turning inward when addressing what is outward and unjust might be a

client preference. At worst, therapists can ignore the external realities of clients' lives, 'helping' them instead *internally* cope with their thoughts and feelings.

Within the CBT spectrum of approaches we recognize a range of approaches and opinions on the kinds of concerns we have been raising. Within constructivist CBT circles one finds construals of reality important, with no focus on correctly articulating reality (as if this could be adjudicated by a knowing therapist). So, the dialogical empiricism we see in Beck's practise of Socratic questioning (DeRubeis, Tang & Beck, 2002) can fit here as a means to contest problematic linguistic constructions while searching for *viable* and fitting constructions of reality (Parker, 1998). Realists would see things differently, inviting clients to dispute distortions or maladaptive beliefs, so who decides what is (or whether one has) a distortion or maladaptive belief is therefore of no small concern to us. Within more behaviourally focused CBT approaches one finds problem-solving and skill-developing approaches to addressing client-defined realities (e.g., Goldfried, 1995). The client-centered challenge is in tailor-making skills and problem-solving strategies to address client circumstance.

CBT practices of "self-management", however, are where our Foucaultian concerns and Layard's cultural prescription for happiness collide. Foucault (1994) partly focused his later career on "biopower" and "technologies of the self". These notions refer to living "correctly" or "appropriately", denoting how correctness or appropriateness have specific personal requirements in differing historico-cultural contexts. These are moral requirements as much as they are prescriptions for proper living. Once embedded in psychological discourse they take on a prescribed and presumed scientific correctness (Cushman, 1995; Danziger, 1997), not unlike the moral correctness one associates with religious practices of confession followed by spiritual direction (Foucault, 1990). CBT's practices of "self-management" (e.g., Rokke & Rehm, 2001)

focus on "self-instruction", "self-monitoring, and "self-control". The problem here is with the

word "self". From Foucault's perspective, extended to considering CBT "self-management

practices", this involves taking on CBT in apprenticing oneself to its practices of "self-

subjectification", and policing or disciplining oneself accordingly. Said another way, this is how

one learns to be a person on CBT's terms. Ideology can creep into CBT in insidious ways, even

though the intentions behind Layard's prescriptions of CBT are obviously meant to be helpful.

The practices and philosophy of certain approaches to CBT, applied as a personal technology for

self-conduct, can be seen as a kind of ideology. Where things can get problematically ideological

is when, in a sense, clients are instructed to disattend to certain features of their realities that

can't be remedied with thought modification (e.g., poverty) or in forms of "self-monitoring" and

"self-control" that preclude other avenues to happiness and contentment.

<div align="center">Coda</div>

For words only have meaning in the stream of life.

<div align="right">Wittgenstein, 1988, aphorism 687</div>

Our aim here has been to share our dialogic and discursive views on CBT since it has

become a dominant and pluralistic presence. We identify with some aspects of CBT's pluralism

more strongly than others and admire its creative hybridity in incorporating research and

theoretical developments. Particularly dear to us have been the growing efforts to collaborate

with clients in aspects of practise formerly deemed the therapists' prerogatives. In this regard, we

have shared our ideas and concerns from social constructionist theory, dialogue theory, and

discursive research, to further discussion on potential new hybrids of CBT. For us, it is

fundamentally important to locate the practise of CBT as a dialogic practice, as an activity that

takes place in "streams" of respectful and generative dialogues. We extend this to our thinking

about our part in dialogues that might further the practise of CBT in ways we have described.

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