On the advantages of symptoms: Exploring the client's construing

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On the perspective of George A. Kelly's Personal construct theory the article outlines points of view concerning 'advantages of symptoms'. A procedure for eliciting possible advantages is presented ('The ABC-model') and compared with a more conventional psychoanalytic approach as exemplified in a previously published case story. From a Kellyan view people are 'personal scientists', seeking—by testing their hypotheses—to predict and control events. Personal scientists may, however, get stuck with their hypotheses, possibly resulting in 'symptoms', and may need a fellow scientist (e.g. therapist) to encourage them to see and try out alternative procedures. The authors underscore that the therapist should beware of imposing own interpretations on the clients, but rather invite them to participate in a joint effort to elaborate and understand (analyze). This is a joint process, but principally based on the client's own personal meaning structure (construction). Since there is more than one alternative or one answer to the client's situation, the therapeutic process will probably call for frequent reconstructions.

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The present article outlines points of view inspired by Kelly's (1955) personal construct theory, a theory which regards a person's interaction with the world as characterized by that person's wish to anticipate events through his/her structural interpretations. The Kellyan approach is based on personal meaning and meaning structure: each person organizes and creates meaning through use of a system of bipolar constructs (which may be preverbal, not restricted to language alone). As new situations occur, a re-construction (change) may be called upon for a person to be able to accurately predict events. A person may, however, be stuck in one of the choices (choosing one pole of a construct). The choice may seem optimal at the time for certain aspects of life, but prove restricting as time goes on. This is similar to Steiner's (1974) discussion of premature and forced decisions resulting in emotional disturbances.

From this perspective we developed the ABC-model, by help of which a person may take a renewed look at his/her own choices (construing) and maybe find more satisfactory ways (re-construing).

The ABC-model was originally presented from an individual perspective. In this article we show how the model may be extended to situations where more than one person is involved, and thus different ways of construing are involved. To illustrate we have chosen a case presented by Sederer & Sederer (1979) and discussed by them from a psychoanalytical point of view. Since our position has been presented in detail elsewhere (Tscheudi, 1977) we here limit ourselves to present one of the clinical examples from that paper and a short summary of the "ABC-model". The example will be seen to have some interesting resemblances to the case presented by Sederer & Sederer. We than tentatively cast Sederer & Sederer's case in the same mold, and go on to discuss the therapeutic implications from our proposed approach.
The young man—a case of phobia

Don Bannister tells the following story: The young man had phobia for telephones and travelling. About a year of systematic desensitisation treatment enabled him to travel and use the telephone. He commented on the utter pointless of such an achievement since he had no one to ring up and no one to travel to. He had formed no relationships with his fellows. About two years of psychotherapeutic exploration and experimentation, and the young man was going to social gatherings, visiting his newly found friends, was a member of this or that hobbies group. He then pointed out that no one could care less than he did for the kind of superficial chit-chat relationships, mainly with men, which he had now formed in great numbers. What he wanted as a deep, passionate, intense sexual and exclusive relationship with a woman (1971, p. 192).

In the ABC-model the symptom (the presented problem) is regarded as one pole of an A-construct and labelled $a_1$ while the contrast, the positive and desired pole (the direction in which the client wants to move) is labelled $a_2$. The client may be asked for the advantages of $a_2$ and disadvantages of $a_1$. The answers to these questions give a new construct, labelled $B$, which elaborates and gives reasons for the A-construct. Generally subscript 2 denotes a preferred pole, subscript 1, a negative pole, but it is important to bear in mind that in many cases "positive" and "negative" are not clearcut for the client. The crucial step is to ask for evaluative reverse implications: advantages of $a_1$ (labelled $c_2$) and disadvantages of $a_2$ (labelled $c_1$). The emerging C-construct provides an answer to the question of what prevents movement. Schematically our analysis of the case of phobia is diagrammed below.
The young man is at a₁, but is prevented from moving to a₂ because there are advantages of the symptom (indicated by "but" arrows), c₂: conversely, there is a threat, c₁, connected with a₂. The C-construct keeps him from moving. In this case C does not state any positive goal, the choice is to confront a negative state c₁ or to avoid this confrontation, c₂. We call such a construct an avoidance construct. Such constructs call for replacement by statements of what the person wants to move towards. A' is a transformation of C to bring forth a positive goal, a₃ (have friends). This example calls for a further level: there is a new avoidance construct, C, which again can be transformed to a new problem oriented construct, A". (Not all C-constructs are avoidance constructs. As the discussion of Sarah and David reveals, C can be an approach construct with c₁ as a preferred goal. Further elaboration may, however, reveal that c₂ is a "contaminated goal" which again may call for constructive restatement (Tschudi, 1977, p. 342).

Fig. 1 clearly brings out that the young man had severe social problem, and it seems like a waste of therapeutic effort to spend a whole year with systematic desensitisation for the phobia. (Bannister (personal communication) agrees with the present analysis and points out that the present case represents a quite early therapeutic effort.) Our position is that one should start therapy with directly eliciting the advantages of the symptom. Greenwald (1973), who has greatly influenced our position, sometimes directly asks "what's the payoff" (of the symptom), but in the present case a more gentle approach, e.g. asking to whom the person might wish to call, may be used. In the case of the young man it would then seem advisable to work simultaneously with what appears to be the young man's hierarchy of goals: telephone and travel—have friends—obtain true love.
Sarah and David: A family myth: Sex therapy gone awry

In their article Sederer & Sederer (1979) discuss the case of Sarah and David, a couple who sought therapy and presented as their main problem ("symptom") that Sarah was "sexually inadequate", she had never achieved orgasm. They believed that it was this "inadequacy which was at the cornerstone of their disharmony" (p. 315). Towards the end of the article, the authors reveal their view of symptoms: "Any symptom or myth serves a purpose. It is the work of the therapist to understand what it provides" (p. 319). The main point of their article is to warn against any form of sex therapy which does not properly recognize this.

In this present context it is important to note their wariness of sharing their understanding of the symptom with the clients: "exploding the myth may not be at all in the interest of the couple". If, however, they deem that the clients "have anywhere else to go", they will consider "disrupting the myth", aware that this "is tampering with the foundation of the union". In the final hour they then bluntly point out that "the client's source of conflict was a fundamental disinterest in one another that they had managed to mythologise as a sexual problem, and thereby temporarily bury a truth that neither was prepared to recognize" (p. 320). Sarah right after that made plans to leave David. Though "there is an undercurrent of strong dependency as they told of their plan to meet upon Sarah's return, there is strong doubt as to whether there is any future hope for this couple. With a sad, yet hopeful note, we terminated therapy".

We agree with the general point on sex therapy and we are much in sympathy with "symptoms serving a purpose". We do, however, want to present a different view on if and how this should be communicated to the clients. Our position is that the therapist
should attempt to elicit purposes or "advantages" (if at all possible) in the very first hour. Instead of seeing this as hazardous, we see it as a primary tool for furthering therapeutic movement.

Our basic clinical objection is that therapy ended where it should have started. "After the review, and having reached a decision to intervene, we set aside two therapeutic hours for the purpose of leading the couple through an examination of themselves, their marriage and these myths" (p. 319).

Our analysis of Sarah and David

The case report of Sarah and David suggests two different representations: one which shows joint advantages and disadvantages, the second showing separate advantages and disadvantages for each of them. The terminology used in the two representations is culled from the article with some rephrasings. Even though Sarah and David would not have expressed themselves as below (e.g. in A’ and B’) their dilemmas might be rephrased like that.

Looking at each person separately brings forth how they are locked in an unsatisfying, conventional sex role pattern with asymmetric distribution of power. David's domination is related to his fear of rejection: "their marriage was considerably male dominated ... David ... viscerally reacted to strife as a sign of not being loved" (p. 316). For Sarah
"success, namely orgasm was anathema because Sarah was unprepared for all that might ensue if she became orgasmic." (p. 316) She is thus stuck in a dependent, submissive position.

The other view of the relation—which looms larger—is symmetric: Sarah and David are described as equally bent on protecting the unviable relation: "each dreaded the loneliness and anguish of separation to a degree that would not permit them to speak of matters that might be the ruin of their relation." (p. 319).

The three representations show interrelated problems: power, structure and fear of fundamental disinterest are interwoven. The joint representation suggests that what prevents movement (c’2) might be a wish to keep status and relation to family. Elaboration of this construct pole might reveal a non-viable position provided that Sarah and David’s marriage is more than a relation solely based on "reason". Maybe the goal is to find some sort of structure and security (avoid c’1). The joint representation suggests that this is presently obtained by belonging to a family network. The separate representations imply that David prefers to be "loved" even if the love is unsatisfying. Sarah prefers to be dominated even if it prevents self-realization.

The other pole, c’1, is threatening, implying as it does loss of structure and meaning. Being placed in such a dilemma may easily result in a feeling of strong and mutual dependency. Loss of structure and meaning indirectly signifies a variety of alternatives for providing meaning. However, since the couple does not get the opportunity to explore these possibilities they might easily end up with feeling of emptiness, which then is filled with a conventional sex role pattern. This may be a typical reaction: their vulnerability lead them to adopt the most readily available stereotype in our culture, a pattern of dominance/submission. At this point we should emphasize that the constructs here introduced are not Kellyan personal constructs, but rather the therapist’s interpretations. Sarah and David’s own constructs would probably have quite different connotations. From the present point of view the important thing is not for any such representation to "reveal the truth", but to provide the couple with help to get moving from the rut where they are stuck.

It is important to underscore that one should avoid trying to impose one’s own constructs on the couple. This might have been what happened when "we began to comment on the distribution of power, the male dominance, only to be rerouted back to the boudoir" (p.328).

Discussion—a Kellyan view of therapy

Both for the young man and Sarah and David we believe that therapy should not blindly start with the symptom the clients offer. (Notice that systematic desensitisation plays a similar role for the young man’s phobia as Masters and Johnson type sex therapy plays for Sarah and David’s presented problem). Rather, therapy should start by exploring with the clients possible advantages of the symptom. To understand the purpose of the symptom is not, as Sederer & Sederer imply, something the therapists should do "on their own". One might object that this immediately could lead to a dead end, that it might be to threatening to the clients and lead to reactance. But it is possible to circumvent such an outcome. As we stated: "with a relaxed, partly humorous mood it is not too difficult to elicit such advantages. The therapist may also suggest poles which the client may then accept or refuse " (Tschudi 1977, p. 324).

This is what Kelly calls the invitational (or hypothetical) mood: "suppose we regard the floor as if it were hard", "suppose we regard your feeling as if they were a shield against the hazards of loving someone" (Kelly, 1968, p. 149, 156) are some of the illustrative
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examples he uses. So we might ask: "suppose we regard your problem as if it hides something that might threaten your relation. What could that be?"

There is a variety of alternative questions more directly related to the presented problems as for instance: "Suppose Sarah gets her orgasm. What consequences could that have for your relation? What changes might follow? Is it at all possible to harbour the thought that Sarah's problem might give your marriage some kind of safety ... a certain distance? No need to change? No need to look for other problems?"

There is a precarious balance between the invitational mood and imposing one's own constructs. The questions should be asked in an atmosphere of open and honest curiosity, and there may be many steps from the opening question to getting at the sources of the problem.

If asking for advantages of the symptom should draw a blank stare, one might also consider some of the techniques Kelly describes for "loosening" (Kelly, 1955, ch. 20), which are procedures for making the clients able to stepwise face the more threatening aspects of their construction.

Since the presented problem deals with sex, where there might be strong sentiments against considering any implications, one might consider dealing with the problem in terms of analogies, as M. H. Ericson does (see e.g. Haley, 1973). Often therapy may only indirectly deal with advantages of the symptom and a concrete suggestion may emerge as a hypothesis which the therapists present to the clients for comments and corrections.

The invitational mood has the advantage not only of reducing threat but also provides a metacommunicational point of view regarding the symptom. In the terminology of Bernal & Baker (1979) exploring advantageous of the symptom corresponds to a move to the transactional level, which they see as basic for avoiding being trapped is dissatisfying cycles of interaction. Kelly expresses it like this: "man would be hopelessly bogged down in his biases if it were not for the fact that he can usually assess the outcome of his predictions at a different level of construction from that at which he originally makes them" (Kelly, 1955, p. 13).

The invitational mood follows from Kelly's view of people as personal scientists, ever seeking—by testing their hypothesis—to predict and control the course of events with which they are involved. Personal scientists may, however, be stuck with their hypotheses, trying out the same experiment again and again and never succeeding. They may need colleagues (e.g. therapists) who can invite them to see alternative procedures.

But the Kellyan therapists will always bear in mind that "reality is subject to many alternative constructions, some of which may prove to be more fruitful than others" (Kelly, 1969, p. 96). This is the essence of Kelly's basic philosophical position, what he calls "constructive alternativism". This position runs counter to any theory which claims to find the cause of (psychological) events. Interestingly, the Kellyan stance is highly similar to the pluralistic view in linguistics (Tschildi & Rommetveit, 1982). From such a position there is no such thing as the meaning of a situation, differing perspectives will always provide alternative constructions.

Any ABC-network may be regarded as an ad interim hypothesis, subject to change as new evidence emerges. From this point of view it is not of basic importance if the initial construal of advantages is "correct" or not. As previously stated, the point is to start a process, and "given the network ABC, find a step from anywhere in the network which seems likely to lead to change and which the person decides to carry out. If this does not lead to the desired change, reevaluate the network and find a new step. This may call for reconstruction, forming new constructs" (Tschildi, 1977, p. 325).

Returning to Sarah and David it is hard to be concrete in suggesting possible therapeutic steps for them since we are limited to the therapists constructions. As previously stated,
the clients might have provided different constructs than in our representations. Yet there would probably have been signs of "fundamental disinterest" or that they did "reveal how neither barely felt a quantum of lust, love or affection for each other". (Sederer & Sederer, 1979, p. 329). Whatever "fundamental disinterest" might be a correlate of, there would, however, also be a correlate of the contrast pole "interest" (in each other). Here there would be possibilities which the therapist could invite the couple to explore. Granted that "fundamental disinterest" does not sound too promising; there is also the "undercurrent of strong dependency" which may signal that "interest" may not be completely uncharted waters. (We doubt that such exploration is possible without also working with the power issues, but this can not be further pursued here.) From a Kellyan point of view, the basic theroretical point to be made is that people are not necessarily trapped in construct poles: constructs are choice points where both options can be explored.

There is of course no guarantee that our approach might save the marriage. As stated in the joint representation, "growth or dissolution" of the relation is very much an open question. Our objection is that the therapists do not provide the couple with sufficient opportunities to explore the possibilities themselves. We are struck with the hostile imagery in Sederer & Sederer's discussion of myths: "exploding ... disrupting the myth" and particularly--before the final hour, "the decision to intervene" has been made. The therapists seem to be on the verge of saying "this farce must be stopped"—scarcely providing a context where the viability of the marriage might be explored.

Sederer & Sederer seem to have come to a fatalistic position quite contrary to constructive alternative to the invitational mood. In this context the decision to intervene scarcely shows respect for the personal scientists, their constructions do not emerge. Could not the energy and versatility employed in "procting" the relation have been transformed to more audacious ventures?

The basic point by Sederer & Sederer is "the importance of maintaining a psychodynamic eye when engaged in the application of techniques based on learning theory" (Sederer & Sederer, 1979, p. 320). We argue that the "psychodynamic eye" should be no means be reserved for the therapist. Rather the clients should right away be invited to look at the problem through this kind of eye. It should be clear that we do not mean that Sarah and David would see the same thing through such an eye as Sederer & Sederer. We adopt the metaphor of the psychodynamic eye in the spirit of the invitational mood, encouraging them to see their situation in not obvious perspectives. This is very much in line with constructive alternative which implies inviting the clients to see at the world through other glasses than their customary ones.

For the presented problem, we are in line with Sederer & Sederer in the respect that any simpleminded approach based on learning theory would probably be insufficient. Both our analysis of the young man and Sarah and David bring this out. The therapeutic step must take cognizance of the construct network or the implications of the symptom. There are implications of the wanted position, $a_2$, which the client does not master and which must be dealt with.

We do not, however, want to dogmatically insist on "advantages or the symptom". If the clients do not see anything through "a psychodynamic eye", in spite of all invitations, there are two possibilities. First, there may simply be no advantages. Following Kanfer (1975), we call this a behavioural deficit. In this case there does not seem to be any alternative to an approach based on learning theory. (Such cases may be rare for phobias: see Lazarus, 1971) Second, advantages may remain hidden despite the therapist's invitation. In this case it also seems reasonable to suggest a learning technique, generally some small steps towards $a_2$. Since the clients see no advantage of their position, $a_1$, what possible objection could they have? Our suggestion is that such technique should then be
regarded as a step in a diagnostic venture. With a failure of this technique (which would be likely), there is fresh material for reconsidering the question of advantages of the symptom. We do not subscribe to a linear view of therapy; at any point the whole process may have to be repeated.

REFERENCES