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Dialogical Nature of Transferential Processes: Tacit Moral Frameworks

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Abstract

This paper explores the fundamentals of dialogism in psychotherapy. The role of transference and countertransference will be defined in their original meaning as well as how they are colloquially used in therapy today. These transferential processes will be redefined dialogically in contradiction to psychoanalytic and prosaic definitions today. Additionally, these authors will elucidate how a dialogically-redefined approach to transferential processes increases the therapeutic potential for counselors to explore offenders' moral frameworks, therefore increasing the opportunities for meaningful transformation.

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Vignette

John, a 16-year-old member of a local Crip gang, sat face-to-face with his therapist with whom he had worked for 4 months since he was admitted to a residential treatment center (RTC) for their substance abuse program.

The therapist set up the meeting to give John a heads up about threats being made against him. John listened carefully as the therapist explained that three members of a local Blood gang, also receiving treatment from the same RTC, had been plotting to "jump" him. The therapist reminded John that he was getting close to discharging to a lower level of care and a gang-related fight would not be looked upon favorably by this Child and Family Team.

The therapist worked hard to build rapport with John knowing from his prior placement at the same RTC, less than a year earlier, that John could not simply be told what to do or who to be. The therapist told John for four months that he would never be told what to do or who to be out of respect for the man. The therapist reminded John of this almost every therapeutic intervention: "This is just something for you to consider, John, to avoid fighting them at all costs, but I respect you too much to tell you what to do." The therapist's mentality had contributed effectively to building rapport with John.

> **John**: "I appreciate the good lookin', but I have no business *wit dem* boys."
> **Therapist**: "May I ask why?"
> **John**: "I want *outta* here. If *dis* was the *outs* [this] would *git* real but I want *outta* here. And I want to be done *wit* all *dis* gang [stuff]."
> **Therapist**: "I understand," the therapist recalled the many sessions John had processed about escaping the gang lifestyle. "Well, for what it's worth, I think you're making the right decision."
> **John**: "I won't *be* startin' [stuff] but if *dey* attack me it *ain't* in me to just take it. I want to know where you, as my therapist, would stand on that to my team."

The therapist thought silently, imagining to himself what he would feel like if he was in John's position. "I would never take away a client's right to defend him- or herself. That is your Constitutional right regardless of therapy. So, I will make a deal with you: if you promise me to remain in eyesight of staff at all times and aren't the initiator of any fight, but you physically defend yourself if you're *jumped*, I will back you up to staff and your CFT all the way." John nodded his head and verbally committed to the agreement.

John successfully discharged seven weeks later without incident. He thanked the therapist repeatedly in his last session for standing by him at all times and respecting him as a man and not as "*sum* client *wit* problems and [stuff]." John also processed about his desires to leave the "hood lifestyle," pursue a career installing audio equipment, and pass his GED. The therapist praised John for his hard work in therapy and the two parted ways with mutual respect.

Introduction

This foregoing vignette illustrates a therapist's experience while working at an RTC. At the time of his admission, John readily admitted to his therapist that he had not changed one bit since his first admission. When asked why, John reported that he felt like his prior therapist never listened

to him and always told him that his "stinkin' thinkin'" and "unhelpful beliefs" had to change. John reported that he felt misunderstood the entire time and that his gang lifestyle was constantly criticized.

John's case sets a precedent for a unique type of responsibility for therapists, one that is dialogical in nature as advocated for by phenomenological thinkers (Bakhtin, 1981; Baxter, 2004; Draper, Polizzi, Breton, Glenn, & Ogilvie, 2013; Levinas, 1969; Macmurray, 1999; Marion, 2002; Mensch, 2003; Morson & Emerson, 1990; Richardson & Zeddies, 2001; Richardson, Fowers, & Guignon, 1999; Taylor, 1991). This paper will discuss how this responsibility is understood dialogically, including through the use of transference and countertransference, how it establishes a new ethic in therapy, and the clinical implications it has for policy.

Dialogue and Transference

Dialogue. Dialogue is the primary method by which therapy can occur. For phenomenologists such as Makhail Bakhtin, there could be no social experience without language: "Social experience is always discursive" (Baxter, 2004, p. 14). Even when clients do not speak in therapy, they communicate dialogically via their body language and paralanguage (voice tone, rate of speech, prosody, emotional tone), and such language is still understood discursively by the recipient. According to Zeddies (2000), language is fundamental to human nature and is the only way we can learn about others and ourselves (Macmurray, 1999). Baxter uses, in a similar vein, Bakhtin's conception of dialogue in its first sense: as a constitutive process. Taylor (1991), building off of Bakhtin, presents the same idea in his essay *The Dialogical Self*, in which he establishes that there is no autonomous "self" (what therapists might refer to as the self-concept) but rather there is only a dialogical self that is understood in relation to others, in conversation with others. In other words, what these thinkers, however wittingly or unwittingly, share in common is their belief that engaging in ongoing dialogue is how identity is formed. There is no self-concept in the way it is commonly understood in mainstream psychology (Myers, 2005; Rogers, 1951) and beliefs about ourselves are not limited to autonomous self-schemas (Markus & Wurf, 1987).

Take the vignette of John for example. John knew who he was when he said it was not in him to take violence from another person or persons: "It *ain't* in me to just take it." However, he still inquired of his therapist as to where he stood in relation to this particular aspect of John's identity. How John acted upon that aspect of who he is was partially constructed by the therapist's identity *vis-a-vis* what the therapist would do in the same situation: refrain from initiating the confrontation and stay in staff eyesight, but if attacked, defend yourself.

John and his therapist simultaneously shared similarities and differences among their respective beliefs. Baxter (2004) describes the self, what Taylor (1991) calls the dialogical self, as "[t]he self of dialogism" that is always "a *relation* between self and other, a simultaneity of sameness and difference out of which knowing becomes possible" (p. 3). John and his therapist were able to reflect upon the same future possibility (being attacked) with personal beliefs that were simultaneously similar and different (the right to defend one self, but different views regarding how and why to exercise that right), and by doing so, were able to dialogically, and collectively, establish a course of action that still enabled them to remain true to their respective identities. (And both valued protecting John's welfare, even if it meant a conflict with his potential aggressors.)

This is illuminated by the fact that John knows he is a person who defends himself; he will not allow others to victimize him and assert their physical dominance over him. As a member of a Crip gang, he does not care about the laws of the land, including the rules and expectations of the current RTC. Simultaneously, the therapist is likewise a person who defends himself but respects the laws of the land and the rules and expectations of the RTC. In the moment when John said, "I want to know where you, as my therapist, would stand on that to my [CFT] team," both identities converged in the same time and space (what Bakhtin (1981) referred to as *chronotope*) as the

catalyst, or raw material, for something to be dialogically figured out, or co-created. The mutual process of co-creating became meaningful enough to John, and who he is, to act upon it after the therapy session.

John agreed to remain in staff eyesight at all times, an agreement that his therapist and other staff observed John upholding, when in the recent past, John would have taken it upon himself to seek out the rival gang members as an act of dominance. This agreement came from the belief of his therapist which John incorporated into his identity at that time, or chronotope, and then acted upon it because it had become meaningful to him. John referenced, in the seven weeks that followed, prior therapy sessions with his therapist as one of the influencers in his decision to quit initiating and provoking aggression toward his peers. John's identity was gradually being influenced by the co-created meaning between him and his therapist. Interestingly, this co-creation of meaning is indicative of what some therapists misunderstand countertransference to be, given that countertransference is believed to occur when the therapist shares subjective beliefs and experiences with the client. However, the original definitions of transference and countertransference would not support this current view.

Transference/Countertransference. In their original definitions, transference is when the patient unconsciously and habitually relates to the therapist as though the therapist as though they were someone like a caregiver figure from the patient's past (Kapelovitz, 1977); while countertransference is the emotional enmeshment of the therapist with their client's emotional state of being (Horacio, 2005). Based on these definitions, examples of each would be demonstrated, respectively, by a client relating to a male therapist as a father figure, and the therapist becoming emotionally enthralled with, and perhaps co-dependent toward the client.

Zeddies (2000) refers to two kinds of self-disclosure as therapists: one that is inadvertently done by the therapist and the other that is willfully and deliberately done. The therapist's self-disclosure in the vignette is undoubtedly type number two: "I would never take away a client's right to defend him- or herself. That is your Constitutional right regardless of treatment." This told John that his therapist believed in self-defense rights, that his therapist was aligned with him, and that his therapist was not his enemy. This ultimately conveyed to John that he could defend himself without fear or worry of his therapist giving an undeservingly negative report at his next child and family team (CFT) meeting. It also told John that his therapist understood the reality of his situation, and that reframing his "stinkin' thinkin'" and unhelpful beliefs was not going to protect him from three members of a rival Blood gang.

Through this kind of self-disclosure the therapist is also enabled to help John process his identity and beliefs in order to arrive at new meaning and understanding: "In doing so, the therapist's disclosures are communication that reveal important aspects of the [client's] experiences that the [client] is (temporarily) unable to symbolize, reflect on, and communicate with words" (Zeddies, 2000, p. 479). The difference between the dialogical approach and mainstream approaches is beautifully articulated by Richardson, Fowers, & Guignon (1999): "Understanding is achieved through a process of 'fusing horizons,' an attempt at achieving agreement" (p. 230), and "not a matter of miraculously breaking through barriers in order to empathize with another or reconstruct the other's mental process" (p. 231).

An effort to reach an agreement is diametrically opposed to mechanized approaches that amounts to an automated cycle of output/input: the client outputs his thoughts, feelings, and behaviors for the therapist to input and in turn output back to the client what the therapist believes is erroneous and distorted, therefore providing a therapeutic solution, or reframe, that the client is then persuaded through rapport to input as a dogmatic axiom. Dialogism in therapy does not lend itself to this oppressive tendency of manipulatively using rapport to "persuade" the client to think the same way the therapist thinks. "It is, instead, a matter of integrating another's horizon in such a way that the one's own outlook is changed in the process" (p. 231) so that both therapist and client are edified. These horizons of understanding that are fused (Warnke, 1987) consist of values, beliefs,

prior understanding, moral frameworks and strong evaluations (Taylor, 1989) of our moral aims and goals, and pieces of our own identity.

It is these kinds of values and horizons that inform therapists' practice. Without them, therapists disempower themselves (Christopher, 1996) and by so doing inadvertently disempower their clients. Where mainstream psychotherapy advocates value-neutrality (Richardson, Fowers, & Guignon, 1999; Slife & Williams, 1995), dialogism promotes a unique relationship between therapist and client that first, enables a safe exchange of ideas; second, values and empowers the client; third, models this exchange to the client; and fourth, enables the clients to synthesize the beliefs and values of others into his own. Dialogism purports that this kind of exchange is the key to people learning from others in ways that enrich their own lives (Richardson, Fowers, & Guignon; Richardson & Zeddies, 2001).

That the self "arises within conversation" (Taylor, 1991, p. 312) is synonymous with what Baxter (2004) was referring to when she builds on Bakhtin's sense of dialogue as constitutive of identity. Zeddies (2000) advocates that therapists use this type of self-disclosure to fuse their horizon (identity) with the client's:

> Rather, states of consciousness and unconsciousness are dependent on and emergent from specific relational and intersubjective contexts in which people come together and share aspects of their experiences with each other. In the clinical situation, therapist and [client] co-create an intersubjective process that weaves together the [client's] disparate threads of meaning and understanding into more complex and enriched tapestry, a process that cannot be fully appreciated by referring mainly to what one participant contributes to the dynamic interchanges (Zeddies, 2000, p. 479).

Paul Ricoeur (1970), speaking on transference in psychoanalysis, when attempting to bridging the gap between it and phenomenology, paid homage to what he calls the "derealized [unspoken] field of transference" (p. 390) as being responsible for "the return to true discourse" (De Waelhens, 1960). From this we gather that true dialogism cannot transpire without transference and countertransference. To converse without transference and countertransference would render the conversation dialectical (Baxter, 2004) and less relational and meaningful. By re-understanding these transferential processes as dialogical and relational, they cease to be neurotic unconscious processes and instead become shared positions of meaning, a matter of perspective in the conversation.

Basically, transference becomes the client's understanding of the person of the therapist and his or her experience and perspective. Countertransference on the other hand, is the therapist's understanding of the person of the client, and his or her experience and perspective. When are transference and countertransference problematic? As alluded to above, transference becomes problematic when the client relates to the therapist as more than such, e.g. father figure, abuser; and countertransference becomes problematic when the therapist becomes emotionally enthralled and enmeshed with the client. In their original definitions, transference and countertransference are inauthentic ways of relating, and to engage in such diminishes the healing value of the therapeutic alliance.

Therapists informed by first- and second-wave versions of CBT may be hesitant to entertain countertransference so freely, given the history of the term and its historically negative connotations. Indeed, most cognitive therapies hailing from the traditions of Beck and Ellis, which are more common in RTCs than correctional facilities, leave little-to-no room for it in practice. The same is true for most eclectic approaches given that many of them are void of any theoretical grounding (Slife & Reber, 2001). However, countertransference can be a strong sense of guidance for clients when its

use is theoretically and dialogically informed, even by third-wave variations of CBT. An example of this can be found in a form of CBT known as Social and Community Responsibility Therapy (SCRT), where the role that personal values play on cognition and ensuing behaviors are addressed in forensic psychotherapy (Wanberg & Milkman, 2014). Through the theoretical models presented in this discussion, or through others such as the aforementioned SCRT, client is able to learn key lessons and values from the therapist's revealed beliefs.

As stated above, Christopher (1996) calls to our attention the tendency of therapists, in their quest to be value-neutral or objective, to disempower themselves when working with clients by ignoring their values instead of allowing such values to dialogically engage with the client's values, through countertransference, in effortful ways to advantageously co-create meaning and identity. Ricoeur (1970) alludes to transference and countertransference as a means for the client to gain an instrumental advantage in overcoming psychological distress and gaining newfound strength. However, this is only advantageous to the client's on-going establishment of identity when it is co-created by both the therapist *and* the client in a dialogical relationship of fusing horizons.

Despite claiming to avoid countertransference, all therapists still self-reveal through Zeddies's first type of self-disclosure: the inadvertent type. Take cognitive-behavioral therapy for example. A CBT therapist, hailing from the traditions of Beck and Ellis, may never reveal explicit information of himself while working with clients. However, every time he reframes a so-called cognitive distortion, he reveals unarticulated information about himself to him clients. He is in effect revealing his beliefs by sending the message, "*I* do not *believe* that thought to be helpful, and therefore virtuous or of any value; ergo, it needs reframing." Just the mere act of calling a cognitive distortion unhealthy, or leading to unhealthy emotional patterns, presupposed it to be *bad* and signifies that it must be reframed into something that is healthy and therefore *good* (Richardson, 2005; Slife, Smith, & Burchfield, 2003). While this is not necessarily bad therapy two dilemmas still present themselves: first, it flies in the face of mainstream and other eclectic approaches purporting to be value-neutral and avidly avoiding countertransference; second, it leaves the hermeneutic crust intact (Polizzi & Draper, 2013a), meaning we fall short of allowing clients to *fully* reveal themselves.

While mainstream approaches no doubt provide counselors with excellent tools and skills that can be offered to the client, they cannot explore the full social, cultural, and historical synchronies of the client's life-world that make up his identity (Cushman, 1995). The end result is that they are never able to breach the hermeneutic crust—the taken for granted cultural meanings of a process like therapy and the definitions of "positive" or "negative" thinking, in the case of CBT (Polizzi & Draper, 2013a). These therapists, because of their undaunting, yet sometimes sabotaging, de-contextualizing and scientifically reductive theories and methods often fail to be self-critical and can perpetuate the very dynamics they wish to circumvent (Richardson, Fowers, & Guignon, 1999; Slife & Williams, 1995; Slife, Reber, & Richardson, 2005). Taylor (1985) acknowledges that this process has "turned out to be an embarrassment for everyone" (p. 47). This is tragic because, as Martin and Sugarman (2005) pointed out, all psychological inquiry must be faithful to human nature: what it means to be human and to have experiences. However, the hermeneutic crust can be breached when therapist and the client engage in a deep and meaningful sense of dialogue, one that permits the productive use of transference and countertransference, both are enabled to explore and interpret what it really means for the client to be a human being and to have experiences, which is the art and theory of hermeneutics (Martin & Sugarman); and to further recast those meanings into their relational contexts. Because of this shared experience, what a person means in therapy, and what the therapeutic context means to the participants therein, can change.

By dialogically interpreting what it means to be human and have experiences, therapists are able to break through the hermeneutic crust to find the background (Taylor, 1993) information and beliefs (what Zeddies (2000) is referring to in the unconscious) so that they can be reconsidered openly and honestly, in the backdrop of our relational human nature, with the client in an effort to learn more about him- or herself (Ricoeur, 1970), especially when transference and

countertransference become one of the vehicles for such dialogue. As this happens, the therapist can then offer new perspective and meaning to the client that first, enable him to re-experience his life-world in new ways and second, enable him to re-negotiate his place in society (and even re-negotiate what society means to a small or large degree). This new re-negotiation affords the client the opportunity to free himself of oppressive experiences that he may have inadvertently brought upon himself *vis-a-vis* his previous societal engagement:

> According to this perspective, individuals enhance the potential for experiencing the world in new and better ways if they bring out of the darkness of inarticulacy the old, familiar, and (ultimately) constraining patterns they (unconsciously [or consciously]) enact, a process that is grounded in language and, by extension, in dialogue and relationship (Zeddies, 2000, p. 477).

It is little wonder that Ricoeur (1970) pointed out that transference is the necessary path toward recovery. We would argue that transference and countertransference are inseparably connected with dialogism and its constituting effect on identity.

As an aside, similar perspectives have been expressed through the works of Gill (Stagner, 2005), who rejected Freud's techniques and methods in favor of a hermeneutic approach (which he ultimately abandoned due to unresolved philosophical dilemmas) that was designed to help clients find meaning. Grotstein (Merkur, 2010), influenced by the works of Wilfred Bion, posited that unconscious processes in the id and ego could be articulated through phantasy and dream exploration in psychoanalytic dialogue. More recently, psychodynamics has attempted to promote greater acceptance of and commitment to one's internal processes, e.g. personal values, by incorporating evidence-based practices from dialectical-behavioral and acceptance and commitment therapists (Stewart, 2014).

Clients engage in two kinds of transference in therapy: immediate and habitual. Both kinds of transference emerge in relation to others and reveal important information about how clients have negotiated their social roles. However, the therapist need not always therapeutically dig for deep-rooted meaning, trauma, or childhood experiences to understand either type. When understood prosaically, these kinds of transferences merely reveal their embodied (Marion, 2002) ways of relating to others.

Immediate transference and countertransference involves the emotional actions/reactions we have with others in our relationships that are not necessarily based in long-term habit, but something more immediate. Take John's statement, "It *ain't* in me to just take it," for example. If his therapist has questioned him about his unwillingness to comply with treatment and lack of receptiveness toward therapeutic intervention, he may have felt wrongfully judged (recall that he explained the day of his second admission to the RTC that he felt misunderstood by his therapist), may have felt compelled to verbalize his frustrations to his therapist. This would not have necessarily been habitual, but rather a direct response of something more immediate: John's therapist's misconceptions of him, and the two would have had to clarify the misunderstanding. In these cases there is no need to evoke elaborate constructs, when it is all a common-sense process of two people trying to relate to one another (prosaic dialogics).

Habitual transference/countertransference occurs when we habitually act and react with others in an emotional way because that is what we have typically done. For example, a client with a long abuse history habitually distrusts male authority figures. As a therapist tries to work with him, the client will habitually distrust the therapist. This has to do with something entirely prosaic. He is in the habit of distrusting authority figures, the therapist is an authority figure, ergo the client distrusts the therapist. Clients and therapists are not always fully aware of their habits, but therapists should

strive to grow in awareness of their own. One possible way to be aware of such habitual ways of relating can be found in the writings of Charles Taylor.

According to Taylor (1989), "nature's voice", and our inner connection to it, became a constituting source of identity around the 18th century in response to the radical enlightenment. Taylor demonstrated how this paradigm of inner nature consisted of not only our need for unlimited access to it internally, but *only* each respective individual could receive their own personal messages from it within:

> This radical individuation was obviously facilitated by expressivism and the notion of nature as a source. What this voice of nature calls us to cannot be fully known outside and prior to our articulation/definition of it. We can only know what realizing our deep nature is when we have done it...? If nature is an intrinsic source, then each of us has to follow what is within; and this may be without precedent. We should not hope to find our models without (p. 376).

The connection between "nature's voice" (Taylor, 1989) and therapy is this: inner nature becomes constitutive of individuals' identities and influences their embodied and habitual ways of relating to others (Marion, 2012). What is not inner nature is therefore "outer" like another person's thoughts feelings or perspective. Furthermore, these inner/outer barriers further separate individuals from each other in society the potential for alienation and further oppression because it maintains the dichotomous status of *self* and *other* and promotes an empty individualism. This process unfortunately prompts people to look within for meaning, and that the meaning they find there may only be true to them individually. Unfortunately, as Cushman (1995) points out that looking within for meaning can help, but ultimately those who continue to seek within for meaning find that meaning exhausted quickly. Using transference and countertransference, therapists would help clients "speak" to this embodied and habitual way of relating/Being and empower that voice (when it's authentic to empower it) *and then* to help them fully engage in dialogue with others who also speak their own voices, breaking them out of their own individual world of internal meaning. The hermeneutic/dialogic position breaks down the artificial barrier of "inner" and "outer" when it comes to the self and to relationships which in turn can help clients re-negotiate their roles in said relationships with the hope of diminishing the cycle of oppression and alienation in society.

In John's case, he had learned how to take a different role with his therapist. John had previously viewed people "in authority" as the enemy and untrustworthy, causing him to relate to them defiantly and aggressively. However, as his therapist, an authority figure, dialogued meaningfully with him, he had learned to relate more cooperatively. John had learned to trust an authority figure, not only enough to open up to him but also to heed his counsel.

Recasting "nature's voice" relationally, without inner/outer barriers, speaks to our dialogical nature as human beings and provides an avenue for reevaluating our own habits of relating. Lysaker and Lysaker (2005) talk about the kind of dialogical positions that Bakhtin and Nietzsche described. These dialogical positions are like difference voices of ours and fall into two categories: first-order-positions are comprised of the operating roles we take up in society (e.g., self-as-fireman, self-as-brother, self-as-father, self-as-student, self-as-citizen); and second, metapositions are our reflexive positions (e.g., self-as-successful or self-as-failure) and emotional positions (e.g., self-as-sad or self-as-happy). Additionally, metapositions can become first-order-positions (e.g., self-as-criminal or self-as-successful). Lysaker and Lysaker explain that the simultaneity of these positions is constitutive of what Bakhtin refers to as our polyphonic (multi-voiced) nature. These various dialogical positions, voices, are in constant flux as individuals dialogically relate to others and their life-world, continuously aligning and realigning themselves hierarchically. It is precisely these roles that constitute our identity (*cf.* Baxter (2004) and Taylor (1991)) and enable us to re-cast "nature's voice"

(Taylor, 1989) in a relational and contextual light, leaving behind the paradigm of the highly autonomous individualized self.

Lysaker and Lysaker (2005) explain that we engage these roles habitually because they are intertwined and "partly constitute the existential praxis that form the bases of our being-in-the-world" (p. 10). In other words, therapists habitually self-disclose because the various positions they take up when relating to the world around them, including their clients, are their primary modes of being, which consist of various values and beliefs, what Gadamer termed "prejudices" (Warnke, 1987).

Recall Taylor's (1989) articulation of strong evaluations and moral frameworks. Strong evaluations are what we deem as aims and goals worth pursuing. As these strong evaluations are formed, they are then categorized and ordered based on importance into moral frameworks that constitute our sources of good or the good life. They become moral sources to us. These moral frameworks in turn determine our ethical space: our place in the world. It is this ethical space, which includes our moral frameworks that habitually guide our dialogical positions when relating to others. In so doing, they are habitually revealed through transference and countertransference; i.e. they are the "tidbits of information" that Zeddies (2000) referred to. Furthermore, the degree to which we relate to, and continue to relate to others will influence the fluctuations of our moral frameworks. In other words, moral frameworks are never finished, they are never decided upon once and left as such. Many times our moral frameworks are influenced and renegotiated by the moral frameworks of others as we participate in them through transference and countertransference.

Take the case of John. When he asked his therapist where he stood, the therapist shared a strong evaluation: "I would never take away a client's right to defend him- or herself regardless of therapy." A therapist adhering to a mainstream approach may have challenged the client's "stinkin' thinkin'" and/or unhelpful beliefs as had been done to John previously, causing him to feel misunderstood. That the therapist shared a strong evaluation had a profound impact on the client, to the degree of even influencing John's decision to incorporate them into his own strong evaluations.

It is precisely this kind of profound influence on a client's identity (dialogue as constitutive [Baxter, 2004]) through countertransference that creates the catalyst for a dialogical responsibility that therapists have to their clients. A therapist can either jump to correcting "unhealthy" thoughts which often leaves the client feeling misunderstood, or open himself up to a dialogical approach where the client can feel understood and a solution can be proposed, and agreed upon, that relates to the client's current horizon and leave open the future possibility of further dialogue.

A New Ethic of Dialogical Responsibility

Dialogical responsibility can be thought of a therapist's responsibility to engage in dialogue with clients regarding choices, options, and lifestyles (Chessick, 1996) because of their relational and *unfinalized* (Baxter, 2005; Edinast-Vulcan, 2008; Morson & Emerson, 1990) nature. This is even more so the case considering Macmurray's (1990) argument that communication with others is our primary source of knowledge. This is not exactly unprecedented as evidenced in the works of Gordon Allport, who sought to break away from the closed systems of psychodynamic therapist by created an open system with his Trait theory (Engler, 2006).

Clients will inherently make choices based on their strong evaluations of what constitutes the ends they seek and their conception of the good life, or in other words, their moral frameworks. Therapists have the dialogical responsibility of providing the necessary information to clients that will influence when and how they evaluate their strong evaluations so that they can make well-informed choices that will impact how they grow and develop in life.

The Ends We Seek and The Good Life

As previously mentioned, it has been argued that all people live their lives according personal moral frameworks established from strong evaluations, which are contextually situated and co-constructed (Taylor, 1989), regarding the personal aims and goals they pursue. These moral frameworks and strong evaluations constitute a certain *telos* that provides meaning, governs behaviors, and can even impact emotional aspects. More to the point, these moral frameworks make up clients' perception of the good life which motivates them.

That clients seek certain ends necessitates the responsibility of the therapist to dialogically assist them with evaluating these ends, especially because doing so can profoundly impact how they relate to others and negotiate their place in society. In the example of John, the therapist evaluated his moral frameworks to fight back and not be victimized by others. Being informed by his own rights for self-defense, the therapists conceded to John's rights for the same. However, the therapist still dialogically re-negotiated a modified *telos*, or strong evaluation, for John's consideration by encouraging him to do everything he could to avoid the opposing gang members and remain in staff eyesight. Dialogically, the therapist vindicated part of John's idea of the good life by stating he would "never take away a client's right to defend himself regardless of therapy," but also sought to re-contextualize self-defense as a last-measure and not a primary go-to strategy.

John is not oppressed by his therapist's own expectations of the good life or by any theoretical tenets of a mainstream therapy. His therapist very well could have chosen to process with him about how his belief that, "It *ain't* in me to just take it," was irrational or distorted, or that fighting is an oppositional behavior that needs to be abandoned altogether. These can be perceived by clients as oppressive to their identities and/or their choices. However, this was not the case for John. Instead, John felt vindicated as a human being and his agency respected. Dialogically, an agreement was made that brought the client to a greater sense of truth and understanding (Warnke, 1987) and to re-evaluate his own moral frameworks, all while still preserving his right to choose for himself without the penalty of therapeutic consequence.

This is also an example of the therapist's own moral framework and strong evaluations revealing themselves in therapeutic dialogue. It is arguable that such a therapeutic compromise could not have occurred if the therapist had not been informed by his own sense of purpose and role in society. This further necessitates the dialogical responsibility of therapists to be constantly aware of their own moral frameworks, willing to re-evaluate their own (especially when calling upon clients to do so), and to remain dialogical when relating them to the client.

It is well known by all practicing therapists that there is a certain ethic, or responsibility toward clients: *do no harm* (American Counseling Association, 2014; American Psychological Association, 2010). However, when therapy is re-cast in the light of relationality (Heidegger, 1962; Macmurray, 1991; Martin and Sugarman, 2005; Richardson, Fowers, & Guignon, 1999; Slife, 2004), the standard ethic is reformulated into a new ethic: one of dialogue with the client, but not in its traditional dialectical (Baxter, 2004) sense of cyclical input-output-output-input. Rather, the new ethic that is created is the kind of dialogical relationship with a client that promotes safe conversations (Glenn & McCormick, 2015). It is a new ethic "which has moral as well as epistemological dimensions, [and] entails... *critical openness*" (Martin & Sugarman, 2005, p. 275, authors' emphasis). In some ways, it is "like learning to be a good conversation partner" (p. 275).

This new ethic points to the responsibility of therapists to be more than just therapists: they also need to be good persons. Persons with their own moral frameworks and strong evaluations of how to achieve the good life since it is precisely these that will inform their practice (Christopher, 1995; see also Cormier & Hackney, 2011; Fowers, 2005). It also points to the responsibility of therapists to evaluate the ends they seek in therapy in order to match them up with the ends of chosen theoretical orientations. This involves the responsibility of therapists to be honest with themselves about the theoretical orientations they employ in practice, eclectic or not, and whether they are true to human nature and achieving the good life (Richardson, Fowers, & Guignon, 1999; Slife, Reber, & Richardson, 2005).

There may be some hesitation on the part of therapists to employ this new ethic in an effort to remain value-neutral. There is good cause for this as therapists do not want to lend their practice to dogmatically pushing values on clients. However, without values, i.e. strong evaluations, we are left with nihilistic relativism, a sort of unhealthy chaos. Instead, when values become informative rather than oppressive or coercive, then moral frameworks and strong evaluations are dialogically situated within a fusion of horizons between the client and therapist.   Such dialogue is necessary because human beings by and large are always already *unfinalized* beings in dialogue (Morson and Emerson, 1990), hence the reason to constantly re-evaluate ends being sought after.

Unfinalized and Pivotal Role

Two of the authors have discussed the *unfinalized* nature of human beings elsewhere (Draper, Polizzi, Breton, Glenn, & Ogilvie, 2014). There, we discussed what Bakhtin means by *unfinalized* beings in dialogue: beings who take up meaning in their participation in relationships. We identified *finalized* beings as those who "lose Being" (p. 20) and their individualized capacity to engage in meaningful relationships in unpredictable ways. We recounted Bakhtin's argument that the *unfinalizable* nature of dialogue sets a unique precedent for responsibility to contribute to relationships and dialogues in ways that co-create meaning for themselves and others. In other words, therapists play a pivotal role in the crossroads of their clients' lives by assisting them in co-creating meaning and truth that can serve as teleological moral frameworks and strong evaluations (Taylor, 1989).

Levinas (1969) also wrote about a similar concept which he referred to as yet-to-be. This *unfinalized*, yet-to-be mode of existing curtails the importance of understanding that our clients are not finalized. Erdinast-Vulcan (2008) demonstrates how Bakhtin makes a radical move from the "said" to the "saying" in his form of dialogue. In other words, Bakhtin creates a new ethic of understanding each human being as a being-always-in-process-of-becoming that has "not yet uttered his final word" (Bakhtin, 1984, p. 59). Erdinast-Vulcan explains that the ethic is created here per a person's conversations with others and how such conversations constitute their being-always-in-process-of-becoming. It is through the co-creation of meaning and truth that human beings "become" individuals, ironically through their relationships with others. However, there is a certain element of subjectivity here.

Contextual truth and meaning are indeed subjective constructs between two or more individuals. However, Bakhtin embraces this subjectivity by insisting that it is formed through, and as an outgrowth of, dialogue; and, this kind of subjectivity is not only essential to the constitutive role it has on a person's identity formation (dialogue as constitutive [Baxter, 2004]) but that its authority comes from the structures of dialogue with the Other rather than the Other and a person's agency to choose (Erdinast-Vulcan, 2008). This means that therapists have not only the responsibility of focusing on the subject matter (Warnke, 1987) of discourse in therapy, but a new ethic is created from what Bakhtin recognized as "an attitude of "facing" the other in a dialogic relationship, a position of choice" (Erdinast-Vulcan, p. 56), while accepting responsibility for the influence we have on others.

When we "face" our clients, we maintain that attitude of *critical openness* (Martin & Sugarman, 2005) in our dialogue. We do not finalize them in cognitive processes (Erdinast-Vulcan, 2008) and therapist's ventriloquist dummies (Polizzi, Draper, & Anderson, 2013) who merely utter back what the therapist would have him know or believe. This attitude of "facing" the client, as the therapist did in the case of John, effortly to "face" the issues and challenges presenting in the client, as well as to face their *unfinalized* nature of "yet-to-be" (Levinas, 1969).

One of the authors of this article was working with a 13-year-old female client in a group setting. That client was processing about her drug abuse, having to give up all her friends to turn her life around, and trying to establish who she is *vis-à-vis* her new chosen path of sobriety and pro-social behavior and without her prior friends who still partook in abusing substances and get into trouble often. She expressed feelings of sadness, anxiety, joy, and hope. During the course of dialoguing

with the client, one of the authors asked her what her assigned therapist for individual therapy had been saying. To which she replied, "[My therapist] just says I have depression."

The attitudes we take up with our clients are matters of choice. We can choose to finalize our clients as dehumanizing diagnoses, distorted cognitive process, or irrational core beliefs, and by so doing, risk inadvertently perpetuating societal forms of oppression. We can also choose to "face" our clients in their true nature as *unfinalized* beings comprised of ongoing dialogue and play a more pivotal role in their overall growth and development which can potentially help them re-negotiate a non-oppressive role in society. "And making choices is what ethics is all about" (Erdinast-Vulcan, 2008, p. 56), ethics which justify responsibility and in turn inform policy.

Implications for Policy

That therapists who understand this new model of transference and countertransference can utilize an alternative dialogical approach of *critical openness* (Martin & Sugarman, 2005) and make it part of practice policy in prison.

Currently, CBT is the norm, and sometimes by policy, in prison given the seeming preponderance of empirical data relative to therapeutic outcome (Wilson, Bouffard & Mackenzie, 2005; Baro, 1999). However, a closer look at the empirical data reveals an interesting finding overlooked by prison healthcare administrators. Some meta-analyses of CBT and outcome demonstrate that CBT is no more effective than other forms of therapy (Culipers, van Straten, Andersson & van Oppen; 2008; Oei & Free, 1995). Additionally, some recent meta-analyses have demonstrated that the effect of CBT is actually falling for some disorders (see Johnsen & Friborg, 2015). In fact, even when considering the effectiveness of CBT, little of the actual beneficial effects of CBT are due to the empirically studied techniques. Rather, Norcross and Wampold (2011) found that the degree and quality of rapport that the client has with their therapist predicts positive therapeutic outcome far more than any other factor.

In light of this, forming psychotherapy treatment policy that encourages forming a strong therapeutic relationship, rather than one that requires a particular method of treatment to the exclusion of others. We propose this tentatively, however, because policy does not really control behavior so much as give method or reason to punish noncompliance. With the relationship between counselor and client taken up as foremost import, both counselor and client can attend to the implicit and explicit transferential and countertransferential meanings that always already contribute to the dialogue anyway. Rather than dismissing or ignoring these processes, the therapist can be encouraged (in practice, not necessarily in policy) to attend to them and encourage the client to do the same. By attending to and making explicit many of these implicit processes, therapy becomes a matter of mutual respect and negotiation, rather than a one-sided dictation of what is helpful or healthy. In the case of John, for example, the therapist did not just prohibit or deflect the client's question about the violence that may happen. Instead, the therapist reflected an understanding and validation of the client's issue, and even committed to advocate for him under conditions both of them understood and agreed upon. Because the dialogue involved explicit mutual understanding through the transference and countertransference, a communication of messages usually left unspoken, the dialogue between the therapist and client in this case proved authentic and helpful for the client.

The ideas of authentic dialogue are not new, and there are indications that other researchers have taken similar ideas to prisons that inform practice. For example, Ward and Gannon (2006) describe the Good Lives Model (GLM) as a model of treatment in prison. Ward identifies what he calls "primary goods" and "secondary goods" (p. 79). Primary goods are those needs we all have as human beings and include:

1. Life
2. Knowledge
3. Excellence in work

4. Excellence in play
5. Excellence in agency
6. Inner peace
7. Friendships/relationships
8. Community
9. Spirituality (meaning and purpose)
10. Pleasure
11. Creativity

Ward and his colleagues argue that these universal human needs are non-problematic in and of themselves. However, how people go about achieving those goods he calls "secondary goods." These secondary goods may or may not be problematic depending on two issues. First, whether or not these secondary goods are harmful to others, and second, whether or not meeting these secondary goods actually or potentially prohibits meeting the primary goods later. In the case of John and his therapist, for example, both valued the primary good listed first, and that is life. Iit also involved agency (self-determination for the therapist and client) and relationships (gang affiliation for the client, but also the relationship of the therapist *and* client). The reason they could connect on this issue is because both shared these primary goods and the therapist was open to the experience of sharing a good in common with the client. Granted, the therapist would also share that there may be other ways of obtaining these primary goods through means that will further them (more prosocial) better than other secondary goods (antisocial or criminal activity). The client can help the therapist to determine whether or not that is possible in their lives, and if so, how (and if not, why not).

Through navigating these secondary goods to obtain these primary goods, the therapist and client attend to these transferential and countertransferential processes as they dialogue about what their mutual goal is or will be. By encouraging openness about this process, they are more likely to fuse horizons, which means to come to a mutually-informed understanding of the issue and potential solutions than either of them had individually. Ward and his colleagues already report tentative success with this more relational model in a variety of settings (Purvis, Ward, & Willis, 2011; Ward & Marshall, 2004).

The insights offered by Ricouer on the dialogical nature of transference and countertransference, treatment ceases to be a dictatorial relationship wherein the therapist keeps his or her subjective position to him or herself (which given the implicit and explicit nature of transferential processes is impossible) and becomes a relational process instead, where these processes are an important part of the dialogue wherein both participants might be transformed.

Conclusion

This discussion has set out to connect the aspects of therapy known as transference and dialogue into a cohesive element that facilitates safe, non-oppressive conversation with clients that enable them to re-evaluate the ends they seek toward the good life. Since clients are *unfinalized* beings, counselors are charged with a new ethic of dialogical responsibility that also have critical implications for policy. This discussion has mirrored a similar purpose of Martin and Sugarman (2005) that:

> is less to convert readers to a particular set of assumptions than it is to invite them to frame their own critical encounters with the material they study [and live by] in terms of a respectful and attentive, yet probingly honest, conversation (p. 276).

This includes the conversations that they have not only with themselves, but with their clients.

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