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Negotiating Alternative Constructions of Disorder Between the Client and the Therapist During the Psychotherapeutic Dialogue

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The case of a 67-year-old man, who had a year-and-a-half long psychotherapy with the author of this article, is presented to illustrate the process of negotiation between client and therapist about the meaning of his symptoms. Mr. B's symptoms were intrusive pictures of a sexual nature, pointing towards obsessive-compulsive disorder. However, he had a number of psychotic breakdowns throughout his life and had been diagnosed as schizophrenic on several occasions. The exploration revealed that his construing of his symptoms—and, more so, his construing of self—were highly influenced by his 12 years of psychoanalytic psychotherapy. He was pre-emptively holding onto this framework, which might be explained by his limited ability to organize his experience around a functioning core identity. One of the lessons for the psychotherapist was about limitations in the person's ability to change. Some experiences might have occurred in formative years—whatever they may be—and work like imprinting (or "freezing of the meaning-making process"), which made the constructs developed at that time held on to as if "life depends upon them". In the case presented, both client and therapist moved slowly (if at all) towards re-construing of the disorder, respecting the existing framework that had almost become an identity. The main therapeutic tool was the psychotherapeutic relationship that worked as a "container" for a very fragile self.

Keywords: constructivism, psychotic breakdowns, developing a new narrative

On Alternative Constructions of Disorder

> People perceive the world from a point of view, and differences between subjective points of view need to be resolved thorough interpersonal communication and negotiation. In constructivist psychology, individuals and the societies they form create representations of disorder as part of the human effort to draw meaning from experience. (Raskin & Lewandovski, 2000, p. 16)

One of the dominant constructions of mental disorder in Western societies is the Diagnostic and Statistical Manual (DSM). DSM has been conceptualized as an "impartial, scientifically based system that describes naturally occurring phenomena". Indeed, formal diagnosis (such as the one used in the abstract) classifies people and provides an idea about a pattern of disorder. However, there are many ways of understanding human distress, and, at the most general level, these ways should be thought of as human inventions rather than reality. Raskin and Lewandovski (2000) made a substantial effort to show that DSM-IV is a cultural construction rather than a scientifically based classificatory system, as claimed by its authors. The far too common problem in the construction of disorder as suggested by DSM-IV is that it provides dominant viewpoints that hardly allow other, alternative interpretations.

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However, DSM-IV is not the only dominant framework for construing mental health problems. There are other major systems, such as psychoanalysis, behaviorism, etc., that could be equally pre-emptive and at some point present an obstacle to the therapist's best efforts to help a person in psychological distress.

The important assumption here is that a particular construction of disorder may affect the person's construction of self and lower or raise the level of distress they may suffer.

There is a choice. The therapist is in the position to choose the best system/framework for understanding a disorder. In their review of empirically validated treatments, Roth and Fonagy (1994) demonstrated how some constructions of disorder work better for some clinical problems, therefore the idea of "treatment of choice". On the other hand, there are equally convincing voices promoting humanistic therapies, described as "growth orientated and meaning making models" (Bohart, O'Harra, & Leitner, 1998, pp 141-157p.). Generally, these models are not meant to be specific treatments for disorder; rather, they aim to provide a growth-producing climate that may or may not result in symptom reduction. "The therapist is treatment of choice, not the therapy, nor any treatment package" (Bohart et al., 1998, p. 145), therefore therapeutic relationship (and not the "empirically validated" techniques) would be the main agent of change.

For clients, accepting alternative construction of their disorder may be a difficult, sometimes impossible task. Clients have their ways of construing a disorder, based on common knowledge, culture, and previous experience with mental health professionals, including psychotherapists. To start with, the therapist should find out what the client's construction entails, including both verbal as well as pre-verbal constructs.

Finding the best framework with a particular client may take some time, and Kelly's (1955) transitive diagnosis is a very useful concept. I hope to illustrate the process of negotiating and re-negotiating the conceptualisation of the problem between the client and the therapist and the therapeutic usefulness of it. The client was a 67-year-old man who was referred as suffering from obsessive-compulsive disorder, but had also suffered a number of psychotic breakdowns throughout his life. It took time for the therapist to understand his conceptualisation of his condition and to offer alternatives. The outcome was a compromise between different conceptualisations of disorder.

The Person and His Problem

Some of the data have been deliberately changed in an attempt to protect the client's anonymity.

Mr. B was a 67-year-old man who had a year-and-a half long psychotherapy with the author, comprising 41 sessions in all. His main complaints at the time were intrusive pictures of a sexual nature. A careful psychiatric exploration brought the conclusion that the "pictures" were not hallucinations, therefore the diagnosis.

The therapist took a credulous approach and did not check the client's medical notes at that time. The assessment interview revealed a life-long history of "neurotic disorder", several serious psychotic breakdowns, and 12 years of psychoanalytic psychotherapy. Mr. B's family of origin were poor, second generation Jewish immigrants. He did well at school and graduated on one of the respected universities, where he also completed his MA. He managed to keep different jobs for some 10 years after graduation. His first psychotic breakdown occurred when he was 26, followed by a number of psychotic episodes over period of 40 years.

Mr. B married aged 36 and divorced 10 years later. The couple had two children. He described his ex-wife as a cold, obstinate person "with no deep feelings". She became a devout Christian and introduced children to

the same rigid sect. By the time Mr. B reached middle age he was already unable to hold any job, and has been on a Disability Living Allowance ever since.

His treatments included a psychiatrist's interventions and psychotherapies, some of them quite short. He stayed in his long-term psychodynamic psychotherapy as long as he was able to pay for it, seeing his therapist occasionally after termination. His analyst died 10 years ago.

The problem at the beginning of this therapy:

1. Intrusive images. "My images are awful. It is my racing mind that produces them". He looks in the mirror and sees his face with a big penis for a nose and anus for a mouth. He makes faces in the mirror, feeling this as a compulsion. He sees people in the underground with their sexual organs on their faces. His brain "is polluted with rape scenes, scenes of homosexual rape". There was a repetitive image of his brother raping him.

2. Identity. "Who am I? A little girl? A homosexual? The idea of being homosexual was repulsive". He did not want to be seen with male friends in case someone might think he was a homosexual.

3. Emotional maturity. "Emotionally, I am a three-year-old child. I would like to grow up".

4. Normality. "I am a person with an affliction. I would like to feel normal".

Construing a Disorder: The Therapist's, the Patient's and Wider Constructions (i.e., Languages of Disorder)…

None of the theoretical models at hand seemed to fully explain this person's functioning, and so, the pluralistic perspective in construing his problem was felt to be the right choice.

Several constructions of disorder were taken into consideration.

According to DSM-IV, intrusive pictures would be a symptom of obsessive-compulsive disorder (OCD). The etiology of OCD is not well understood, but there is some evidence that it may have an organic/neurological base (DSM-IV; Insel, 1992). Alternatively, the pictures could be hallucinations. Mr. B did not seem to have other OCD characteristics at the time and he did not seem to be psychotic. He was extremely punctual in attendance and he always looked well cared for. He seemed to be able to keep a proper distance during the therapy hour, although his relationship to the therapist evolved into a dependency beyond the one expected or wanted. His "obsession" with his pictures seemed understandable, given the amount of distress they caused.

An alternative construction was attempted using Personal Construct Theory (PCT). Mr. B was a very loose construer and as such closer to Bannister's disorganized schizophrenic than to obsessive-compulsive disorder. According to PCT, an extremely loose construer would be a person who suffered serial invalidation during formative years. In order to protect himself/herself from further invalidation, person develops loosely organized construct system that is relatively invulnerable to invalidation (Banister, 1962). The same author described "residual islands of structure" that should be validated and expanded in psychotherapy (Banister, 1975). Leitner (1997) and Leitner, Faidley, and Calentana (2000) introduced the idea of "structural arrests" that caused "the freezing of the meaning-making process such that self, other, and relationships are predominantly experienced as they were in these earlier periods of life" (pp.417-32 p.). Lorenzini, Sassaroli, and Rocchi (1989) differentiated paranoid from schizophrenic premorbid predictive systems, a conceptualization that may explain Mr. B's movements from relatively fragmented thinking to psychotic paranoid episodes, and back. The first one is characterized by "scanty hierarchical organization and scanty integration", whereas the second one presents with "high degree of integration and scanty differentiation". Both protect the person from invalidation of their predictions.

During this therapy, Mr. B was desperately searching for an identification figure, but nothing was long lasting. The identification figures were picked up from history and literature, apparently at random, although his disgust with himself was a common theme. (I am Hitler; I am Rasputin—the killer of an old woman; Am I a homosexual? A Jew or not a Jew?). His predictions were erratic, leaving a huge area of anxiety. He would dilate enormously, which was followed by constriction.

Yet another dominant way of construing a disorder had to be taken into account. Mr. B spent years working on his early experiences and the "islands of structure" (or "focal points for understanding") that were elaborated at that time were defined by psychoanalytic constructs. He felt strongly that he did not finish the exploration of his personal history, mainly of his traumatic childhood, and he was obsessively clinging to it. The idea of unresolved infantile conflicts made him search, repetitively and unsuccessfully, for causes of his disorder. If he only could find what lay behind it, his problems would be solved. This search for meaning in the psychoanalytic conceptualization of the schizophrenic patient was aptly described by Levin (1987).

With the characters from history and literature brought into sessions, a constructivist (narrative) approach seemed to be the right framework. The therapist followed the patient's initiative, as this seemed therapeutically promising. There was a hope that his construing of self may move from searching for unconscious conflict and for the hidden meaning of his symptoms to the production of more encompassing and therefore more functional narratives. It was accepted that narratives might initiate the process of organizing experience into more coherent accounts. Neimeyer (1999) elaborated the role of client-initiated narratives in psychotherapy, suggesting that narratives serve both intrapersonal as well as interpersonal functions. "In the interpersonal context of the therapeutic relationship, client stories can be told to instruct, entertain, impress, implore, test, admonish, invite or distant the therapist" … but they also "have a vital *intra*personal function, namely *to establish continuity of meaning in the client's lived experience*" (Neimeyer, 1999, p. 233, italics R. N.).

Psychotherapy Process by Phases

Phase One: What? Exploration of the Symptom

What were the actual pictures he was seeing? How often, how upsetting, on what occasions? According to Cognitive-Behavioral Therapy (which was suggested by a referrer as a "therapy of choice"), Mr. B would have to write a diary, with the columns for Time, Situation and Thoughts/Images. This might help him to identify potential triggers for his intrusions. Mr. B wrote the diary for one week. It was detailed, honest and very upsetting. It did not reveal any particular situations that might trigger his images. Writing this diary apparently made his pictures more frequent, therefore it was agreed that this should be discontinued.

Phase Two: Why? Why I Am Like This?

This was the major issue for Mr. B. His childhood experiences were explored over many years, and he strongly felt the process was not finished. He described an obsessive, controlling mother, whose child-rearing methods included force-feeding and a regular use of enema ("I was being attacked from the front and from the behind"). His father was described as a permissive and socially inefficient man. A 7-year-older brother has been described as a bully. There was an element of seduction in his brother's behaviour, but no actual memories of sexual abuse. Mr. B described himself as a miserable child, confused about his identity, particularly his sexual identity ("Am I a little girl? I felt like a girl").

Without knowing how or why, his "pictures" became less frequent some six months after the beginning of this therapy. Instead, the details from childhood were becoming repetitive, with little space for anything else.

Phase Three: What Are We Doing Here? Confrontation

Six months later, there was a break due to the therapist's annual leave. Mr. B's condition worsened; he developed intrusive thoughts of killing a woman who was a family friend, suffered panic attack, and the Crisis Team was called. According to him, this happened because he had a break in psychotherapy. At that time, both client and therapist came to the point where they needed to summarize the effects of this therapy.

The therapist challenged Mr. B around two issues. His repetitive shift into fantasy world made him avoid talking about recent events and real people, so cutting off reality quite successfully. Was he really as isolated as he appeared? The therapist asked: Would he rather live in a real world, as opposed to a fantasy world? He would, indeed, he said. So, why could he not let go of his fantasy world? The dilemma was explored by using Tchudi's (1984) ABC model, where the client is asked about disadvantages of his problem (situation) and advantages of the opposite. The model helps to understand that the complaint/or the symptom makes sense, as it helps a person to achieve something important.

Table 1

ABC for "Living in a Fantasy World as Opposed to Living in a Real World"

Living in a fantasy world	Living in a real world
Disadvantages	Advantages
Advantages It is like being in a cinema, on the screen. Just a projection of my mind, a sort of creativity. I have always wanted to write a book. Like me being Pinocchio and looking to find my father. And becoming a real boy. But it can take you too far. Like recently, I was looking in the mirror and once again saw this horrible Gonzo face: penis, testicles, mouth as anus!	

This is the picture of a dramatic constriction in face of a threat, which this time was a prospect of giving up on his fantasy world. He would not let it go as: (a) reality meant failure on a number of issues (professional, relationships, and money); and (b) living in a fantasy world made him special. He would not allow the therapist to "seduce" him into something that was out of his way. He had built up this identity over many years of hard work and suffering, and did not seem ready (or able) to start again.

The next point of disagreement was his clinging to his childhood experiences. The therapist agreed that childhood traumas were important, but their lengthy exploration did not bring any solutions. There were alternative ways to explain his problems, and they might help him move in a different direction. Why not give up on psychoanalytic explanations? He could not give up on this, he said. "At that time, psychoanalysis provided the meaning for my internal chaos. In addition, my symptoms are the key to find who I am, if I could only understand them".

The therapist's tacit (and open) suggestion was to leave the symptoms as they are and elaborate other areas of experience. It was hoped that the change of focal point of understanding might eventually move him closer to a "near normal" (as opposed to "afflicted") identity, even though he still may experience some of his symptoms (minus anxiety).

Table 2

Spelling out Our Differences

Client's goals	Therapist's goals
To get rid of his symptoms However, in order to find out about his identity, he had to keep "analyzing" his symptoms, as they were a key to understanding who he was. This made them central To find whether he is homosexual To find "the solution to his problem". The previous therapist "circled around his sick core, but never extracted it". "You (ND) had an opportunity, but you were doing the same" He wanted to continue and hopefully complete his analysis Client's challenge: "This therapy does not work".	Help Mr. B to contain his anxiety Help him de-invest symptom constructs (make them "peripheral" rather than "core") and elaborate alternative explanations for his condition. Elaborate and re-construe other areas of his life, such as real life situations and "the others" (that were not taken into account as confirming or disconfirming his construing of "self"). His fragmented construing required synthesis that might produce a "near normal" identity.

The client wanted the therapist to "extract his sick core" but this was not happening, therefore "the therapy did not work". Amongst other things, his "pictures" defined his " ("islands of structure") that were made important in psychoanalytic psychotherapy and he was clinging onto them. This fragmented self needed reconstruction and synthesis. The word "synthesis" was repeatedly used, to replace his construing of his therapy as "analysis".

The story that emerged at that time has become a central issue. He found a new identification figure in Pinocchio[1]. It covered some of his repetitive themes, put together in a much more coherent way. Pinocchio would become a real boy after long, painful learning. There were a loving father and a fairy godmother (a mother figure), deceitful "friends" and a shamefully long nose as a punishment for lying. The issues of 'being good' as opposed to "being bad" were major criteria of self-definition. There was a hidden idea of sexual seduction (Play land), of oral regression and the prospect of returning to reality (for those who may have forgotten, Pinocchio was swallowed by a whale but managed to get out, saving himself and his "father" by doing so).

Mr. B produced a drawing that pictured him inside a whale; he did not dare to get out, as his brother was out there. He did not finish the story, as this was felt to be too much for the time being. However, it was recognized that his symptoms were not meaningless.

Phase Four: Termination

Mr. B was discharged as improved; he was looking forward to spending a holiday with his elderly aunt. Three months after termination he suffered another psychotic breakdown. He was hospitalized and diagnosed as suffering from "paranoid schizophrenia". His new psychiatrist disclosed that Mr. B missed his "analysis" (this therapy). The doctor's comment was that psychoanalysis was not the best choice for a man like Mr. B.

In retrospect, it seemed that Mr. B was able to function at three different levels. His diaries were fragmented images, more or less "psychotic". His in-session discourse was a better-controlled narrative, albeit repetitive. It seems that he managed to appear "normal" in real life situations.

The concept of heterogeneously distributed self (Wortham, 1999) may help to understand discrepancies.[2]

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[1] Carlo Collodi, Pinocchio (2003). A more than a century old story about the wooden puppet that wanted to become a real boy by his transformation from a selfish, heartless creature to a "good" person. For Pinocchio, the world outside is cruel, and he had to pay the price for being greedy, lazy and insensitive. One of the central issues is the idea of development trough personal effort. To become a real boy, Pinocchio had to work much harder than the ordinary child, as "being real" was not given to him.

[2] Wortham sees self as emerging from structures at "various levels of explanation rather than being a primarily psychological entity". To demonstrate how non-psychological factors can partly constitute the self, he describes the level of interactional positioning in conversation. What is relevant for our story about Mr B is the claim that "… multiple-level account, an account of the self as heterogeneously distributed, makes better sense than an attempt to reduce all relevant patterns to one level or another" (ibid, p. 170).

What Made This Therapy Difficult?

Reading the notes from sessions again, I came to the conclusion that Mr. B had been, after all, "psychotic". His identity was "a made-up identity", most probably the result of both his pathology and the long process of making sense of it during his "analysis". While for the most people self develops automatically, tacitly, with no extra effort, for some people (such as some "schizophrenics") self appears as a result of a life-long struggle. This man's disorder did not seem to be a consequence of his childhood experiences, although they may have modulated it. Once again, alternative constructions of disorder were considered.

Machoney (2000) assumed dynamic and continuous ordering processes as the most fundamental principle of human existence. The person's powerful ordering processes operate well beyond the range of explicit (expressible) symbols; they are primarily tacit as well as unique to each individual. Mahoney conceptualizes self in terms of processes, introducing the term self-organizing processes, or "core ordering processes". These are said to "organize experience and activities along dimensions that include emotional valence (good vs bad), reality status (is vs is not, necessary vs impossible), personal identity (I vs you or it) and power (control, efficacy, or agency or their opposites…)".

Chronic disorganization, dysfunction and distress result when challenges continue to exceed individual capacity for systemic reorganization (Machoney, 2000). To extend this idea further, it is possible to assume that an inefficient core ordering process may, at least partially, be explained by an inefficient "core ordering mechanism"[3].

In an attempt to understand some disorders we have to be able to think in both directions, that is, assume that disorder could be the result of particular ways of construing, but (vice versa), the construing of self may be the consequence of a disorder, or 'the best outcome of a bad job (or of a given potential).

The most general assumption relevant here was put forward by Machoney (2000) who writes: "Like so many of my ancestors and colleagues, I believe that people organize their experiencing—create a basic 'sensory order'—through processes that are fundamentally categorical or classificatory…" (p. 49).

This brings us to a different theoretical perspective. In the lengthy review of the research on cognitive functioning in obsessive-compulsive disorder (OCD). Tallis (1995) demonstrated specific deficits in memory (visual memory in particular), frontal lobe function and abstract thinking (categorization) in people suffering from OCD. While solving cognitive tests, people with OCD were found to be under inclusive in their

[3] Or "hardware operators" as described in dialectical constructivist framework. This theory assumes "dialectical interaction among informational structures (schemas) and innate, general purpose processing recourses (hardware operators). 'The interactions of the different hardware operators and types of learning result in effortful, rapid logical learning as well as in slow, effortless, detail-rich, and experiential learning" (Greenberg & Pascual-Leone, 2000, p. 171). The logical assumption here was that deficient experiential learning, or "emotional ordering processes" might explain Mr B's life-long struggle to find who he was. However, it looked as if there was something more basic than that. It seemed that the "general purpose processing recourses" (such as attentional energy, active inhibition and the gestalt field factor (an attention "closure" operator), were in some ways deficient as well. Mr. B was not able to follow any instructions during the sessions and all questionnaires that were given to him (to monitor therapy outcome) were brought back empty. Repertory grid was tried by eliciting constructs in the session and was given to him to fill in at home. It was returned empty, with the comment that it caused a lot of confusion for him.
Post script:
The case was presented at the XV International Congress of Personal Construct Psychology under a different title. While writing this paper, I found that I was gradually reducing the patient's story in favour of elaborating the theory and my own understanding. The result may be a more useful account of the psychotherapy process. It is a therapist's "self ordering process" that is at stake here. The therapist's professional self is based on accumulated experience, plus what was made of it. At the best of times, this experience needs further elaboration. More often than not, we (therapists) have to make sense of something rather complex and not easy to grasp via official ways of understanding. I believe that this presentation may contribute to generalisation of experience.

categorizations, meaning that they form too many categories in comparison with controls. Also, there was a deficit with set-shifting tasks in this client group. Cognitive deficit was even more obvious in schizophrenia. According to Nuecheterlein and Subotnik (1998), and based on McGhie and Chapman's (1961) hypothesis, "a defective filtering mechanism was a primary defect in schizophrenia, thereby emphasizing the role of impaired selective attention" (p. 19).

This partly explains Mr. B's condition. In his "loose" phase, Mr. B had trouble to organize his identity around any fixed theme or any permanent focus. In his efforts to find what defines him, he was meandering through an enormous number of themes, leaving those chosen at the time to be replaced with similarly inefficient new ones. The most relevant piece of information was not easily picked up. For some reason, both selection (of relevant data) and categorization were deficient. Psychoanalysis, as practiced decades ago, was not the right approach to this type of a construer, but it was assumed that his previous therapist understood his task better than original psychoanalytic theory itself would allow.

Constructivist, particularly "narrative" approach, provided a better theoretical rationale. If the main problem was organization of experience into a coherent account, narrative discourse might be cultivated to produce a better life story and still answer some of the "burning" questions. Mr. B's narratives were fragmented at first, but he eventually produced the one that 'held' and that covered a number of issues he felt were important.

What Did the Therapist Learn From the Experience?

Was the DSM-IV classification useful? After all, Mr. B did not have an obsessive-compulsive disorder (except for some of his characteristics) and he did not appear to be paranoid at all during this therapy. Eventually, he developed a paranoid psychotic episode, which according to his medical history would have been expected as another phase of his "illness". In PCP terms, he was moving from a loose (fragmented) to a tight (paranoid) organizing mode, both being a characteristic of his self-ordering process.

On the positive side, DSM-IV described his level of functioning, providing an idea of how far he could go. In addition, this is the language that allows communication across systems.

The importance of Kelly's "transitive diagnosis" was confirmed. The search for alternative construing of the self and disorder was based on careful listening and it was very much client initiated.

Although he worked on his "normality", Mr. B's life was seriously affected by his "illness". There were obvious limitations in terms of what he could achieve, and this would probably be the case even if he had not had traumatic childhood experiences. His psychoanalytic therapy provided meaning to his "chaos"; it helped him find a focus, but it did not result in a fully functioning identity. It is questionable whether any other explanatory system would have produced one.

This therapy was extremely important for Mr. B. In retrospect, it was understood that the relationship with the therapist was the main agent of help, and that it served as a "container" for a fragile self.

Conclusion

What my client got from this experience?

Human contact, number one. It is well demonstrated that relationship with a therapist works as a potent

factor in any form of psychotherapy. For people who are fragile in any kind of way it is even more important. The other person serves as a ladder, a container if you like, to keep this fragile self integrated.

What did I get from the experience?

Some understanding of what is the psychotherapy process. The therapist's professional self is based on accumulated experience, plus what was made of it. This experience needs continuous further elaboration. More often than not, we (therapists) have to make sense of something rather complex, which is not easy to grasp via official ways of understanding. Here I made an effort to contribute to generalization of experience.

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