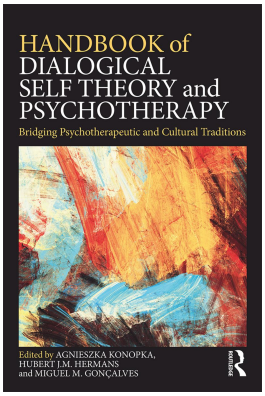

Handbook of Dialogical Self Theory and Psychotherapy
Bridging Psychotherapeutic and Cultural Traditions

Agnieszka Konopka, Hubert J. M. Hermans, Miguel M. Gonçalves

From dissociation to dialogical reorganization of subjectivity in psychotherapy

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Claudio Martínez, Alemka Tomicic
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12 From dissociation to dialogical reorganization of subjectivity in psychotherapy

Claudio Martínez and Alemka Tomicic

Contemporary psychoanalysis, and its emphasis on the relational and intersubjective field, shares with the dialogical approach the notions of a decentered self and a view of the mind as a set of discrete states of consciousness. From the perspective of relational and intersubjective psychoanalysis, the human mind is regarded as a non-unitary configuration; that is, as the conjunction of discontinuous states of consciousness that follow a nonlinear course. These states reach a level of coherence that surpasses this discontinuity and leads to the experiencing of a cohesive feeling of personal identity and oneness: the healthy illusion of being "oneself" (Bromberg, 1998, 2011). From another perspective – the dialogical approach – and taking into account Bakhtin's theory and his polyphonic metaphor, Hermans (1996, 2003, 2004) conceptualized the self as "a dynamic multiplicity of relatively autonomous *I*-positions in an imaginal landscape" (Hermans, 1996, p. 33). This multiplicity of positions constitutes the identity of a person, which not only emerges from the dialogue with another person but also from the dialogue with other positions of his or her own inner world. For its part, this multiplicity of the self is not only embodied in a social and cultural structure: it also has a neurobiological representation. For instance, LeDoux (2002) proposes a connection between the multiplicity of the self and brain processes, observing that each component of the self correlates with the activation of specific brain systems, which are not always synchronized. This represents a major difference between the idea of the self as an emergent unit or state and the view of the self as a non-unitary process. With respect to the latter point, we know that not all aspects of the self manifest themselves simultaneously, and that these multiple aspects may even be contradictory.

In turn, these self-states, namely subjective positions or *I*-positions (Hermans, 2014), may be thought of as expressions of relational patterns developed during early attachment and subsequently modeled by new significant relationships within a given social and cultural context. As a result of the quality of past interactive experiences, these self-states will remain disconnected – dissociated – or will become dialogically connected.

Pathological dissociation, trauma, and psychotherapy

Pathological dissociation is defensive in nature and undermines a person's reflective ability by decoupling the mind from the self. Donnel Stern (1997,

2010) describes what he calls "passive dissociation" as a rigidity that, due to various unconscious reasons – defensive, traumatic, or a combination of both – causes certain narratives to occupy a person's description of his/her own identity and other narratives to become unimaginable to him/her. This is a non-conscious rejection of certain meanings that remain unsaid, linked to unformulated experiences in interactions with significant others in early childhood (Stern, 1997). Unlike repression, this defense does not affect the conscious being or the narration of a certain feeling, fantasy, thought, or memory; instead, it is a response to a state of identity, a way of being, a self-state. This is what Bromberg (2006) refers to as a *not-me* state: one that is unable to participate in relational discourse and that usually represents the effects of traumatic life situations or events. In other words, these correspond with aspects rejected by the self, which appear not to participate consciously in the behavior of the individual, although they influence it from the shadows – in DST terms, a "shadow position" (Hermans & Hermans-Konopka, 2010).

Trauma is not just a special situation, but a continuous process that demands our attention only when it interrupts or threatens the continuity of the self experience. All of us are vulnerable to the experience of having to deal with something that exceeds what we can psychologically handle, and it is common to observe differences in this coping ability among patients receiving psychotherapy. For some people, experiences with others can be too stressful for their psychological functioning – too stressful to deal with during a state of internal conflict – and so the mind attempts to relieve this stress through the defensive use of a normal brain process: dissociation (Bromberg, 2011). Dissociation allows certain experiences to be adaptively kept in separate self-states with no connection with one another, at least for some time. This period may be brief for some, but permanent for others. For the latter, dissociation is not only a mental process aimed at dealing with everyday stress, but a structure that organizes their life, reducing the range of experiences that can be lived. Therefore, this mechanism – capable of structuring a person's experience – ensures the preservation of the continuity of the self but at the same time limits reflective capacity. In the therapeutic relationship, these patients need to recognize their most dissociated aspects rather than only understand them. In turn, therapists must accept this act of recognition, both in the patients' development and in the psychotherapy (Bromberg, 2004). In fact, Bromberg (2011) calls *structural change* the process that, via psychotherapeutic intervention, allows a patient to gradually move from dissociation to conflict, which may be clinically represented by his/her increasing ability to adopt a reflective position in which one aspect of the self observes and reflects – often with some degree of displeasure – on other aspects that were dissociated in the past.

Psychotherapy contributes to the modulation of and to the dialogue between the multiple *I*-positions of the patient, activating the relationship between them, allowing those less conscious or dissociated positions of the patient to become more conscious and integrated. The aforementioned constitute an intra- and

intersubjective *regulatory process* that occurs in the patient–therapist exchange (Martínez, 2011b; Martínez, Tomicic, & Medina, 2012; Martínez, Tomicic, Medina, & Krause, 2014).

From this perspective, psychotherapy is regarded as a process of articulation of what is left unformulated, by means of the dialogical experience of generating, together with the patient, a space for him/her to learn about him/herself through the other's *ears* and eyes. The therapist acts as an emotionally responsive witness who recognizes the patient's dissociated and unformulated self-states (Stern, 2010). The recognition and witnessing operation that patient and therapist direct to these dissociated states allows the patient's self to expand by naming, formulating, and mentalizing them (Martínez, 2011a; Tronick, 1998). In other words, this operation makes it possible for multiple positions and voices of the self to communicate and engage in a dialogue, which enables them to struggle and negotiate with one another in the safe exploration space provided by psychotherapy (Duarte, Fishersworring, Martínez, & Tomicic, 2017; Fonagy & Allison, 2014; Martínez et al., 2012).

Recognizing voices: model of analysis of discursive positioning in psychotherapy (MAPP)

Upon the basis of the aforementioned theoretical backgrounds, we have created a method that makes it possible to depict the way in which the multiple subjectivities of patients and their therapists are organized in their speech and participate in an active dynamic of mutual recognition.

In the field of psychotherapy research, several methods have been advanced to make multivocality visible and reveal the relationship between voices and their unfolding throughout the psychotherapeutic process (Hermans, 2008). All of them have in common the notion of self-multiplicity and approach subjective positioning by means of the participants' narratives. Even though some of them consider both patient and therapist self-states (see Seikkula, Laitila, & Rober, 2012), most of them focus only on the patient's dialogical dynamics.

We have developed a model of analysis of discursive positioning in psychotherapy (MAPP) based on the notion that a discursive position is equivalent to a subjective position or an *I*-position, because it is a point of view or a way of being in the world that is expressed through utterances that shape the discourse of an individual (Larraín & Medina, 2007; Martínez et al., 2012).

The MAPP is a three-level system (see Figure 12.1). The first level is composed of the *voices* of an individual, patient, or therapist, which constitute the most idiosyncratic – and therefore embodied – expression of subjectivity in discourse. The second level is formed by the *personal positions* of a patient or therapist, which group together repertoires of voices that voice them. Lastly, the third analytic level of the MAPP is an abstract *taxonomy* that represents the typical organization of the personal positioning of patients and therapists accounting for a level of social organization of these positions or social positions (Martínez & Tomicic, 2017).

Regarding the first level of the MAPP, we consider that patients and therapists can express different points of view in an utterance by means of voices. Thus, a voice not only expresses spoken contents, but also the perspective from which those contents are addressed. Patients or therapists talk by means of a set or repertoire of voices that constitutes the essential elements used by each of them to construct versions or interpretations of reality; these, when weaved into discourse, preserve the coherence of such interpretations (see Wetherell & Potter, 1988). The repertoire of voices usually is diverse and unique in the case of patients: it represents the very specific way everyone's subjectivity is organized (see Table 12.1). In the case of therapists, because their voices express their point of view within their professional role, they show much less diversity, with the *inquirer, meta-analytic, confrontational*, and *assertive* voices being frequent (see Morán et al., 2016).

In the second level of the MAPP, the patient's and the therapist's voices are regarded as jointly voicing a recurrent perspective, labeled "personal position," namely a self-state. In other words, a specific repertoire of voices involves a shared subjectivity as part of the multiple self-states of the patient or the

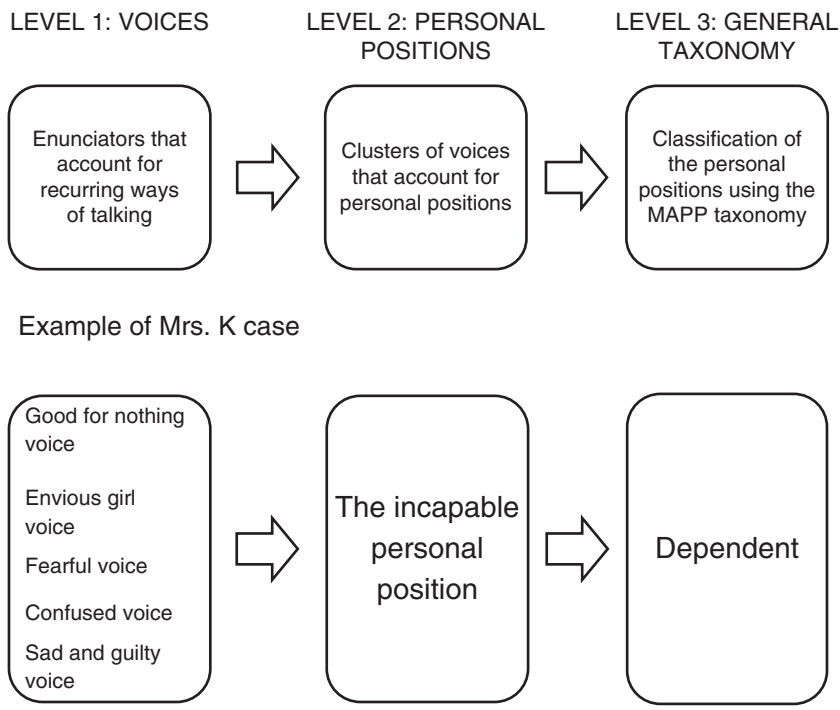

Figure 12.1 Three analytical layers of the MAPP.

Note: The Mrs. K case will be used to illustrate the dialogical analysis using MAPP

therapist. Again, at this level there is a difference when comparing the specificity and idiosyncratic features of the positions of patient and therapist. Pushed by the uniqueness of their voices, the patients' positions reveal the very idiosyncratic perspectives and ways of being of each one of them. On the other hand, the positions of the therapists are linked to their specific role (Martínez, Tomicic, & Medina, 2014), and in that regard, reveal the perspectives that can be adopted within their "social positions," for example "I as therapist, helper, counselor, psychologist" (Hermans, 2001, 2004).

As mentioned above, the third level of the MAPP proposes a general and very abstract taxonomy representing the configurations of positions that are typically adopted by the participants of the therapeutic encounter. This taxonomy emerged from the categorization of the personal positions of both patients and therapists resulting from the analysis of several psychotherapies (see Table 12.1; Martínez & Tomicic, 2017). In the case of patients, three general positions represent the typical configuration: reflective, dependent, and independent. As for therapists, two general positions do so: proposer and professor.

Table 12.1 Mrs. K.'s and her therapist's voices, personal positions, and MAPP taxonomy

Therapies	*Patient's personal positions and voices*	*Therapist's personal positions and voices*	*MAPP taxonomy*
Mrs. K.'s therapy	**1 The integrative**	**1 The proposer**	**Patient**
	1.1 Continuity voice	1.1 Inquirer voice	1 The reflective
	1.2 Self-dialog voice	1.2 Confrontational voice	2 The dependent
	1.3 Down-to-earth/ grounded voice	1.3 Metaanalytical voice	3 The independent
		1.4 Self-revealing voice	**Therapist**
	2 The incapable	**2 The expert**	1 The proposer
	2.1 Good for nothing voice	2.1 Asserting voice	2 The professor
		2.2 Specialist's voice	
	2.2 Envious girl voice		
	2.3 Fearful voice		
	2.4 Confused voice		
	2.8 Sad and guilty voice		
	3 The detached		
	3.1 The voice of duty		
	3.2 Disaffectionate voice		
	3.3 Angry voice		
	3.4 Carefree voice		

Therefore, for patients, a triadic organization of positions has been described. First, the *dependent* general category is characterized by the patient's self-positioning as needy, weak, damaged, and/or vulnerable. In contrast, the second general position – called *independent* – is characterized by the patient's positioning as someone strong and self-sufficient and/or as someone who does not need help from others. These two general positions speak upon the basis of a single truth in a more monological manner (see Martínez, Tomicic, Medina, & Krause, 2014).

Finally, the *reflective* general positioning category accounts for a subjective stance in which the patient is able to have a distant – but not disconnected – perspective of emotional situations, listening and critically looking at other positions while encouraging dialogue between them in the manner of a meta-position (e.g. Bertau & Gonçalves, 2007; Georgaca, 2001). This meta-position has been regarded in Dialogical Self Theory (DST) with some qualities similar to the reflective positioning described here. For example, it allows a distancing from other positions, which in turn allows a panoramic vision and simultaneously of the different positions of self, thus providing a dialogical space for conversation between voices and opposing positions. (Hermans, 2003).

In turn, the first general position of therapists is called *the proposer*, in which the practitioner positions him/herself as someone who shows the patient what he or she observes and offers him/her a new perspective, thus generating a dialogical space between the patient's positions. In addition, the general positioning category labeled *the professor* is more dominant and monological, establishing the therapist as someone in possession of a truth or knowledge that can be presented, taught, or sometimes imposed on the patient as the only alternative.

In sum, the three levels of the MAPP reflect a view of the self as a dialogical entity that encompasses the multiple expressions (i.e. voices) of the patient's and the therapist's subjective positioning (i.e. personal positions), which in turn reflect a socially and culturally determined organization of subjectivity (i.e. MAPP taxonomy). In the MAPP taxonomy, multiplicity is believed to reflect certain aspects of the personality and development of individuals that constitute a supra-organization, a notion already proposed in other theoretical models as a way of organizing subjectivity (see polarities of experience, advanced by Blatt, Shahar, & Zuroff, 2001; or attachment categories such as *avoidant* and *preoccupied*, advanced by Main, 2000).

Trauma and dissociation in the case of Mrs. K.

To illustrate the MAPP, we will present two fragments of a long-term psychotherapy with Mrs. K., a patient diagnosed with a personality disorder and whose issues allow us to examine in greater depth the dialogical dynamics at work in a context of trauma and pathological dissociation. The therapy took place in an outpatient psychological clinic in a public psychiatric institute in Santiago, Chile. The psychotherapy lasted approximately 18 months, with weekly sessions. The psychotherapist has a psychodynamic orientation and over 25 years of experience.

Mrs. K. was 31 years old at the time of the first session. She was a married housewife with two school-age children. She was seeking psychological help due to her severely aggressive behavior towards her 6-year-old daughter. The last time she beat her daughter, she became aware of the excessive force used and the damage that she had caused her. In the first session, she reports that she no longer beats her daughter, but that she sometimes grabs her and yells violently at her; she says that sometimes she does not recognize herself while performing these acts. This also happens to her when she drinks alcohol at weekends, as she becomes someone else: a more disinhibited, daring, and sensuous person. The rest of the time, she describes herself as a shy, bashful, and rather foolish woman. She finished secondary school, but has been unable to practice any of the trades that she learned afterwards.

Mrs. K. was born in a very poor family and is the youngest of four daughters. She was raised in an environment that bestowed upon her the importance of cleanliness, order, and good habits (e.g. personal hygiene, table etiquette), but that at the same time harmed her through physical and psychological abuse, parental alcoholism, a lack of safety, and an uncaring attitude from her caregivers. She was sexually abused twice when she was aged between 8 and 9 years of age, by friends of the family who came to drink with her parents at the weekend. Mrs. K.'s mother had committed suicide five years before the patient sought help, while her father has a severe case of cirrhosis.

In the first interviews, she comes across as an intelligent patient with a very high motivation for psychotherapy. She conveys a very marked feeling of identity diffusion, which causes her much anguish and has even led her to consider suicide.

Mrs. K.'s discursive voices and discursive positions

We identified three personal positions in Mrs. K.: the incapable, the detached, and the integrative (see Table 12.1).

In the *incapable* personal position, Mrs. K. becomes a person who establishes herself, before herself and others, as a worthless person who lacks skills for tackling the challenges of everyday life and who is trapped beneath feelings of fear, confusion, sadness, and guilt, which, as a whole, reflect her vulnerability. Speaking from this position, she comes across as someone who is unable to take responsibility for herself and others who require that she behave like an adult; also, she expresses the need to be aided and understood. While in the *incapable* position, Mrs. K. appears to express her motivations for requesting psychological help and suggests foci for the psychological intervention. This position is expressed through a variety of voices: a *good-for-nothing voice*, an *envious girl voice*, a *fearful voice*, a *confused voice*, and a *sad and guilty voice*. According to the MAPP taxonomy, the *incapable* personal position of Mrs. K corresponds to the *dependent* general positioning category (see Figure 12.1 and Table 12.1).

Within the variety of voices expressing the *incapable* position, the *confused* and *fearful* voices appear to be the main bearers of trauma – her history of maltreatment

and abuse. The *confused* voice appears to express or embody the patient's personality disorder. Mrs. K. is locked in a dissociation state, not knowing what she is doing or why, "not feeling her identity," all of which results in a loss of agency. Using this voice, she reports actions and desires that she finds alien, expresses her feeling of bewilderment at what she does or says, and notes the key importance of other people's gaze for her to "become aware [of things]." For its part, the *fearful* voice allows Mrs. K. to express anxious aspects that interfere with her everyday life. She permanently conveys anxiety, nervousness, and a feeling of being in a rush. With this voice, Mrs. K. positions herself as a woman who is unable to take responsibility for herself. This is a voice that transmits weakness, a need to get help, and at times even panic. In addition, it expresses fear and nervousness in her interactions with the outside world (fear of needles, of elevators, of being on the street): "I'm afraid of everything," "And I start getting nervous and my hands start sweating," "and then with someone else it's like I get nervous . . . or I walk down the street and I'm scared . . . so it's like . . . it's like everything's weird," "Like, I'm sort of in a hurry all day . . . I'm never calm when I'm doing things . . . I'm like a very nervous person."

In the *detached* position – which could be regarded as contrary to the *incapable* position – Mrs. K. comes across as someone who does without affective bonds and who finds it easier to live without others. In addition, with this position she is able to reveal her ability to function in the world according to the norms of what must be done, while also managing to push aside the painful aspects of her life that could make her weak and vulnerable. Thus, from this position, the patient displays agency and autonomy, although by sacrificing her innermost desires, feelings, and needs. This position is expressed through four discursive voices: the *voice of duty*, the *disaffectionate voice*, the *angry voice*, and the *carefree voice*. According to the MAPP taxonomy, this idiosyncratic position constitutes the *independent* positioning category.

In the case of this position, the *disaffectionate* and *carefree voices* appear to manifest the dissociation of the painful and debilitating aspects resulting from Mrs. K.'s traumatic childhood experiences. In other words, these voices appear to contribute to the preservation of a strong self with a high level of agency; however, this task has a major impact on her feeling of well-being. Specifically, she uses the *disaffectionate voice* to refer to her relationships with significant others, mainly her daughter and husband. With this voice, she expresses how unnatural her maternal role feels to her and how uninterested she is in adopting it: she simply does not feel like giving or expressing affection; she is never moved. This is especially visible when she refers to her daughter, as she conveys not only her lack of concern and interest but also her strong feelings of rejection regarding her requests for affection. This voice allows Mrs. K. to express egotistical, self-centered, non-empathetic, and detached aspects of herself. She avoids emotional and physical contact and considers such actions to be embarrassing signs of weakness:

> I feel I don't love her [her daughter]. Sometimes she cries, and I feel like laughing. I see her crying and I think "oh, she's so dramatic." That's the sort of

> thing I say. I'm also rather cold towards him [her husband]. He is always worried about me and everything, and I buy things for myself but I never think of him. I buy things, but just for myself, I don't get anything for my children, nothing. It's like I only care for myself. It's like I never think of others.

For its part, the *carefree voice* allows Mrs. K. to minimize the issues affecting her, which she has not managed to or does not know how to solve. With this voice, she adopts an indifferent or apathetic attitude towards issues that are clearly important to her; she uses expressions such as "that's the way things are" or "why should I bother?" Thus, she stops trying to solve or examine in detail what is hurting or affecting her, avoiding these painful or pending aspects. She comes across as a strong person in contrast to the possibility of allowing herself to be affected, of "overthinking things," an approach to which she gives a negative connotation: "being weak." With this voice, she moves from worry and anxiety to a detached and carefree attitude:

> Oh, no, not that, no. Right! I remember now that my mom had a shorter fuse, she was quick-tempered . . . she was . . . um . . . and no, the fact that my mom died doesn't affect me now. I feel . . . it's like . . . it's like . . . it's a distant thing . . . as you say . . . it's like . . . that's it, why should I bother?

In the *integrative* position, Mrs. K. articulates several aspects of herself and her circumstances. Here – speaking from this meta-position – she comes across as someone capable of describing and reflecting on her dissociated aspects and generating an understanding of the origin and dynamics of her problems, in which she incorporates other voices of her self. While in this position, Mrs. K. manifests her commitment and responsibility regarding herself and others, which causes her to live enthusiastically. For its part, this position is expressed through three discursive voices: the *continuity voice*, the *self-dialogue voice*, and the *down-to-earth/grounded voice*. In the MAPP taxonomy, this idiosyncratic position constitutes the *reflective* discursive position.

Throughout the psychotherapy, the *self-dialogue* and *down-to-earth/grounded* voices were particularly interesting. The former is characterized by its integrative nature: this is the voice with which Mrs. K. refers to and reflects on her dissociated aspects – which are present in other discursive voices. With this voice, she distances herself and adopts a perspective grounded on a coherent and regulated emotional state. With this discursive voice, she devises theories and notions regarding the origin of what is happening to her and what she does, while also challenging herself in her self-dialogue:

> Maybe that happens to me because I feel bad inside and that's why I do things. It's like I take it out on others. Maybe it's that? I take it out on others. With my son, he's small, and why do I wash him so aggressively? It's like I want to clean myself.

For its part, the *down-to-earth/grounded voice* allows Mrs. K. to express commitment and responsibility towards herself and others, especially her children. Also, she uses this voice to express a feeling of well-being and her identification of a core in which "she is herself"; she expresses her pride in being able to function in a grounded manner, while also experiencing a feeling of "normality." The *down-to-earth/grounded voice* reveals that Mrs. K. knows what is happening to her and why; with it, she validates and accepts her feelings, is able to be flexible and adapt to situations, gives affection without feeling weak, and takes an interest in living:

> "No, I'm fine . . ." I said, but after some time I said, "No, I'm not okay. I'm not okay with myself. I'm not at peace with myself." So I came here [to get therapy] and I kept coming, I always come here, I think I have never abandoned this, it's like I'm really interested in this, because, I mean, I need to heal.

A confused self: "I can't say who I am"

The following extract was taken from the very beginning of the first therapy session. In this fragment, Mrs. K. presents the central issue that led her to seek psychological help: her difficulties for recognizing herself in her own behaviors.

44. Mrs. K: But I still haven't noticed that; it's like I don't think I have – I don't notice it. It's that I don't know who I am – it's like I act differently later I'm someone else in another place.
45. Therapist: What do you mean? Let's have a look at that.
46. Mrs. K: Like, for example when I'm talking and all . . . but then umm . . . I don't feel that nervous and then with someone else it's like I get nervous or I walk down the street and I feel sort of scared it's like; it's all quite weird. I don't know . . . it's like I feel I'm this way and I'm cranky or I'm nice or I'm umm short-tempered . . . I don't know I can't tell.
47. Therapist: Uh-huh.
48. Mrs. K: . . . who I am because sometimes I say I'm not cranky . . . I'm happy . . . I'm nice . . . I have everything – it's like I say, I have everything mixed together so I think it shouldn't be so . . .
49. Therapist: Uh-huh.
50. Mrs. K: It's as if everything – since I don't – I don't feel my identity – it's like I can't say who I am.
51. Therapist: Uh-huh.
52. Mrs. K: It's like I'm acting; like for example I get together with some friends who . . . who drink, who like to party and all and I like start drinking and I become a party animal and all . . . then I get together with other friends who are . . . who don't drink or smoke or anything and I stay with them there and I don't I don't drink and it's like I lie to them like I tell them that I don't drink, that I'm a quiet person – I tell them those things.
(. . .)

59. Therapist: So maybe you get to think it's not a lie when you're telling your friends "No, I don't like to drink. I don't party, in fact."
60. Mrs. K: It's a lie, right?
61. Therapist: Yes, why?
62. Mrs. K: Because it's true. I drink.
63. Therapist: Okay but I'm thinking that the one who says that maybe umm, in fact doesn't: doesn't drink.
64. Mrs. K: It's that I don't know – but I say why do I? Lie, I mean. Why do I say that?
65. Therapist: You see it as a lie.
66. Mrs. K: Yes, I do.
67. Therapist: Okay.
68. Mrs. K: And then I ask myself why; I ask myself because I even ask questions and I answer myself (ha).
69. Therapist: Uh-huh.
70. Mrs. K: It's like I ask why I am; why do I tell them I don't drink? Why do I lie? Why don't I show myself as I am?
71. Therapist: Uh-huh … but you say you don't know?
72. Mrs. K: It's that I don't either and when I drink I also say that I say I'm not like that. I mean, I don't drink. I'm not a heavy drinker but I drink anyway.

Two moments can be identified in this extract of the dialogue between Mrs. K. and her therapist. First, between speaking turns 44 and 58, the conversation is mainly led by the patient's *confused voice* (see Table 12.1), which converses with the therapist, who adopts the *proposer* position, expressed through the *inquirer voice* (speaking turn 45).

The fragment starts with the patient speaking with the *confused voice*, through which she presents her central problem – her lack of recognition of herself in this self-state: "I don't know who I am." The therapist, adopting his role and using his *inquirer* voice, participates only minimally and invites the patient to explain and *show* him what she is talking about: "Let's have a look at that." In speaking turn 46, Mrs. K. responds from a single position – the *incapable* – but expresses it through two different discursive voices. One of them, the *confused voice*, shows how the patient behaves differently in various situations and how this reinforces another voice – the *fearful* one – that expresses the affects and emotions that are activated due to this confusion, that is, feeling scared and nervous. In other words, the appearance of these two discursive voices of the patient at this point of the conversation reinforces and adds nuances to this self-state – that of inability and vulnerability. In the following three speaking turns (48, 50, and 52), Mrs. K. uses the *confused voice* to narrate more events of her life that stress her confusion; in them, the recurrent expressions "I don't" and "I can't tell" seem to indicate the first recognition of the *me and not-me* of dissociation.

In the second moment of this first extract, the dialogue transforms between speaking turns 59 and 74, displaying a greater diversity of voices and positions, mainly of the patient.

This fragment starts in speaking turn 59, where the therapist proposes an interpretation identifying a link between the patient's actions and her mental functioning, highlighting with his *metaanalytic voice* that this may not be exactly a "lie." This leads to a shift in the patient's position in speaking turns 60, 62, and 66. Here, using her *voice of duty* – part of the repertoire of the *detached* discursive position – the patient reinforces the notion that her behavior is deceitful and that she is therefore committing an offense. For his part, the therapist switches positions, using his *asserting voice* to identify and reaffirm the right of another position to exist in Mrs. K. ("the one who says that"), a position that also tells the truth ("in fact doesn't: doesn't drink"). This intervention by the therapist lays the groundwork for a process in which the participants acknowledge the patient's multiple voices; this process, one year later, would manifest itself through one of the most relevant therapeutic changes for Mrs. K., as shown in the following fragment of session 30. Nevertheless, at this initial stage of the therapy, this intervention by the therapist only seems to cause tension and conflict between some of the patient's voices and positions. On the one hand, her first reaction in speaking turns 64 and 66 is again expressed through the *voice of duty*, as if she were trying to reassert, monologically, the truth of her lies. On the other hand, in her two subsequent speaking turns (68 and 70), the *self-dialogue voice* rears its head: "but I say why do I? . . . I ask myself why." This voice, though weakly, manages to pose the question about the patient's *me* ("why don't I show myself as I am?"), but then quickly yields to the power of the *confused voice* (speaking turn 72).

These difficulties telling who she really is mark a key point in Mrs. K.'s psychotherapy; however, the situation starts changing towards the end of her psychotherapeutic process. The fragment analyzed below illustrates this change.

An integrated self: "but now I feel like it's mine like it's . . ."

In this second extract, taken from session 30, a year later, Mrs. K. returns to talk about her internal voices. However, this time she refers to her voices from a different position: an *integrative* one, mainly expressed through the *down-to-earth/grounded* and *self-dialogue* voices.

328. Mrs. K: and I know that I can't go on living like this and that I cannot be sad and because I no longer feel that sadness that misfortune . . . I can no longer have that grief. I said that sadness it's because it's not so much anymore (. . .)

336. Mrs. K: Not anymore because now I feel grief – we all feel grief – but I mean not that grief; that normal grief, I think, and it's like I no longer have that . . . What was that thing that I said to myself? Something about

my head that I wanted to do something and it's like someone else. I don't know, a feeling, like another person said to me.

337. Therapist: I remember that at the beginning you told me you had lots of dialogues inside you.
338. Mrs. K: Yes.
339. Therapist: Like with yourself but it was a confusion that left you feeling that you didn't know who you were. Do you remember? (. . .)
344. Mrs. K: Like, I was telling myself that I wanted to do something: "Don't. Don't do that because that's not like that," or "Just do it. Because, what's wrong with it? If you are you are nice, you are" I hear sort of many voices which talk to me like that. (. . .)
348. Mrs. K: I was secretive. I mean – like, I used to drink and I didn't make a big deal of it but my voice wanted to do something and said, "Do it. Nothing, nothing will happen. Yes, yes, you're pretty. Right, you are"; I felt like the greatest person in the world when I drank. I felt sort of the best, the prettiest, the most gorgeous. And later now the week, the week before last, I drank and drank and that thing of feeling like, like someone else was talking to me, didn't happen to me.
349. Therapist: okay
350. Mrs. K: Like, I felt – I felt sort of, sort of normal like it was me who was drinking.
351. Therapist: Uh-huh.
352. Mrs. K: Something like that.
353. Therapist: Okay.
354. Mrs. K: And sometimes I'm fine. I'm normal and I want to do something but I think about it first anyway.
355. Therapist: Uh-huh.
356. Mrs. K: Like, what do I say? oh "do I do it or not"? Umm but now I feel like it's mine like it's . . .

Mrs. K. starts the fragment (turn 328) using the *down-to-earth/grounded voice* to talk about her sorrow, which does not seem to overwhelm her as it used to and that she currently accepts as a part of her life. Later, in speaking turn 336, along with normalizing her current grief, she refers to another of her internal voices – the *confused* one – alluding to it as "that thing that was said to me" or "another person said to me." In speaking turn 337 the therapist intervenes from a *proposing position*, recalling the patient's internal voices and alluding to them as "dialogues" within the patient. Then, specifically in speaking turn 339, he reminds her that those dialogues made her feel confused. In speaking turns 344 and 348 Mrs. K. responds from an *integrative position* that is expressed with the *continuity voice*, providing material that supports what the therapist says, such as memories that allude to "talking with herself" and the "many voices which talked to me like that." However, she no longer speaks from a position of confusion, but from a more integrated place that appears to acknowledge and accept these dialogues within herself. In the following turns, she reinforces the idea that she no longer feels that

she is another person pulling her in a different direction; instead, she accepts that she can have contrary ideas within her, but she realizes that they are hers, that they belong to her. The fragment ends on speaking turns 354 and 356. Here, with this *down-to-earth/grounded voice*, she highlights the fact that now, when she wonders whether she should do something, she thinks and decides, certain that this dialogue is hers – that she is talking with herself: "like what do I say oh do I do it or not? Umm but now I feel like it's mine. Like it's ...."

Conclusions

As human beings, we move within cultural spheres, which envelop and constitute the individual (Joerchel, 2011; Slunecko & Hengl, 2007). This implies that the dialogical self resonates in a specific social and cultural context that, for its part, provides a structure that organizes the space in which the voices and positions of the self move and influences the dialogical interactions among them (Joerchel, 2011; Slunecko & Hengl, 2007). Individuals flourish due to their participation in social and cultural spheres, which necessarily occurs with others. One of these emerges very early on and has been entitled intersubjective intimacy of early life (Trevarthen & Aitken, 2001), that is, the mother–infant space that is itself already within a certain cultural atmosphere (Joerchel, 2011).

Mrs. K., severely traumatized during her childhood, is part of a discursive chain (Bakhtin, 1986) in which her subjectivity has been organized in a dissociated manner, and that originated in the cultural spheres that constituted her, first as a daughter and later as a mother. These spheres, dominated by a mother who provides a dissociated discourse – cleanliness versus chaos – constitutes in the patient a self dominated by a position of inability that, through pathological dissociation, keeps her in a state of confusion that shifts alternately from *me* to *not-me*, thus restricting her cultural and social existence. Psychotherapy, as another cultural sphere, provides her with a space of recognition and acknowledgment of other relegated voices of herself. Thus, the patient manages to move from dissociation to a dialogical reorganization of her subjectivity – a reorganization in which she integrates her internal dialogues, gains agency, and broadens her experience of her own self and of herself as a person in her social and cultural world.

By means of this case, we illustrated the MAPP as a tool that gathers and nourishes itself from the DST in the conception of self as a concert of *I*-positions or states of self that can or cannot dialogue with each other. Likewise, from the background of relational psychoanalysis, the application of the MAPP allows us to analyze the way in which these aspects are dissociated from the self (e.g. shadow positions) and are integrated in the inner dialogues between the voices and positions of a patient, building bridges between this psychotherapeutic theory and the DST. Thus, through the Mrs. K case, we exemplified the idea that a new organization of the inner dialogue between the patients' voices and positions – a form of self-regulatory behavior – could constitute an important element of the psychotherapeutic process of change.

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