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Dependency Constructs: Developmental Aspects and Implications for Short-Term Psychotherapy

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Abstract: When George Kelly first published *The Psychology of Personal Constructs* in 1955, he offered an image of men as scientist, thus emphasizing human agency and choice. People develop personal construct system which consists of hierarchically connected dimensions of meaning that are bipolar. Personal Constructs Psychology PCP is a forerunner of what was developed into a family of post-modern therapies, i.e. constructivism(s). In this paper, I will present the main concepts that address the question of dependency in the theoretical framework of constructivism. The ways to work within this framework in psychotherapy is my next theme. I will try to present the ways how we learn from our efforts to help clients, including successes and failures.

Key words: Dependency, threat and guilt, eating disorder, therapeutic relationship.

Theory

It is generally acknowledged that psychotherapy works on changing problematic ways of organizing experience through the use of interpersonal relationships. Further, therapies work via “specific” and “non-specific” factors, the specific referring to the therapeutic techniques, and non-specific to the psychotherapy relationship, as elaborated by Henry [1].

Why is changing problematic ways of functioning so difficult?

By its very nature, psychotherapy addresses two issues that might be threatening:

(a) *A prospect of change*. The founder or theory Kelly [2] described in great detail how transition/or the prospect of transition evokes anxiety, threat and guilt. Anxiety will be provoked by movements into the areas for which there are no constructs. Also, any change may present the risk of the violation of the core role, and any sudden and major change does involve threat.

(b) *A prospect of getting close to another person*. Kelly’s definition of role emphasizes the understanding of another person. What is fundamental of a role relationship, according to Kelly, is an ability to construe the process of another person’s construing more than the contents of his/her personal construct system.

The client's response to the hazard of intimacy may be to withdraw from the relationship, which is recognized as one form of “resistance”.

Here I am interested in the ways in which client responds to both threats (the threat of change and the threat of intimacy) as they may be serious obstacles to psychotherapy.

In PCP, difficulties of this sort are described in terms of preemptive and impermeable construing. Further elaboration, I hope to demonstrate, will show that these kinds of difficulties are found in clients with dependency developmentally shaped by threat and guilt.

The origin of those problems will be found in childhood. It is assumed that infants will construe regularities which will shape their core constructs. So, people will be construed as performing some actions relevant to the infants maintaining processes. Some of the meanings thus evoked will become part of the person’s core roles.

The concept of dispersed and un-dispersed dependency is further elaborated by Kelly. It describes the distribution of one’s dependencies in a social

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network. With optimal maturation, dependencies gradually become dispersed and the person comes to depend on many people, rather than a few, or only one. This was elaborated in more detail by Winter [3] and Walker [4], who claim that lack of dispersion of dependencies leaves the person to depend on few or only one other, and as such they are vulnerable to change. The more elaborate model for understanding and managing dependencies is proposed by Chiari and Nuzzo [5]. Authors talk about three paths of dependency, the path initiated by aggressiveness, as opposed to those initiated by threat and guilt.

Aggressiveness in this theory means active elaboration of the person's perceptual field. If the relationships to parents are not perceived as threatened, children will be able to actively elaborate areas of anxiety pertinent to the social world and develop structures for them.

Threat, on the other hand, is brought by the caregivers' withdrawal from the relationship. Later, the threat will be activated by anticipation of losses outside the family as well. There is continuous expectancy of loss.

Guilt is even more complicated. By definition, guilt assumes dislodgement from ones' core role. But there are some inconsistencies in using this as the way originally proposed by Kelly. The example would be the identity of "bad daughter" who does not fulfill the expectancies of her caregivers. In cases that this was a general and life-long message to the child, this forms her identity; being a bad daughter is the "proper way to be". The person is behaving as a bad daughter; therefore she is a person she is supposed to be. Here, where is dislodgement?

Well, the stereotype of a good child is continually socially validated as proper behavior. Therefore, a "bad person" guiltily dislodges herself from the normalized core role of a good child. They are, somehow, made aware that they do not behave as expected.

It is obvious that we are dealing here with the two levels of communication and two types of messages. Both verbal and non-verbal messages play a part in building both images, the one of a good and one of a bad child. As seen in psychotherapy practice, actions and non-verbal communications are the main basis for the development of the image of a bad child.

I hope I will be able to illustrate through a story of my client.

The implications from the dependency paths initiated by threat and guilt

	THREAT	GUILT
Parents	High dependency on both parents	Low degree of dependency on both parents
self	Low degree of self-dependence	High degree of self-dependence
others	Few people construed as extremely reliable, most strange and threatening	Other construed as unreliable and untrustworthy

According to description given by Chiary & Nuzzo, 2010.

I will use the model to demonstrate how development of dependency initiated by threat as the main issue may influence the ability to form relationships in general and how it may affect the psychotherapy process. Although threat was the main issue, I have found that guilt and hostility also played a prominent role.

Practice

The Case of Ms K.

K. was a 28-year woman working in marketing. She was referred to as suffering from obesity and depression, the depression being the response to her inability to control her eating and her weight. K. indeed presented as overweight, but in a strong, rather than plump way. K. described herself as a compulsive eater who binged large amounts of food some evenings after coming home from work. Her problem was not a food, it was emotional, but she was not able to find what this was all about.

K. was single, and was living with her parents in their big family house. She was brought up in a family

of four, consisting of a mother, father and two daughters. Talking about her childhood, she remembered having been considered as a bright child but "underachiever". She was seen as a "bully" as a young child, and later on perceived as a tomboy. At the time she had a very good friend with whom she shared everything. They found the way to protect them from being bullied, with the conclusion: "do not be too visible and don't be too smart".

From the begging, she told me that she had difficulties in communication. Sharing intimate thing was difficult, she could not talk about herself and very often she did not want to, what was about her constant fear of being criticized and being seen as "'stupid".

My initial task was to develop an atmosphere of safety, with as little pressure on her to talk as possible. As Leitner [6] nicely described it, we have to find optimal therapeutic distance, the *simultaneous experience of connection and separateness* that is the hallmark of role relationships. On the other hand, to address the main problem, I hoped to help her bring into awareness and explore at least some of her preverbal experience. Also, I considered it important to introduce some work on her sociality early in therapy. In terms of her dependencies, and in accordance with the model proposed, I assumed a developmental path initiated by threat. I assumed she had a problem with over-dependency on her parents and at the same time low level of dependency on others.

The main problem for her was her eating behavior. A good review of this category from different perspectives was provided by Raskin [7]. I assumed that her compulsive eating and consequent obesity had a specific place in the whole dynamic, as it kept her isolated and out of competition in both the academic and social spheres.

Psychotherapeutic Relationship

According to Chiari's model, in the therapy-type dependency, few people will be construed as extremely reliable, while the rest will be construed as strange and threatening. This seems to have been the way that K. construed people throughout her life.

(i) Beginning

K. had negative expectations of therapy, particularly as she had problems with sharing intimate things with another person. It was too obvious that she found it difficult to talk and there was a relatively long period of silence. Still, her ability for insights (discoveries), when connected in psychologically meaningful ways felt as a good basis for the process of change.

(ii) Psychotherapy process

Relatively early she felt OK talking to me. However, she did not want anyone to know that she was seeing a psychotherapist.

When I asked for feedback early in therapy (5th session) she said we covered a lot. However, she let me know that she felt anxious before the sessions, which gradually changed as the sessions continued, to disappear completely at some point. I found that I was feeling the same.

In out seventh sessions she asked whether I wanted to hear her dream.

K. dream: "I am swimming in a water…Deep blue sea,…cliff on the one side…colorful fish around me, and I can breathe under the water."

How was she feeling? "Nice pleased, relaxed."

And mighty, I would say.

She smiled for the first time. For me, trust was gradually being established.

Very often, she found she has trust in the person (like her mother) but does not want to talk. I took this discovery as an indication of her construing others as threatening, but at the same time as her choice. We explored difference between *cannot tell* and *do not want to tell*, as she expected criticism I introduced the task: to observe in a systematic way other people' behavior and see whether others are always critical.

As a result of this, she said she changed her behavior on a few occasions. She accepted to go out with her sister and her husband. They had a good time and she felt she was good company for them.

What followed was the first rupture, as she did not attend her next (11) session. She came back, responding to my letter. I suggested that we start reviewing what has been achieved by then. She told me that she was *getting angry and feeling helpless, as nothing had changed in spite of all the work done*.

What she was talking about was her eating behavior. Her compulsive eating looked like "taking care of herself", a form of self-sufficiency, as bulimia can be seen as "acting out" of a desperate need for a specific form of satisfaction [8]. Assuming that she saw psychotherapy as a simple "kick out the bad habit" enterprise, I initiated the exploration of her construing of positive change.

She could not take positive action even when she felt OK. She said that positive things have happened, but those had not made her feel happy. By that time she saved money and paid off her debts; she had a pay rise and was assessed as very good at work. However, on the day of her promotion at work she went home and binged.

One way was to work on her dreams. She brought a collection of dreams to her 14th session, and continued to do it until the end. She understood their meaning quite well. At one point she told me that it felt like producing dreams deliberately, *like dreaming for me* (ND). In the sessions she said, she was a different person, as if this was not real. "Like different part of my life. *Here, I understand more and feel free to think.*"

But to allow her to take in what we were working on she was *gradually becoming dependent on me and this was threatening*.

By that time we have already elaborated the meaning of her symptoms. It was made clear that not going out because she is overweight meant that she would maintain her compulsive eating. It was important to develop different roles for herself. I introduced the idea of fixed role, asking her to depict a person who is fat and sociable. I asked her to imagine what this person would wear, how she would walk and talk, what she would talk about, who she would meet…

She accepted the idea. Could accept herself as "fat" and an interesting person who is able to go out and be with people. She brought her character sketch to the next (19) session, laughing at what she had done. The following week she had to present something in a group meeting at work, having to talk for approximately one hour. She was optimistic about her ability to do so.

(iii) Termination

After a two weeks break she did not return. As she had once told me, she did not want her home number to be used, as she did not want her parents to know about her sessions. I used her office number to contact her. She agreed to see me the following week, but did not turn up. She also did not respond to the letter I sent.

Developmental Issues: Parents

K. always thought of her parents as carrying and good people. When I asked about family rules, she said they were strict but just. Although, she could remember her saying: "This is not fair."

Her younger sister was painfully shy, and all their parents wanted her to overcome her shyness. K. was different.

At some later point K. remembered that she stole sweets in the local shop when she was about 8.When mum found out she paid for it. As a teenager K. shoplifted, mainly to prove to herself that she could do it.

I assumed that her general feeling about herself was to have been a demanding and difficult daughter. Also, she was a daughter who did not fulfill expectations. As a young child she described herself as a bold, active, a strong character, a bit of a bully. On the other hand she clearly remembered having fears, such as a disaster on the large scale, on being left alone, or not being able to control things.

To start with, I assumed two sources of threat. One was construing her family as fragile as her dreams clearly demonstrated. Her duty was to protect them. The other was her relationship with her parents, which I believe is being at risk of falling apart if she did not

take care of it. There must be a recurrent invalidation in her childhood that explains hostility and guilt. This was difficult to explore, *as K. had to protect her family from me as well.*

She could not talk to her mother. At any time, the conversation starts with the same issue—her diet. It stops before they came to anything. "My mother would like to know everything—if she does not know, then rejection".

I asked her to write an angry letter to her mother, explaining that anger should be verbalized before it is resolved. She accepted the idea, promised to do it but I only found that she was not able to.

Her dreams were enlightening, and also well understood by her. Examples of letting off rigidity and constriction, so dominant at this period, were loosening in her dreams.

Developmental Issues: Self

Her self-characterization was enlightening. She found herself "as introspective, very self-conscious, but with a little confidence in herself and with low self-esteem. *She is moody and can be aggressive but also generous and kind. She does not enjoy meeting people and it takes a long time to make friends. She is a dreamer, but she rarely puts her plans into action.*"

All said, how did you become like this?

From her biography, it has been clear that she had been an "active" rather than "thinking person" but she had been ignoring the different selves. She lived with sharp polarities and at this time she did not connect them. When she was an acting person she had a good friend, travelled, she was happy and not overweight. When a "thinking person" she was not able to act (friends, others) and she was a compulsive eater. Sadly, her "introspective" self made her immobilized and stuck.

How about Others

It was difficult with K. to explore this, and there was not much she could say about others.

"*I found my social circle getting smaller and smaller. I would rather not go out than feel uncomfortable and self-conscious with people. It seems that I am protecting myself from people and preventing them from having the power to hurt me…I often blush which makes me even more embarrassed.*"

We introduced some tasks for her in terms of going out and socializing. She was happy to plan what she would be doing (going to the gym, playing guitar, going for walks), but more often than not did not do any of these. It was understood that she needed a more elaborate system for constructing others.

Summary

K. was stuck with a particular way of construing her parents. The main problem was fear of separation based on the felt threat of losing this important relationship if she invested in anything else.

She tried to separate at one point, succeeded, but this was performed as a slot-movement, her different self being cut off rather than integrated.

There is a lot of guilt in her life story as well. We assume that there was repetitive invalidation from caregivers who did not understand the child's needs, which resulted in her hostility and the need to control everything. In one sense, K. was a child left to her own devices.

Herself is characterized by both the low and high levels of self-sufficiency. She takes care of herself in the ways she does not like, by overeating. She can survive with as little communication as possible; being "fat" means no socializing and hiding her real self. Others are construed as "not friendly" or just "nothing much to say" and role relationships are evaded.

In spite of serious obstacles, this therapy course survived for 19 sessions and brought about some changes. Those were:

Different aspects of her life were elaborated; she understood that change was possible. This had happened in one period of her life, but did not seem to be an option at the time being.

The client-therapist relationship developed slowly, and at some time was promising. However, she kept the experience in psychotherapy separate from the rest of her life, and left it like this. My understanding was that she protected herself from getting close to another person, as this was a threat to her main ways of construing "the others".

I received positive feedback on few occasions, and it seemed that K. felt alright with me. However, it was difficult to see that *nothing seemed to work in terms of her eating behavior.* There must be positive effects from our sessions, as we elaborated important topics, and for K. it seemed the "proper" work since it was the first time she touched upon them, but her eating remained the same.

The explanation was her simplistic view of psychotherapy. The other is her super-ordinate construing of a lonely and worried child, who would not invest into anything, for fear that she might lose the precious relationship with her parents.

The problem with her loyalty to her parents was never verbalized, but it was felt. I suspect that this was an issue in her previous therapy, like "It was all your parents fault." I was careful not to impose anything in this sense. I felt that more time was needed for things to come naturally, as some of them did.

Finally, we did not overcome the problem of her inability to connect therapy with life. It was good for me that she felt stimulated and thinking clearly in the sessions, but what I wanted us to achieve was improvement in the daily functioning. This does not seem to happen; the experience in therapy and her daily functioning seemed to stay separate.

Conclusions

K. was a good example of a client who has problems with dependency. The concept of "un-dispersed dependencies" is found to be useful and helps to explain what is happening with difficult clients. It draws attention to the core roles and super-ordinate construing, which have to be addressed if psychotherapy with such a client is to be successful.

What is successful psychotherapy is another big issue. I believe that a psychotherapy course will have to be seen as one experience cycle, during which time the client takes as much as she/he is able and willing to. Some clients will have to go a long way before they solve their problems and develop as persons; some will decide that they may as well stay the way they are.

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