British Journal of Medical Psychology (1997), 70, 193–207 *Printed in Great Britain*

Procedures as dialogical sequences: A revised version of the fundamental concept in cognitive analytic therapy

Mikael Leiman*

University of Joensuu, Finland

Problematic action patterns that patients are unable to abandon or modify are important treatment targets in cognitive analytic therapy. They are called procedural sequences in the conceptual model underlying the approach. Interpersonal events in the patients' lives, and in the consulting room as well, frequently display such patterns. They are called reciprocal role procedures. In the present paper the sequential description of problem procedures will be examined by using Bakhtin's dialogical understanding of mental phenomena. A restatement of the original concept will be presented with the aim of integrating the sequential and reciprocal aspects of problematic action patterns. The revised concept of dialogical sequences will be illustrated by a number of case vignettes. The analysis of dialogical sequences provides a clear conceptual basis for early description of problem procedures in therapy. It also provides an effective tool for a detailed supervision of therapy sessions. Finally, dialogical sequence analysis may be used as a psychotherapy process research method to examine the interpersonal patterns in patient narratives.

Cognitive analytic therapy is a rapidly developing mode of brief psychotherapy attracting growing interest in Britain and, gradually, in other European countries. Its hallmark is the early reformulation of patient problems in terms of problematic repetitive action sequences and role positions. The reformulation process is carried out jointly, involving the patient in an active identification of such patterns from the first sessions onwards. In this collaborative search the therapist is guided by a number of practical and conceptual tools the most important of which is the procedural sequence object relations model (the PSORM). This model is currently fairly complex and will not be discussed here. An excellent summary of the model has recently been presented by Ryle (1995*b*).

A fundamental concept of the model is the procedural sequence. Originally this concept was shaped by the cognitive theories of aim-directed action (Ryle, 1982). Throughout its history this notion has not been satisfactorily integrated with the analytic aspect of cognitive analytic therapy which was strongly influenced by psychoanalytic object relations theory. This was recently pointed out by Tim Leighton in a discussion with Ryle (Leighton & Ryle, 1995). The tension between the two theoretical orientations, although fruitful and innovative, has tended to push the practice into either more cognitive or more psychoanalytic direction.

* Requests for reprints should be addressed to Mikael Leiman, Raivionmaentie 1, SF-83500 Outokumpu, Finland.

In what follows, the concept of procedural sequence will be readdressed and a slightly modified conception will be presented with the aim of integrating more explicitly the sequential and the reciprocal, or dialogical, aspects of the concept. The revised unit of analysis will also be more in line with the currently appreciated dialogical notions of mental processes and personality development (Hermans & Kempen, 1993).

The concept of procedure

The conception of repetitive action sequences was born in the context of psychotherapeutic practice which provided the impetus for a descriptive term that would mediate the efforts at joint understanding in the early sessions of therapy. Hence, the formula for the concept had to be such that it was easily grasped by the patient who then could use it as a tool of self-reflection.

Traps, dilemmas and snags represented the first metaphorical descriptions of the problematic action patterns (Ryle, 1979). In traps negative assumptions generate actions which produce consequences seemingly reinforcing the assumptions. When the person acts as though available action or possible roles were limited to polarized alternatives, we may speak about a dilemma. Snags describe actions that have negative implications. Appropriate goals are abandoned as if they were forbidden or due to the fear that others might oppose them.

The chief merit of traps, dilemmas and snags for therapeutic practice was in their ability to illustrate a broad range of repetitive action patterns. They were readily accessible to the patient and they also suggested three important aspects of repetition. Firstly, being unrecognized by the patient as full sequences, he or she could not get such patterns under conscious control. This was well underlined by the term 'trap' which was used to spell out both symptomatic action sequences and conflictual reciprocal relationship patterns. Secondly, both dilemmas and snags suggested unconscious assumptions that permitted the examination of repetition as something developed in the patient's past. Thirdly, the patterns were self-reinforcing, because the underlying assumptions were frequently confirmed by the outcome of action.

In his 1982 book Ryle related the descriptive terms of traps, dilemmas and snags to a more general conception of repetitive action sequences (Ryle, 1982). To my view, this attempt was mainly motivated by two aims. Ryle had been interested in finding a common conceptual foundation for the various schools of psychotherapy and had previously suggested that the contemporary paradigm of cognitive psychology would best accomplish the integrative task (Ryle, 1978). Secondly, the descriptive terms had to be refined and brought into a more explicit relation with the theoretical field of psychology. Ryle was well aware that without such a conceptual contextualization these terms would soon stagnate and become dogmatic signs of a practical therapeutic school, a not uncommon development in the field of psychotherapy (Leighton & Ryle, 1995).

The solution that Ryle envisaged in his monograph was the generic notion of aim-directed actions, called the procedural sequence, or the procedure, which was largely inspired by the cognitive modelling of rational problem solving. The concept of procedure emphasized the sequential nature of human activity. Its chief merit for therapeutic practice was, and still is, the help it provided for the therapist in looking

more carefully at the stages of repetitive action patterns and, especially, how the stages in any such pattern were sequentially organized.

The procedural sequence was represented by a circular model that registered the stages of the sequence as well as the mental processes that were involved in the execution of action. The concepts used in the model were elementary psychological terms that were commonly used in cognitive psychology and cognition–emotion research. Typical of that tradition, these terms do not imply any kind of dialogical understanding. Cognitive psychology does not study perception, attention, or memory as interpersonally originated mental activities. They are mainly regarded as 'functions' and the cognitively oriented researchers prefer to relate any such function with others as well as to its hypothesized neurophysiological substrates.

In his 1990 book Ryle revised the procedural sequence model, or the PSM, by integrating some notions of the more recent cognition–emotion research (Ryle, 1990). A new kind of mental activity, i.e. emotional appraisal, was considered. In all stages of the sequence an appraisal system is at work that relates the cognitive aspects in the path from intentions to acts with a personal system of meanings and values. This description, in fact, hinted at a form of inner dialogue or, at least, a complex form of mental activity that is involved in the formulation of aims, in the planning of external action, and in the evaluation of the outcome. However, the addition did not affect the general sequential or circular pattern, summarized by the following stages.

1. Define aim (maybe in response to external event).
2. Check aim for congruence with other aims and values, i.e. for personal meaning.
3. Evaluate situation, and predict one's capacity to affect it, and the likely consequences of achieving the aim (the 'general assumptions' in the earlier definition).
4. Consider the range of means or roles (subprocedures) available and select the best.
5. Act.
6. Evaluate (*a*) the effectiveness of the action and (*b*) the consequences of the action.
7. Confirm or revise (*a*) the procedure and (*b*) the aim (Ryle, 1990, p. 10).

The sequence describes a set of highly complex mental activities that precede the phase of external action (stage 5) as well as equally complex reflective activities when assessing the consequences. Although these internal actions are highly condensed and mainly unconsciously performed they represent, in fact, the most advanced end in the developmental continuum of our mental activities. All of these activities have an interpersonal and, originally, externally observable origin although, in the later stages of development, they seem to be directed from within (Leiman, 1995).

The reciprocal role procedures as patterns of recurring interpersonal action sequences

The cognitive model of aim-directed actions does not distinguish between different objects of action as possible sources of variation in the sequential structure. In this sense it is a truly general model. Having been influenced by psychoanalytic object relations theory Ryle was, however, sensitive to the issue of reciprocity in the interpersonal sphere of activity. To emphasize the reciprocity of activity in personal relationships, the concept

of reciprocal role procedures (RRPs) was incorporated into the procedural sequence model.

To provide an early definition of the concept I quote Ryle's paper on object relations theory and the self (Ryle, 1985):

> The procedures governing a person's interaction with another will incorporate a capacity to predict and adapt to the reciprocating acts of the other, and may be called reciprocal role procedures (referred to henceforth as RRPs). Such procedures will be acquired from the early family experiences and from the more general culture in which the person grows up. They will operate largely unconsciously .... The construing of relationships in terms of one's individual RRPs will lead to behaviours intended to elicit the appropriate reciprocations. Non-reciprocation may lead to modification of the procedures but is often met with attempts to force the other to play the expected role (p. 3).

This definition emphasized the interactive character of the RRP. In the paper Ryle, however, pointed out that such procedures also govern the person's habitual ways of relating to him or herself. They are, so to say, internalized dialogical relationships.

Practical difficulties resulting from the non-integration of sequence and dialogical patterns

The distinctly interpersonal understanding of reciprocal role procedures was incompletely integrated with the cognitive model of procedural sequences. Hence, especially in the teaching of cognitive analytic therapy the old sequential illustration, or the procedural sequence model, became more and more a duly venerated relic but it did not, as such, serve as a living and useful conceptual tool for the therapist.

When the practice of reformulation developed into the use of sequential diagrams and to the development of the procedural sequence object relations model (the PSORM) (Beard, Marlowe & Ryle, 1990; Ryle, 1990; Ryle, 1995*a*), the weakness of the PSM in guiding therapist descriptions became more visible. In the diagrammatic reformulation problematic action sequences are seen to emanate from a core of reciprocal role procedures.

In the early days of sequential diagrammatic reformulation the core was mainly defined in terms of unmanageable feelings or a developmentally early state of being. It was however soon realized that such states do have a dialogical structure. They can be described in terms of powerful internalized reciprocal role procedures. It also became apparent that a person may have more than one mental states. Separate self states can be distinguished on the basis of the nucleus of RRPs that are specific to each state. The number, coherence, and content of self-states vary from person to person. Persons with multiple personality disorder represented an extreme example of dissociated self-states, but distinct states with specific reciprocal role procedures could be identified in borderline or personality disordered patients as well.

When describing self-states, the therapist is advised to pay attention to the reciprocal patterns that seem to operate in any such state. The therapist should also identify the procedural loops that represent either direct or transformed enactment of the salient role relationship patterns within the state (Ryle, 1995*b*). However, when describing these action sequences, i.e. the loops that emanate from the state, no succinct analytical tool is available. Consequently, the descriptions tend to acquire quite an occasional character. In

some loop illustrations general aims or wishes are postulated. In others only a list of external actions are produced, connected with arrows that indicate the flow and direction of the sequence. Yet in others the procedural loop is constructed by using a combination of actions, reciprocal roles, and dilemma formulations as falsely polarized assumptions regarding the options of action.

Such a variety in the diagrammatic descriptions are sometimes perplexing for the patients because the visualization of single problematic action sequences in one diagram may employ different modes of construction. The multitude of descriptive strategies is frequently puzzling for psychotherapy trainees who feel that the configuration of self-states and procedural loops seem to emanate from the intuitive wisdom of the supervisor. The theoretical confusion regarding the reciprocal roles and action sequences thus leads into practical difficulties in therapy and training.

Ryle recently (1995*b*) emphasized that, when constructing a diagrammatic reformulation, it is important to recognize the patient's recurring self-states, the salient repertoire of reciprocal role procedures defining each state, and the way that the states are related to each other. When constructing the procedural loops that represent the enactment of the RRPs in the world, either directly or in a transformed form as, for instance, in symptomatic procedures, these loops should start from either pole of the RRP, in order to be an explicit description of the role position that is expressed by the enactment. 'The basic unit from which procedures are generated is a reciprocal role' (Ryle, 1995*b*, p. 32).

This recommendation clarifies the general idea of procedural loops and how they should be visualized in the diagram. However, a clear notation regarding the action in the world and the internal sequences of thinking and imagination will also be needed in order to overcome the perplexing variation in the descriptions. I hope that the concept of dialogical sequence, as proposed below, and the suggested mode of diagrammatic illustration will be a step in this direction and will clarify the visual representation of the patient's problematic action patterns and role enactments.

Procedures as dialogical sequences

Vygotsky's conception of sign-mediated activity as well as Bakhtin's understanding of mental phenomena as dialogic processes have brought some new aspects into CAT theory while, on the other hand, it has re-emphasized the relevance of object relations theory for CAT. Relating Vygotskian and object relations ideas seems to open promising integrative perspectives (Leiman, 1992; Ryle, 1991, 1995*a*).

Vygotsky's main contribution to psychology was his understanding of signs as the primary mediators of our mental activities as well as of our practical operation in the world. Our experiences are stored in the signs that were present when the event occurred, or in the action that was performed. Our learning is a complex process of becoming exposed to the myriad of cultural sign systems as well as practices of using them and, gradually, making them our own (Shotter, 1993). Vygotsky emphasized that this process is always a shared event. Thus, our experiences are never entirely our own. There is a history of collective sign usage that is delivered to us by our caretakers (Vygotsky, 1978).

Mikhail Bakhtin's theory of signs as well as his theory of utterance are relevant in our attempts to describe how mental processes originate and operate and what happens in psychotherapeutic discourse. The theory of utterance contains a peculiar understanding of

words as two-sided acts and of signs that make present that which is meant by them (Bakhtin, 1984; Voloshinov, 1973). It also emphasizes the idea, that words and signs are carriers of voices that have been using them in the past. That is why our words are always somebody else's words too and our utterances are, to a degree, always responses to the other persons that have spoken before us. Bakhtin preferred to use 'speaking' and 'the word' as his basic terms even when he was referring to activity and sign mediation in more general sense.

In line with Vygotsky, Bakhtin emphasized the importance of signs in the formation of mental activities, but his prominence for psychology and psychotherapy lies in his dialogic view of the human psyche. Our mental life is formed in a responsive environment that meets our rudimentary expressions by an interpretative, or evaluative, position. Such a complex event, mediated by socially formed signs, is constitutive to our thinking and acting in the world. It accounts for our internal positions in our relationships to ourselves and to others. It accounts for the quite peculiar way of directing our acts and our thoughts to an addressee even when nobody is visibly there.

Although Bakhtin's terminology is peculiar he has much in common with Winnicott's understanding of the dyadic and intermental quality of our internal world (Leiman, 1992). To illustrate Bakhtin's striking proximity to the British object relations thinking I make a lengthy quotation from Christopher Bollas's opening lines in *The Shadow of the Object*:

> In the early 1950s Paula Heimann, a member of the British Psycho-Analytical Society, posed a simple question that became crucial to the practice of psychoanalysis in what has come to be called the 'British School' of psychoanalysis ... . When listening to the patient's free associations (or broken speech), and tracing the private logic of sequential association as all psychoanalysts had done up until then, she asked: 'Who is speaking?' We can say that up until this moment it had always been assumed that the speaker was the patient who had formed a therapeutic alliance with the analyst, and therefore that he was a neutral or working speaker who was reporting inner states of mind. This assumption comprised the classical view of analytic narrative. But Heimann knew that at any one moment in a session a patient could be speaking with the voice of the mother, or the mood of the father, or some fragmented voice of a child self either lived or withheld from life.
>
> 'To whom is this person speaking?' Heimann then asked. The unconscious admits no special recognition of the neutrality of the psychoanalyst and, given the unending subtleties of the transference, Heimann realized that at one moment the analysand was speaking to the mother, anticipating the father, or reproaching, exciting or consoling a child—the child self of infancy, in the midst of separation at age two, in the oedipal phase, or in adolescence. 'What is the patient talking about and why now?', she added.
>
> Heimann and other analysts in the British School, all of whom had been deeply influenced by the work of Melanie Klein, analysed the object relations implied in the patient's discourse. The patient's narrative was not simply listened to in order to hear the dissonant sounds of unconscious punctuation or the affective registrations that suggested the ego's position and availability for interpretation. The British analyst would also analyse the shifting subjects and others that were implied in the life of the transference (Bollas, 1987, pp. 1–2).

Bakhtin, of course, did not speak of the ego or the transference, but would certainly have accepted the idea of the dissonant sounds of forgotten voices, freed from the biologist underpinnings of the Freudian instinct theory. Bakhtin also emphasized that every utterance is meant for somebody. It has an addressee and the addressee affects the very construction of the utterance. Bakhtin shares with the object relations school the understanding of the importance of the other in our mental life. In his theory of

utterance he has managed to show how the significant others are present in our ways of expressing ourselves and where we can recognize their voices.

In cognitive analytic therapy the concept of reciprocal role procedure has its background in object relations theory. The idea that every role enactment is directed to a reciprocating other, be it another person or an aspect of the self, is very Bakhtinian and opens up possibilities to integrate his theory of utterance with CAT thinking. In this new phase of conceptual integration the non-revised cognitive understanding of the procedural sequence appears increasingly anomalous, offering an incompatible terminology and drawing our attention away from the dialogical nature of mental processes.

In what follows, I shall outline a modified description of the procedural sequence that will, hopefully, be more congruent with these newer views, presented in more detail by Ryle and by me elsewhere (Leiman, 1992, 1994, 1995; Ryle, 1991, 1994, 1995). These ideas have evolved in the context of therapeutic practice and supervision. Thus the task of the descriptive model is to provide a useful notation to illustrate repetitive action sequences, making them accessible and simple to patients and psychotherapy trainees as tools of joint reflection. The concept of dialogical sequence is indeed a tool that is more closely related to practice than to general theories of human activity. In order to elucidate the concept I will present three case vignettes and use the diagrammatic notation that combines the sequence with its dialogical moments.

Case 1

A young female patient presented her problem in her first utterance to the therapist: 'It just happens, when I leave the school. I'm sort of getting an empty feeling, I do not know if it is hunger or what. If I happen to pass a bakery I drop in and buy a loaf. When I come home I get a glass of milk. Then I just sit down and eat up all the bread, and then I feel "Yuck!"'

In this narrative the sequence of events is very distinct because the symptomatic pattern is so well established and familiar to the patient. Its dialogical moments are, however, not directly discernible. In order to arrive at a proper reformulation of the sequence these patterns must be inferred. At this early stage such inferences will serve as hypotheses that may or may not be confirmed in the subsequent work with the patient.

The proposed notation describes the sequence as a combination of internal (dialogical) and external actions. The whole procedure is represented by actions that carry the process forward and the dialogical patterns that mediate or direct the flow of the sequence. The dialogical construction of the patient's symptomatic procedure might look like the diagram in Fig. 1. When the girl leaves the school she is feeling lonely. She tries to make up for the absence of others by self-consolation offering herself a substitute in the guise of bread. However, the ensuing activity (eating the loaf) calls forth another kind of internal dialogue, represented by the 'Yuck!' A resentful, parentally derived, voice appears and despises her weakness and fatness.

A Kleinian account of the sequence might read like this. The girl tries to create the good breast in fantasy by buying the bread. However, she destroys it by her greediness turning it into a damaged breast that then begins to haunt her from within. CAT has received its dialogical understanding partly from the Kleinian tradition. It does not, however, accept the common Kleinian tendency of reducing these dialogues into a play of breasts or other part objects.

The above construction of the symptomatic procedure provides both the therapist and the patient valuable cues about the kind of her internalized object relations that can soon be examined in other activities and in the transference. By alerting the therapist to the dialogical patterns that even simple symptomatic sequences contain, an accurate early reformulation is greatly facilitated.

At this stage a note on terminology must be made. I am using the term 'dialogical pattern' as a rough equivalent to the concept of reciprocal role procedure in the current model. 'Dialogical position' refers to

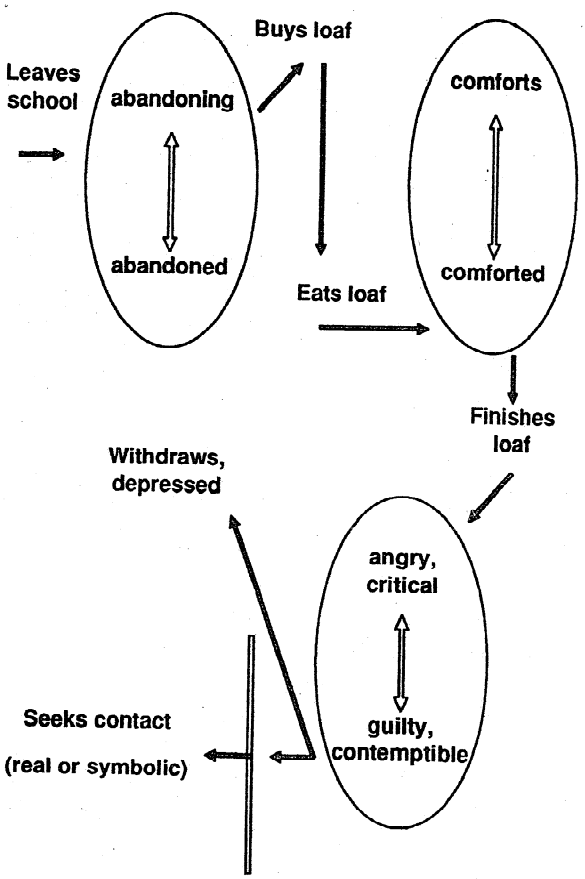

Figure 1. Symptomatic dialogical sequence of case 1.

either one of the poles in the RRP. 'Dialogical sequence' will be used when describing the full procedural sequence that consists of dialogical patterns and actions that may be internal or external. I have called these actions 'transformative' to indicate their role of carrying the sequence forward. The aim is to convey the idea that only those actions that are directly relevant for the flow of the sequence will be noted. They may have structures of differing complexity and consist of either a few or several distinct subactions or operations.

The dialogical pattern is a highly abstracted and fixed description of the dynamic processes going on in the person's mind. As pointed out by Dunn (1993), role procedures may be experienced and described as internal voices. In psychotherapy we trace the often complex juxtaposition of these voices, their content, as well as the stance that they seem to adopt regarding the intended actions of the patient. The diagrammatic presentation points out the positions from which the voice seems to act and to which the patient posits him or herself, while remembering that, because of being internalized in dialogical form, switches to the reciprocal pole frequently occurs.

The term 'dialogical pattern' thus represents a structural snapshot of a living process. In order to emphasize the moving nature of this conceptual unit I've adopted 'dialogical moment' as an alternative term. Its aim is to emphasize that dialogical patterns are mediating units of ongoing action sequences. Even if focusing on the reciprocal positions, we should never lose sight of the double movement involved; the positions represent living voices and these voices mediate the entire procedure.

Case 2

This case was described by Karl Abraham in his early paper on hysterical dream states (Abraham, 1910/1988). I shall reproduce the case material in Abraham's own words and then reformulate it by using the notation of the dialogical sequence analysis.

> ... he used to be overcome by a dream-state whenever he had to recognize the superiority of others and his own inactivity ... . Occasions of this kind would begin by producing a marked activity of his imagination, together with the resolve to work most energetically for the realization of his imaginary desires ... First and foremost would be the thought that some day he would emerge from his seclusion and impress the whole world. He would imagine how he would cause a sensation on account of his great learning, or would be called before the curtain as the author of a drama and so be the centre of universal attention; or how he would become a master-player at chess and go from table to table in a cafe, playing simultaneous games, and would make his moves under the admiring gaze of the onlookers ...
>
> The patient himself described the process as an ever-increasing state of 'enthusiasm'. This condition would merge rapidly and almost imperceptibly into the second stage. His description of the latter was very characteristic: it was that there occurred a complete 'turning into oneself', a shutting out of all external impressions, and that in making phantasies 'one loses the ground under one's feet'. That is to say, he was no longer able to control his train of thought and left the solid ground of reality. At this point he would seem to himself to be in a dream; his entire surroundings, even his own body, would appear strange to him, and he would even doubt the reality of their existence. The typical third stage—that of 'cessation of thoughts'—would follow. Morbid anxiety would develop immediately and usher in the fourth stage, in which he would be seized with giddiness and have the feeling that he was no longer going forward, that he could not lift his legs, that he was sliding, falling, sinking down. These sensations would be associated with the most intense anxiety. People and surrounding objects would appear to him remarkably big. He himself would feel small and want to be so in order not to be seen; he would like to be 'as nothing', 'to sink entirely into the earth'. He also described a feeling that he must crawl on all-fours in order to reach home (Abraham, 1910, pp. 94–96).

The last stage of the sequence was accompanied by a number of somatic sensations that made it to appear as a very early mode of experiencing. Having become anxious the patient would feel a heat wave that would soon transform into a very strong sense of coldness. In this stage the patient felt as if parts of his body had died. Usually this phase lasted for quite a long time. The patient had then learnt to soothe himself by lighting a cigar.

To condense this rich and moving account into a sequence of dialogical patterns and transformative actions almost feels like an act of indiscretion, because it seems to destroy the personal voice of the patient still vividly present in Abraham's account. However, for the sake of illustration Fig. 2 was constructed.

In this remarkable sequence only the first dialogical pattern happens partly in the world that sends the patient a sign which posits him into the status of being inferior. It is well illustrated by Abraham how powerfully internalized dialogical patterns mediate external events providing them personal meanings that could not be inferred from the event itself. Next, a distinct switch of self-state occurs entrapping the patient in an internal dialogue with mounting excitement. The development of the sequence is a vivid illustration of how content mediates affect. The patient's fantasies become more extravagant along the way, finally lifting him above the ground. Then a reversal of positions in the dialogical pattern happens, accompanied by a state switch. It is important to notice that the quality of the counter-position is different for the patient in the powerful and submissive positions. In the submissive position, the power and excellence is seen more threatening and exposing than it felt when being in that position. The ensuing process leads the patient into an ever-increasing sense of helplessness and panic. It is as if he had run too far from home and suddenly realized that he had done so. A question mark has been added to the pattern illustration, because Abraham's account does not clearly indicate the counter-position to which the patient responds by these catastrophic images. Thus they are inferred and presented as hypotheses.

Case 3

My third example is a well-known excerpt from a psychoanalytic treatment, studied by several psychotherapy researchers. The entire session was published as the verbatim transcript of the fifth hour of the tape-recorded

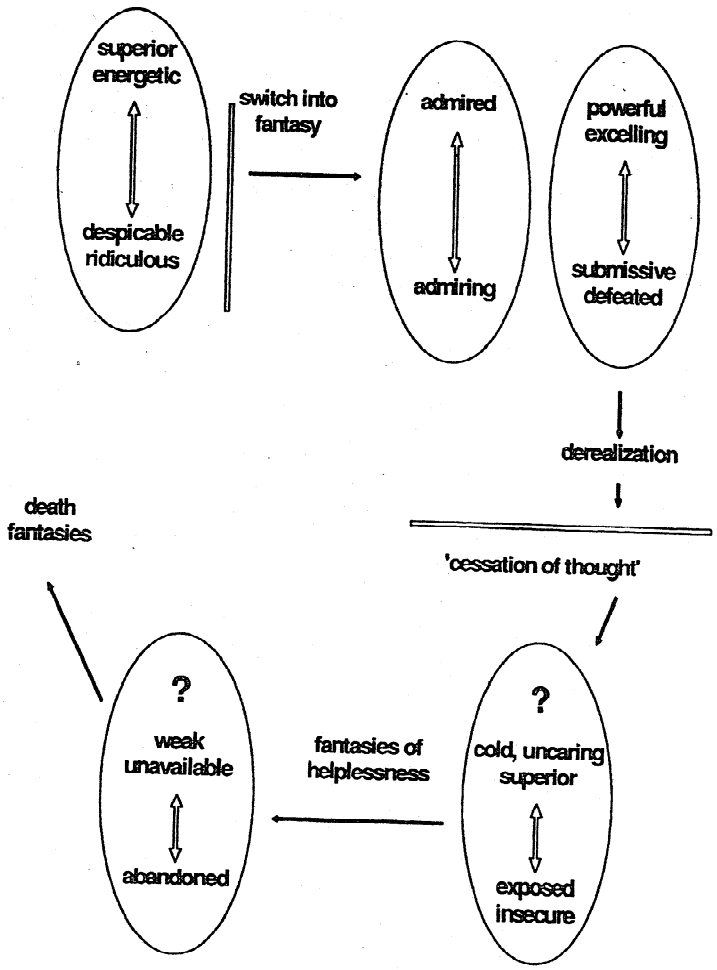

Figure 2. Dialogical sequence in the patient's dream state.

psychoanalysis of a 28-year-old married woman in a book edited by Dahl, Kächele & Thomä (1988). Recently, Dahl & Teller re-presented the case vignette when discussing the FRAMES approach as a mode of studying repetitive action sequences in psychotherapy (Dahl, 1988; Dahl & Teller, 1994; Teller & Dahl, 1986).

I shall first present the excerpt from the session and describe it by using the concept of dialogical sequences. I shall then compare this formulation with the FRAMES description, as provided by Dahl & Teller.

> And this makes me think of uhm, (stomach rumble) friendships I've had with other people and, something that I don't like to admit because I don't approve of it (chuckle), so I can't imagine anybody else would, but I seem to have to find fault with just about everybody that I'm friendly with to some degree whether it's just a small degree or a larger degree. And, even though in a way I might feel inferior to them, and I imagine I feel inferior to a lot of people, I still have to find fault with them and maybe criticize them to David, I don't know. I always have to openly criticize them, but in any case I have to kind've done that and then I can go on to a re-, a some kind of friendly relationship with them. And until I've done that I can't really accept them as somebody that I want to be at all close to in any

way at all. And, and if I can't, if I find I can't be critical of them in some aspect, then I just can't seem to be around them at all. I, I, I don't know, it's more than sort of being, well, it's not being in awe of them. It's just feeling very uncomfortable, I guess, with them.

The analysis begins with the identification of the salient dialogical moments in the narrative. In the quoted passage there are three clear instances that suggest one salient dialogical pattern with slight variations.

The first internal dialogical pattern is present in the expression '... something that I don't like to admit because I don't approve of it'. The patient is going to tell about something. A disapproving voice interferes and she would like to pass the whole issue. She is here speaking from the dialogical position of being critical.

The next sign of the dialogical pattern, the one that in fact contains it entirely, comes directly after the previous statement: '... but I seem to have to find fault with just about everybody that I'm friendly with to some degree whether it's just a small degree or a larger degree. And, even though in a way I might feel inferior to them, and I imagine I feel inferior to a lot of people, I still have to find fault with them ...'.

The salient pattern could now be tentatively defined by the positions disapproving, critical of vs. inferior to, defective. In her account the patient seems to alternate between these two positions both in her relation to herself and to others.

The third instance of this pattern can be found in the last statement '... if I find I can't be critical of them in some aspect, then I just can't seem to be around them at all. I, I, I don't know, it's more than sort of being, well, it's not being in awe of them. It's just feeling very uncomfortable ...'. She reemphasizes the importance of adopting the criticizing position and approaches the personal sense of the other position indirectly; it is not quite like 'being in awe' of the other, but it does seem to be something that is related to that attribute, inferiority perhaps.

In the next step of our analysis we try to identify an activity sequence that is mediated by the dialogical pattern. In the case of this patient, the quotation readily shows one such sequence that can be verbally described: **If close to somebody**, i.e. if a relationship becomes personally important, then **[critical ↔ inferior]. If critical → then friendly. If not critical,** →(*then inferior*) → **then avoiding.**

The dialogical pattern suggests two possible outcomes of the sequence. If the patient succeeds in adopting the critical position, she can go on with the relationship. If not, she is in the risk of becoming inferior. However, she is apparently not fully aware of this. Hence, the position is bracketed, as only the next step, that of avoiding intimacy is clearly visible.

Recently, Dahl & Teller (1994) have used the above vignette in their presentation of the latest developments of the FRAMES approach. The original prototypical pattern, presented by the authors in an earlier study, was a sequence of three summary predicates: *Thinks of friendships* → *Has to be critical* → *Can be friendly.* In their reassessment of this prototype they noted that they had overlooked the passage in the patient's statement that contained her feelings of inferiority. They then summarized the revised prototypical action sequence by the diagram in Fig. 3, which is reproduced here in order to compare it with the dialogical sequence formulation.

The general idea of an action sequence in the FRAMES approach is quite similar to the above cognitive analytic notation of procedural sequences. Both use an inductive strategy that may involve paraphrasing and abstraction in order to arrive at a prototypical description of problematic action sequences. The advantages of such a method are in the flexibility of identifying and describing the units of the patient's activity patterns and in the possibility of keeping the description close to the clinical material.

What is missing in the FRAMES, when compared with the dialogical sequence analysis, is the notion of dialogical positions within the sequence. In the FRAMES approach these reciprocal (or dialogical) positions are reduced to simple sequential events. The relevance of recognizing these positions in any description of action sequences is well illustrated by the above vignette. Being critical and feeling inferior to others represent the two contrasting positions, forming one dialogical structure. In object relations terms, the patient seems to have a powerful internal object, or a voice, to which she relates. Depending on which pole of the pattern she identifies with, she adopts either a critical or an inferior stance that affects both her self-perception and her relationships to others.

Discussion

It is reasonable to ask what, precisely, is the relation of the dialogical sequence analysis (DSA) to the two other descriptive models in cognitive analytic therapy, expressed by the

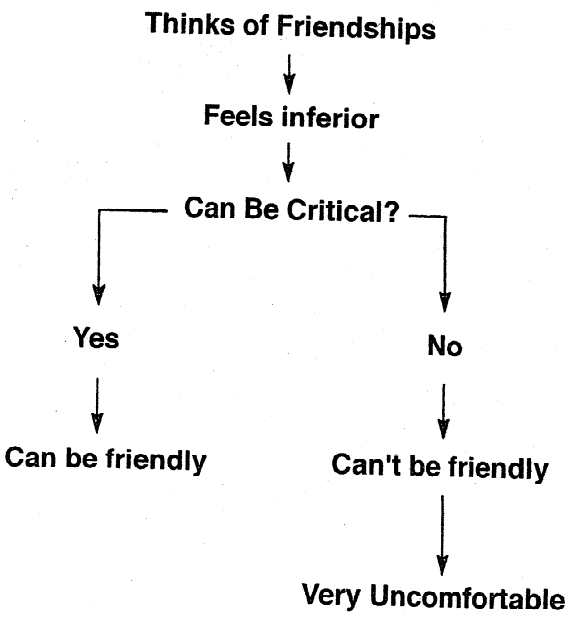

Figure 3. Critical/friendly frame prototype.

acronyms PSM and PSORM. Is it a clarification, extension, or a revision, perhaps even a suggested replacement of these currently fundamental tools of description?

I am tempted to claim that the dialogical sequence analysis is a modification, or a clarification, of the procedural sequence model, elaborating its cognitivist information processing elements by the notion of dialogical patterns that account for our mental activities. Thus the basic stages in the sequence, such as defining the aim of action (stage 1) or checking its congruence with other aims and personal values (stage 2), should be approached as platforms for internal (dialogical) events in which important internalized voices participate. Within such dialogues the person habitually adopts one or another position and, frequently, switches between the positions.

Although these aspects were not explicit in the PSM that used cognitive terminology to describe the sequence, Ryle himself has never been restricted by the 'monologic' thinking characterizing contemporary cognitive theories. When, for instance, discussing the compatibility of the PSM with other cognitive approaches he wrote:

> ... many phenomena, including several of the clinical states ... cannot be explained adequately unless it is assumed that the self includes both an executive and a conceptualizing and judging aspect. This is most notably true when there is a conflict between aims and judgements, or where the avoidance or relief of guilt by expiation or self-punishment becomes a salient aim. The understanding of these issues is one of the important contributions of psychoanalysis (Ryle, 1982, p. 37).

In the procedural sequence model, the judging aspect of the self was manifested in the self-identity criteria by which actions were planned and assessed (stages 2 and 6). Thus, two kinds of dialogical relationships were implied. Firstly, there was the relationship between the 'doer' and the 'judge'. Secondly, the 'judge' echoed the voices of the person's

caregivers as well as the compliant or defiant responses of the person. Thus, in the light of Ryle's own comments in the 1982 book, it appears that the notion of dialogical sequences is an explication of the dialogical understanding that was there but partially eclipsed by the cognitivist terminology in the schematic presentation of the PSM.

Another aspect of the dialogical sequence analysis is the suggestion that there are sequences of different kinds. Not all of them are circular, confirming or revising the initial aims and assumptions, as the PSM appears to prescribe. Rational problem solving may indeed be described by an orderly set of stages that run from aim definition to outcome assessment. George Kelly's view of man as a scientist (Kelly,1955) also rests on this type of implicit rationalism. Behind the DSA there is another metaphor of human activity. More than problem solvers, we tend to be stage managers providing space for unfolding dramas, frequently forgetting our role and engaging in the play.

The conception of dialogical sequences has been developed as a descriptive unit for psychotherapeutic practice. It is primarily used as a thinking tool by the therapist to guide his or her efforts at understanding what the patient is repeatedly enacting both in life and in the consulting room. It should also help the therapist reformulate the material succinctly, yet using the patient's own preferred mode of utterance, either by diagrams, pictures, gestured signs or words.

Because of this practical emphasis, the notion of dialogical sequences is an abstraction that focuses on the dialogical positions in the flow as well as on the strategic actions or situations that mediate the positions, accounting for the course of the sequence or the switch from one position to another. This is best illustrated by the first case vignette. We only describe the symptomatic procedural loop, to use the current vocabulary of the procedural sequence object relations model. Within the loop, however, the dialogical moments are spelled out. If they represent the core reciprocal roles of the patient, they will mediate other action sequences as well and also characterize interpersonal situations.

This is the chief merit of the proposed notation. By alerting the patient and therapist to the dialogical quality of any action pattern reformulation can begin at an early stage of the first session, or even at the assessment interview, by using whatever material the patient brings up. The therapist should only be aware of the fact that, at such a very early stage, only tentative hypotheses about the patient's salient dialogical sequences can be made. In human life there are no fixed meaning patterns that could be exhaustively described by our first impressions.

Like the earlier descriptive units of CAT the dialogical sequence analysis is a joint production of patient and therapist. If successfully done, it serves much like a Winnicottian transitional object for the patient constituting a sign of the therapist's continuing presence outside the consulting room. It is a living tool with the therapist's voice in it. It is to the patient a mediating device for a new, non-collusive dialogical pattern.

It is then important that the notation by which the reformulation is constructed should echo the patient's experience as well as the collaborative spirit of the reformulation process itself. If it is framed in foreign expressions and imposed on the patient, it can become useless, being only an edifice of the therapist's conceptual ambitions.

The notion of dialogical sequences has shown its usefulness in the supervision of CAT as well. It helps us make the whole process of reformulation easier to handle by making it stepwise. We may frequently recognize dialogical patterns in the first 5–10 minutes of

the taped first session both in the patients' accounts of their situation and in their manner of relating to the therapist. Symptoms and other presenting problems can be tentatively reconstructed as dialogically mediated sequences. At this early stage there is yet no urge to combine these separately identified patterns into a full sequential diagrammatic reformulation. We can immediately work with the material the patient presents to us, gradually addressing the question of how the problematic sequences are related. Using the dialogical sequence analysis brings us, in a way, back to the 'classical CAT' allowing us, initially, to work with single 'problem procedures'. The dialogical patterns in any such procedure frequently show up as the patient's 'core role repertoire' later on and it will then become possible to address the presence of different self-states and their mutual relationships.

The third case vignette suggests a further area in which the conception of dialogical sequences might be useful. In psychotherapy process research an increasing number of measures have been developed that aim at tracing recurring maladaptive action patterns in the patient's narrative. Luborsky's core conflictual relationship theme method is currently an influential measure in the psychoanalytically oriented process research field (Luborksy & Crits-Christoph, 1988; Luborksy, Popp, Luborsky & Mark, 1994). The FRAMES approach by Dahl & Teller, and the role relationship models configuration method by Horowitz (Eells, Horowitz, Singer, Salovey, Daigle & Turvey, 1995; Horowitz, 1987) represent somewhat more eclectic approaches to problematic interpersonal action sequences.

Dialogical sequence analysis may have its place within this family of research tools. The main difference between these measures and the DSA lies in the assumption that all of our mental actions are dialogically structured. We may thus detect reciprocal role patterns in many other aspects of the patient utterances than merely in those explicitly addressing interpersonal relationship issues. In this sense the DSA, being inspired by object relations theory and elaborated by the Bakhtinian understanding of dialogical phenomena, allows us to examine the truly multi-voiced nature of patient utterances.

Acknowledgements

Warm thanks are due to Mark Dunn, Psychotherapist, Raimo Puustinen, Lic.Med., Anthony Ryle, MD, Tim Sheard, MD, William B. Stiles, Ph.D and Jukka Vapaavuori, Lic.Psychol., who have contributed to the paper by discussing its themes and commenting on its various drafts.

References

Abraham, K. (1910). Hysterical dream states. In K. Abraham (1988). *Selected Papers on Psychoanalysis*. London: Carnac Books.

Bakhtin, M. (1984). In C. Emerson (Ed. & Transl.), *Problems of Dostoevsky's Poetics*. Manchester: Manchester University Press.

Beard, H., Marlowe, M. & Ryle, A. (1990). The management and treatment of personality disordered patients: The use of Sequential Diagrammatic Reformulation. *British Journal of Psychiatry*, **156**, 541–545.

Bollas, C. (1987). *The Shadow of the Object*. London: Free Associations Books.

Dahl, H. & Teller, V. (1994). The characteristics, identification, and applications of Frames. *Psychotherapy Research*, 4, 253–276.

Dahl, H. (1988). Frames of mind. In H. Dahl, H. Kächele & H. Thomä (Eds), *Psychoanalytic Process Research Strategies*. New York: Springer-Verlag.

Dunn, M. (1993). Some subjective ideas on the nature of objects. ACAT Newsletter, Nr 2, 16–17. London, UK, November.

Eells, T. D., Horowitz, M. J., Singer, J., Salovey, P., Daigle, D. & Turvey, C. (1995). The role-relationship models method: A comparison of the independently derived case formulations. *Psychotherapy Research*, 5, 154–168.

Hermans, H. J. M. & Kempen, H. J. G. (1993). *The Dialogical Self: Meaning as Movement*. San Diego, CA: Academic Press.

Horowitz, M. J. (1987). *States of Mind: Configurational Analysis of Individual Psychology*, 2nd ed. Northvale, NJ: Jason Aronson.

Kelly, G. (1955). *The Psychology of Personal Constructs*, vols 1 and 2. New York: Norton.

Leighton, T. & Ryle, A. (1995). How analytic is CAT? In A. Ryle (Ed.), *Cognitive Analytic Therapy: Developments in Theory and Practice*. Chichester: Wiley.

Leiman, M. (1992). The concept of sign in the work of Vygotsky, Winnicott and Bakhtin: Further integration of object relations theory and activity theory. *British Journal of Medical Psychology*, 65, 209–221.

Leiman, M. (1994). Integrating the Vygotskian theory of sign-mediated activity and the British object relations theory. Doctoral dissertation. *University of Joensuu Publications in Social Sciences*, No. 20. Joensuu: University of Joensuu.

Leiman, M. (1995). Early development. In A. Ryle (Ed.), *Cognitive Analytic Therapy: Developments in Theory and Practice*. Chichester: Wiley.

Luborsky, L. & Crits-Christoph, P. (1988). The assessment of transference by the CCRT method. In H. Dahl, H. Kächele & H. Thomä (Eds), *Psychoanalytic Process Research Strategies*. Berlin: Springer-Verlag.

Luborsky, L., Popp, C., Luborsky, E. & Mark, D. (1994). The core conflictual relationship theme. *Psychotherapy Research*, 4, 172–183.

Ryle, A. (1978). A common language for the psychotherapies. *British Journal of Psychiatry*, 132, 585–594.

Ryle, A. (1979). The focus in brief interpretive psychotherapy: Dilemmas, traps and snags as target problems. *British Journal of Psychiatry*, 134, 46–54.

Ryle, A. (1982). *Psychotherapy: A Cognitive Integration of Theory and Practice*. London: Academic Press.

Ryle, A. (1985). Cognitive theory, object relations and the self. *British Journal of Medical Psychology*, 58, 1–7.

Ryle, A. (1990). *Cognitive Analytic Therapy: Active Participation in Change. A New Integration in Brief Psychotherapy*. Chichester: Wiley.

Ryle, A. (1991). Object relations theory and activity theory: A proposed link by way of the procedural sequence model. *British Journal of Medical Psychology*, 64, 307–316.

Ryle, A. (1994). Projective identification: A particular form of reciprocal role procedures. *British Journal of Medical Psychology*, 67, 107–114.

Ryle, A. (1995*a*). Cognitive Analytic Therapy: History and recent developments. In A. Ryle (Ed.), *Cognitive Analytic Therapy: Developments in Theory and Practice*. Chichester: Wiley.

Ryle, A. (1995*b*). The practice of CAT. In A. Ryle (Ed.), *Cognitive Analytic Therapy: Developments in Theory and Practice*. Chichester: Wiley.

Shotter, J. (1993). Vygotsky: The social negotiation of semiotic mediation. *New Ideas in Psychology*, 11, 61–75.

Teller, V. & Dahl, H. (1986). The microstructure of free association. *Journal of the American Psychoanalytic Association*, 34, 763–798.

Voloshinov, V. N. (1973). *Marxism and the Philosophy of Language*. Cambridge, MA: Harvard University Press.

Vygotsky, L. S. (1978). In M. Cole, V. John-Steiner, S. Scribner & E. Souberman (Eds), *Mind in Society: The Development of Higher Psychological Processes*. Cambridge, MA: Harvard University Press.

Received 26 February 1996; revised version received 19 September 1996