October, 2022

Rodrigo Díaz Olguín
Psychotherapist

Cipra
Psicoterapia Constructivista

Psychotherapeutic problem characterization in a constructivist case formulation

I. Introduction

The constructivist approach used in this discussion has as background the George Kelly (1955) and O.J. Harvey (1961) classic works. In addition to these direct references, notions from Vittorio Guidano (1983, 1994, 2001), Gabriele Chiari and Maria Laura Nuzzo (2009) proposals and Lisa Feldman Barrett (2015) contributions were included.

This approach incorporates the notion of «concept» as a unit of knowledge, which is defined as an action of differentiation or relational distinction, in which the observing subject and the observed object represent interdependent instances. This implies that no change, whether referred to as environmental, bodily, in other people or in one's own representations of oneself, has an inherent meaning, but must be understood relationally constructed from all those reference instances. In other words, given this interdependence, understanding the «relational meaning»[1] is central in the study of experience defined as a psychotherapeutic problem, emphasizing the subjective construction and symbolic interactions between referential objects such as the body and its affective changes, interpersonal relationships significant, the context, changes in self-concept and biographical memory, among others (Díaz Olguín, 2022).

To carry out this study, a clinical case formulation is proposed that aims to systematize the descriptive inquiries of the concepts involved in the therapeutic problem. This formulation includes a characterization of the changes observed in the application of these concepts during the construction of the therapeutic problem, a characterization of the general organization of these concepts, the study of the construction of threats and the associated *closure processes*, and the possibility of explain the therapeutic problem in terms of narrative integration difficulties[2] in self-referential instances (Díaz Olguín, 2022).

[1] A very similar point of view can be found in the work of Lisa Feldman Barrett

[2] In this perspective, the "the narrative nature of experience" alludes to the fact that subjectivity and, therefore, the meaning construction occurs in the integration of three referential instances: self-image (self-concept, personal history, personal prospective, etc.), otherness (subjective construction of others, their motives, intentions, etc.) and corporeality/world (the reference to one's own body, presence, subjective temporality, context, etc.). This notion is distant from the social-constructionist conception of narrative (see Díaz Olguín, 2007), including the totality of the experience (not only the discursive or reflective range, but also the tacit, implicit or pre-reflexive experience) and understanding the integration narrative as a self-referential process, linked to the identity sense.

The methodology in this case formulation is qualitative, idiosyncratic, in which longitudinal process evaluation strategies and intervention strategies focused on the deconstruction, construction and reconstruction of meaning are privileged (Díaz Olguín, 2022).
In the present work, a brief clinical case formulation exercise will be developed in the context of a psychotherapy supervision. For such purposes, in the following section three theoretical notions will be exposed in which the psychotherapeutic problem characterization is sustained in this narrative-oriented constructivist framework:

a. **Description of the conceptual organization.** To describe the organization of the concepts and their changes between sessions, the criteria of «demarcation» will be used —changes in the number of differentiations made—, «valence» —dynamic and changes in the centrality/periphery disposition of the conceptual applications involved—, «control»—subjective/objective control assignment changes respect to conceptual applications— and «understanding» —changes in the articulation respect to other concepts, the degree of openness to refutation, the simplicity or directivity that they can show, and the degree of abstraction of the concepts involved—.

b. **Study of the closure/stress processes involved in the psychotherapeutic problem**. How the person constructs the threatening experience will be studied and the closure/stress response will be characterized, both in terms of specific processes and the possible presentation of phases or global changes in functioning. The specific stress processes are: the reiteration of conceptual applications; the closure to the refutation of concepts and the search for conceptual confirmation; the increase of concreteness in the concepts applied, awareness, generalization and conceptual compensation; and changes in one's own self-image, alterity and corporeality/world construction.

c. **Narrative arrests in reference instances**. More deductive in nature than the previous characterizations, the hypothesis that the psychotherapeutic problem can be explained through a specific integrative difficulty between reference instances will be studied. This type of hypothesis can be highly useful for the clinician, since it allows us to understand changes and modifications in other instances —not the arrested instance— and to strategically focus on a specific integrative difficulty.

Then, in section III, a clinical vignette will be studied using each of the notions provided by the theoretical framework.

II. Characterization of the psychotherapeutic problem

In a narrative-oriented constructivist case formulation, the information produced by the description of the concepts —updated and specific subject/object/context relationships— that constitute the therapeutic problem is organized, registering the variations with respect to criteria agreed upon by the patient. and the therapist for ongoing therapy evaluation. This approach attends to changes in the way of applying, confirming or refuting concepts, of organizing them referentially into ontological categories, and of narratively integrating knowledge between these categories. In this type of formulation, the use of refutable hypotheses is recorded based on explicit objectives, establishing formats for qualitative and quantitative evaluation of the general process.

Next, three of the basic notions of the psychotherapeutic problem characterization used in this approach will be explained (Díaz Olguín, 2022): conceptual organization, closure/stress processes and arrests in narrative integration.

a. Conceptual organization description

From our perspective a «concept» is the basic unit of meaning. It implies an integration, primarily tacit, of the simultaneous differentiations referring to the instances «self-image» —subjective construction of the subject himself—, «corporeality/world» —subjective construction of the context, the world and its objects— and «alterity» —which considers the subjective construction of others, of the intentional mind of another distinct than one's own will—. From this perspective, a concept is of tacit primacy, and involves an emotive quality as well as a cognitive or conative quality. Concepts are actions, they imply an anticipatory state, an application, and a refutation or verification possibility, so they are often defined in those terms, such as "conceptual application". The concepts are polar, their application in one sense immediately implies the affirmation in the opposite sense.

To describe the way in which the concepts are organized, in this clinical formulation four criteria are used, agreed upon by the patient and therapist, in terms of the language installed in the work relationship. The four suggested criteria are «demarcation» —the degree of differentiation, delimitation or discrimination between the concepts—, «valence» —the disposition, orientation or center-periphery dynamic in the application of the concepts—, «control» —the degree of control-object and control-subject experienced in the application of the concepts—and “understanding”—the degree of articulation, openness, directivity, and abstraction of the concepts.

The criteria are used to make an in-process characterization, in the experiential course, therefore they allow to register changes in the observation. Each criterion can be understood as a two-pole dimension, where the therapist and patient can identify changes that occur during a certain set period of time. Each of these criteria will be briefly explained below.

Demarcation

It is the criterion that refers to the differentiation, delimitation or distinction between a concept and another concept (Harvey, Hunt & Schroder, 1961; Witkin, Goodenough & Oltman, 1979). A course of experience with an increase of demarcations will then allude to a high conceptual differentiation, distinguishable conceptual applications from one another. The opposite will point to a "diffuse", "mixed", "ambiguous" or "absent" experience course, which shows difficulty for clear references, discrimination of distinguishable gradualities, etc. In terms of poles, observed shifts toward less differentiation are termed *sub inclusive* or *subtractive demarcation changes*, and observed shifts toward increased differentiation are termed *overinclusive* or *aggregative demarcation changes*.

Of course, neither of the two poles of the gnoseological criterion is pathognomonic. For example, a high demarcation can be found in various psychopathological constructions and in normal articulations, in the same way that a "diffuse" demarcation or loss of differentiation can occur both in different psychopathological syndromes, and in the normal phenomenon of integration between conceptual poles and emerging induction of more abstract, new and ambiguous concepts, which in turn promotes differentiations within the concept. It is also important to remember that the concepts are referentially integrated, therefore the registration of demarcation changes in the reference to an instance can be coupled at the same time with decreases in the demarcation referred to another instance. For example, in a delusional experience, a patient made aggregative demarcation changes by imagining -and even visualizing- that his wife was cheating on him with other family members. At the same time, in gradual changes and immediately prior to the delusional episode, the patient decreased the number of differentiations related to corporeality/world, showing slowness, reducing the variability of movements, with constrictive routines, and actively decreasing the differentiation capacity through alcohol's use. In this particular example, the therapist and the patient register the changes of demarcation, both aggregative in otherness, and sub-inclusive changes in corporeality/world.

Valence

Some conceptual applications are organized as "peripheral" and others as "central". The degree of centrality indicates that certain conceptual applications represent part of an important nucleus about what the person "was, is and will be", about those objects referred to corporeality and the subjective world that constructively represent anchors or important ‘milestones’ for the sense of identity, and on constructions referred to significant others to the extent that they form an important part of the continuity in otherness. The notion of centrality-peripherality alludes to that disposition of concepts in terms of representing an identity core, on the one hand, and on the other hand of being easily interchangeable and expendable concepts. This dynamic disposition[3] is not related to a pleasure-displeasure perspective or a type of pain avoidance, since it is

[3] In a dynamic and complex formulation, as mentioned later, in threat-stress construction courses, parameter changes in the conceptual field (its external limits) can lead to significant changes in the centrality-periphery dimension. Such directionality changes could be expressed in many ways by the therapist and the patient: in terms of attractions-repulsions, in terms of negative-positive valences, in terms of approach-avoidance, or in terms of positive and negative evaluations.

common for concepts of high centrality to involve feelings of suffering, guilt, shame or other varied unpleasant experiences.
Patient and therapist will both be involved in observing changes towards the peripheral displacement of concepts that were previously central and vice versa. For example, a patient who was experiencing feelings of contempt for his partner, after a motorcycle accident made noticeable changes and began to fall in love again, thinking about her more often, making plans, expressing affection in various ways, and so on. In another case, as the weekend approached, changes were recorded where drug use with friends became central and concepts related to caring for family relationships became peripheral.

Control

This criterion alludes to the control assigned in referencing the conceptual applications. The characterization in terms of «control» must take care not to neglect the triple simultaneous referentiality in the instances of corporeality/world, self-image and otherness, instead exploring the integrative relationship between the three. For example, a patient could focus on the reference to corporeality/world —"when I went to the bar I thought I would control consumption, my intention was just to have a drink and go home"—, and at the same time, in the same scene, together to the therapist can characterize the changes in the allocation of control with respect to the constructs referring to himself —for example, his perception of self-efficacy— and to the significant others included implicitly or explicitly in that scene —for example, the expectations of revelation of the relapse to close relatives, or expectations of reaction from others, etc.— (Richards & Glasersfeld, 1979). In other words, the exploration must consider both the assignment of control with respect to others, one's own body or the world of objects, and the experience of control experienced with respect to oneself in those conceptual applications.

Understanding

Whether regarding a thought, feeling, or observable behavior, we speak of "someone understands something", when that person makes a conceptual application and integrates it in a certain specific way in his repertoire of concepts. The incorporation of new movements or motor schemes, or differentiations and recognition of visual patterns, or different corporal affect tones, etc., greatly distances the scope of this definition of understanding from a cognitive-rationalist notion. Characterizing that particular integration can be done through different observations, records or questions. For example, is this conceptual application related to applications availables to the person? Is it related to more abstract concepts, such as issues of personal meaning? Is it based on the integration of more concrete concepts? The understanding processes are open to refutation, or are shutting down to refutation? Is the concept organization understandable to the person himself? What is the degree of abstraction or concreteness in which this conceptual application is comprehensively located?, among others. The characterizations that can be made with this gnoseological criterion are four: articulation-compartmentalization, opening-closing, directivity-mediation and abstraction-concretion.

Articulation - compartmentalization

The characterization «articulation-compartmentalization» can be expressed in terms of the integrative relationship between concepts or groups of concepts. A high articulation of concepts implies that they are shown to be related —for example, they covary— with others at the same level of abstraction and are combined with other more concrete and abstract concepts. As we have emphasized, this does not refer to a cognitive, rational, explicit or discursive relationship, but is related to the form of insertion of a conceptual application in the broader set of concepts. For example, if I decide to eat an apple, that decision could be sustained in an articulated way with more concrete concepts —for example, the pleasure of the taste of the apple, its texture, conceptual applications that consider the recreation of previous related experiences, etc. However, in the opposite sense, a high level of compartmentalization would imply that eating the apple appears «disconnected», as a group of conceptual applications, from other concepts. Then, eating the apple would be guided by the social image, by imagining ourselves to be Adam or Eve, without a recognizable intentionality of our own or even without the possibility of recreating the application, as a "mnemic gap" that is configured by the story of third parties, and so on.

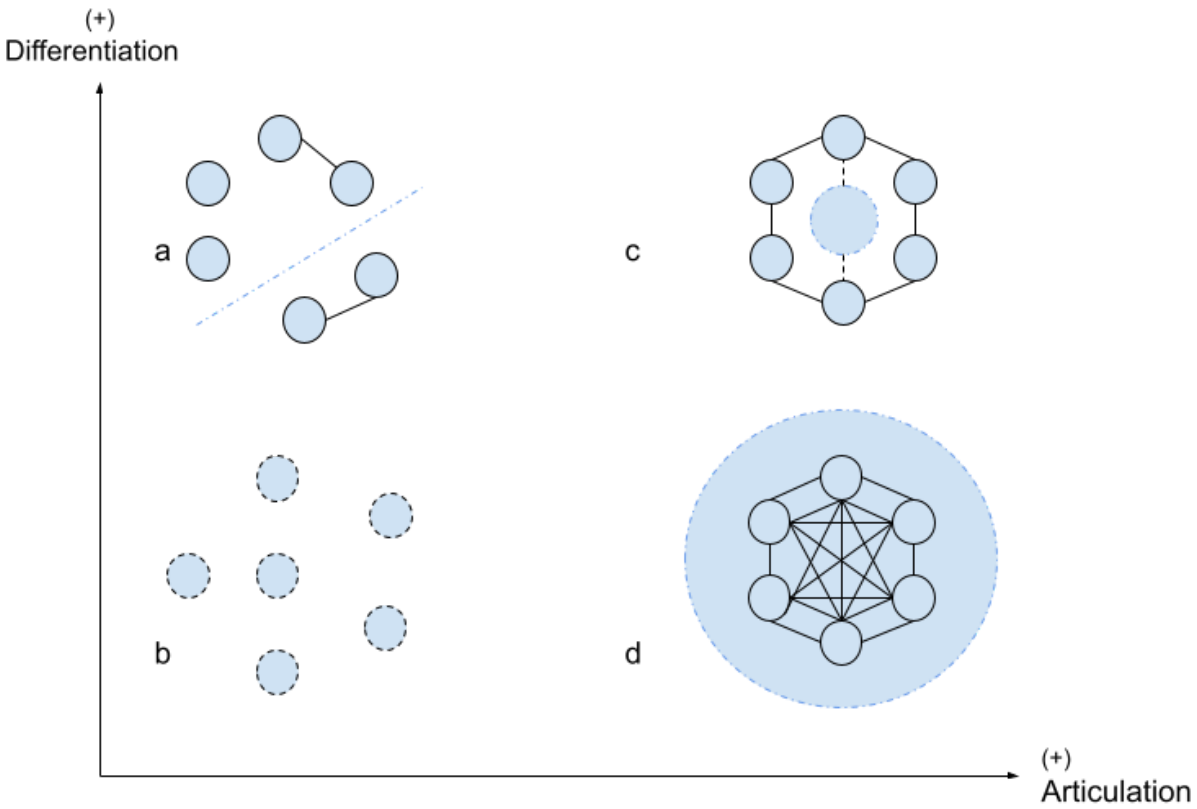

Figure 01. Differentiation-articulation formats in the characterization of concepts: (a) compartmentalized, (b) diffuse, (c) modular and (d) global. Diagram adapted from Díaz Olguín, 2022

Openness - Closedness

The «openness-closedness» characterization can be expressed as the extent to which the concepts are open to refutation and the possibility of alternativism, of alternative conceptual applications. A conceptual closure is analogous to a *tautology* in the sense that it is a self-verifying construction closed to refutation, with specific “protection rules”. One of the most important conceptual closure pathways in clinical practice is that of stress/closure, which in our approach involves the study of activity formats in the construction of a threat. Other formats of conceptual closure, such as doctrines, crushes, habits, prejudices, etc., are not always part of the therapeutic focus.

Directness - mediateness

The «direct-mediate» characterization can be expressed by the notion of operational simplicity of the set of concepts, independent of the number and organizational complexity. In this sense, a person can manage a large number of different concepts, with fluidity and directness, quickly orienting himself to precise objectives. At the other end of the characterization, a person might experience trouble solving as difficult, expression becomes cumbersome, goals appear fuzzy or contradictory, and so on. The mediate and minus operative expression is not necessarily restricted to narrow and specific experiential portions, but can encompass broad groups of concepts; an example may be the structuring of the addictive experience, in which the difficulties of integrating conceptual poles have led the person to confront large groups of contradictory concepts, with the inherent difficulty in giving personal and interpersonal meaning to that experience.

Abstractness - concreteness

Finally, the «abstractness-concreteness» dimension guides the characterization of which concepts are more abstract than others, with particular interest in defining the set of more concrete concepts presented in the therapeutic focus. Although it is a criterion that does not refer to external parameters, but rather to the more general set of concepts applied by a particular person —just like the other characterization criteria—, it is possible to outline that a concrete concept will probably imply simple and global forms of experience, with few differentiations, quick and immediate actions, often related to "sensorimotor" activity. According to this, anticipations and evaluations will be polarized and rapid in new situations, dependent on guidelines or directives from an authority, showing less tolerance for ambiguity (Harvey, 1965; Harvey, Reich & Wyer, 1968). On the contrary, the more abstract concept applications could show less tendency to absolutism, less tendency to cognitive consistency and less arousal and experiential change in cognitive dissonance. The ability to change the frame and the relative focus with respect to one's own experience, reduce stereotyping when facing complex and challenging problems, be able to distinguish between means and ends, place oneself in imaginary or hypothetical situations that are useful for coping with problems, among others possibilities, would be expected characteristics of the application of more abstract concepts.

Psychologists OJ Harvey, David Ellis Hunt, and Harold Martin Schroder, proposed in their classic work *Conceptual Systems and Personality Organization*, four general stages of concretion-abstraction, with three transitions between levels:

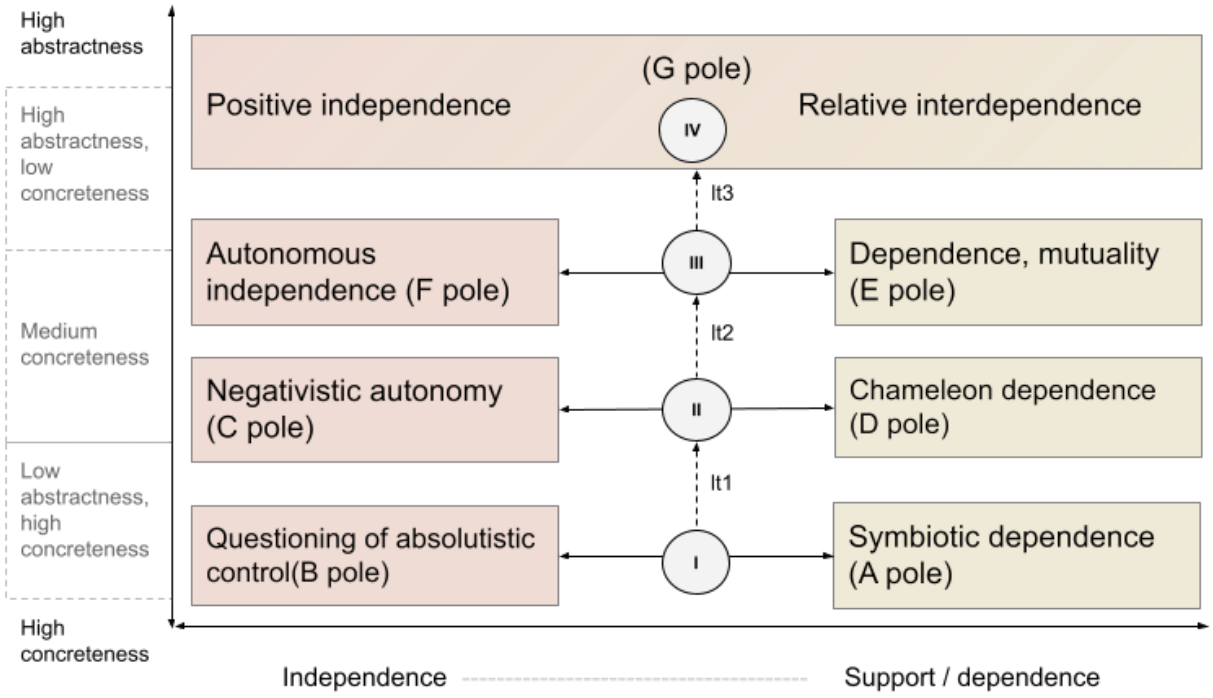

Figure 02. Stages of conceptual abstraction proposed by Harvey, Hunt and Schroder, adapted by Díaz Olguín, 2022

Stage I. In this stage of high concreteness, conceptual applications are experimented with maximum external control, depending on others in absolute terms. The experience is of correspondence with the external control, there are no major differentiations between the rule and the goals. The behavior is immediate, with an external submission. The person is oriented to establish structures and avoid ambiguity. The conceptual applications referred to the self-image, world/corporality and alterity, are of low articulation and a high sensitivity with their demarcation limits is experienced. Since all conceptual differentiations are polar actions of knowledge, at this stage of abstraction two poles can be characterized in terms of autonomy: at one pole we have absolute external control, a one-sided dependence on the source of interpersonal regulation; at the other pole the same differentiations imply an absolute opposition to external control, the achievement of the perception of concrete autonomy through direct opposition to external control, and -through this process- an increase in internal control.

Stage II. The person can apply more abstract concepts, with greater freedom from symbiotic and immediate dependence, can differentiate between external and internal control, and can manipulate the criteria applied to their own behavior by generating different systems of ordering concepts beyond the direct external control framework. The new applications are oriented both to question the generic control —freedom «against the rules»— and the «chameleonic correspondence» with those regulations, building a sense of security by coinciding or not with those expectations or standards of groups, institutions, ideals, principles, etcetera.

Stage III. Only those conditions that simultaneously generate differentiations based on opposition to external regulations and dependence on expectations lead to the emergence of more abstract concepts. At this stage III, the reorganization of conceptual applications can increase awareness of internal causality and the intentions of others are considered with greater relativization, so referentiality does not acquire such a subjective tone as in more concrete stages. It is also possible to visualize that everyone has a subjective and personal point of view, and does not submit or resist them. It is possible, gradually, the appearance of mutual relations. One's own motives and absolute standards diminish, less concern about ambiguity occurs. Given this more abstractness, the person can begin to act «as if», learning from the relationship with the interpersonal environment to differentiate himself from the figures of early regulation. At this stage, an arrest —closure in one of the conceptual poles— could imply intense feelings of loneliness, abandonment, and guilt.

Stage IV. Inorder for a person to experience autonomy as positive and not in conflict with mutuality, *both poles of the third stage must be experienced as positive*, leading to the emergence of a fourth stage conceptual system involving interdependence of informational standards. This interdependence of the evaluations represents the most abstract level of conceptual organization: the person is capable of complete differentiations between the references and the more general field of concepts possibilities, but manages to reorder and synthesize the conceptual applications in a way that perceives interdependence with the field. Mutuality and autonomy are integrated and not separate, in a positive, informative and abstract interdependent relationship. At this stage there is greater resistance to stress, to the extent that closures are less likely. There is greater self-awareness and greater internal locus of control. Failures, loss of control, rejection or isolation can be used as resources and do not represent rigid ways of coping with stress. Unlike the previous more concrete formats, in which closure/stress implied using the same fixed solution even in different changing situations —avoidance strategies, absolutism, extreme compensatory applications, quick and categorical decisions or immobility—, at this stage the abstract formats allow exploring various solutions and informational consequence relationships that are tools dependent on changing conditions. A firm vision or attitude emerges that is not distorted by low differentiation inherent to new situations.

b. Closure-stress and phases

A second way of characterizing the therapeutic problem in the narrative constructivist case formulation, considers the study of the construction of *threat* and the closure-stress response.
The notion of stress refers to a common —non specific— response to a “demand for change”. Hans Selye emphasized this definition, in which the stress response has a "different meaning for different people under different conditions", however generalities of the response can be identified. In his book *Stress in Health and Disease* (1976), Selye reviews some definitions, among which is the one used by the behavioral sciences: a response to the *perception of threat*, with the consequent anxiety, discomfort, emotional tension and difficulty in the adjustment. As Richard Lazarus (Lazarus & Folkman, 1984) mentions, this perception of threat is understandable in terms of individual interpretation, of the psychological meaning that the person assigns to a particular experience.
The emphasis on the importance of subjective meaning regarding the "stressful situation" - “stressful construction” corresponds to a long tradition of authors in psychology[4]. Current research on stress is no longer directed dichotomously at environmental stressors and personal dispositions, but rather is considered as a complex phenomenon that occurs and develops in the person-environment interactive process.

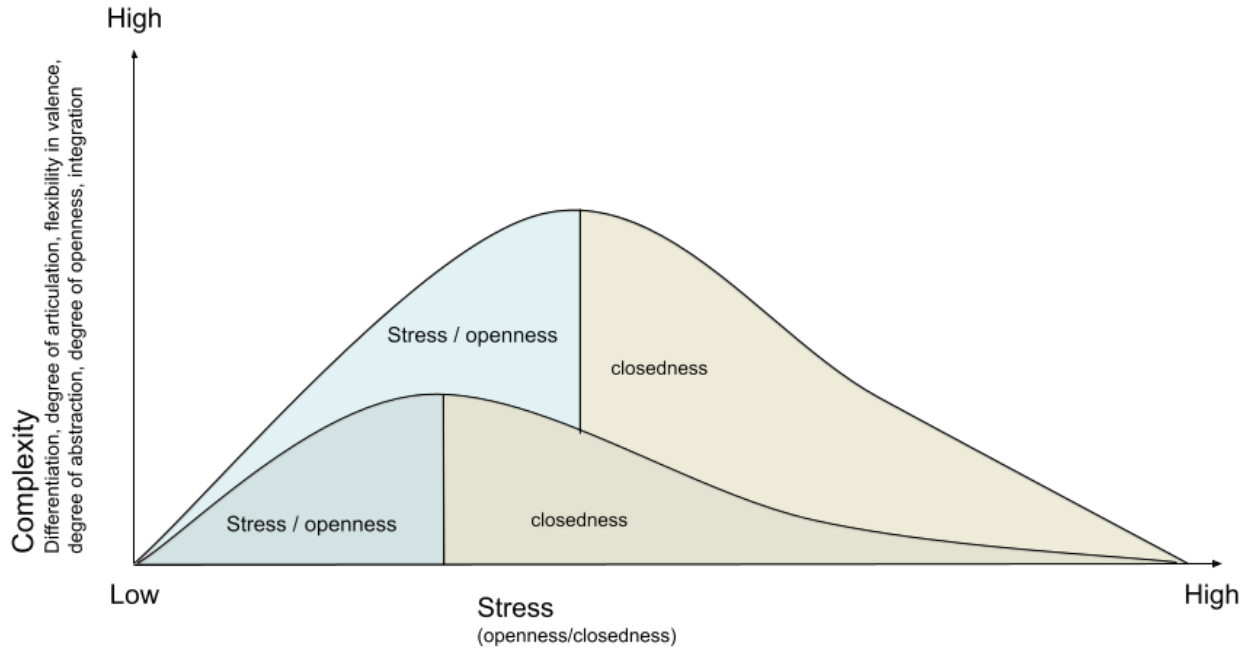

Figure 03. Expected differences in openness and closedness due to stress, depending on conceptual complexity level.

[4] For some classic books and articles, see Bowers, 1973; Endler & Magnusson, 1976; Rotter, 1975; Pervin & Lewis, 1978; Lazarus & Folkman, 1984; Harvey, Hunt, & Schroder, 1961; Schroder, Driver & Streufert, 1967; Laughlin, 2017

In a similar way to what is stated in the Yerkes-Dodson hypothesis, it is possible to propose a hypothetical relationship between the complexity of conceptual applications and the way of experiencing stress. In the scheme above, conceptual complexity is understood in terms of the degree of differentiation and conceptual articulation, flexibility in the changes of dynamic valence, the degree of abstraction and the degree of openness of the concepts. In the same scheme, the stress openness[5] format is plotted. Like any organism, the tendency to conserve energy when it is not sufficiently challenged allows us to consider a positive minimum level of stress or challenge, in the sense that if the constructed experience is relatively simple or of very low complexity, people can operate at less than optimal level. If building a challenging experience, then the person can acquire an openness-stress format, which drives new conceptual applications. However, if the challenging experience continues and if certain particular conditions occur, such a high level of centrality of what is threatened, integration difficulties, high level of concretion, etcetera, the experience acquires a format of suffering, fatigue, weariness and pain. Two aspects of this hypothesis are very relevant:

- It is expected that the more abstraction, a tendency to better manage more complex forms of challenging experience can be observed. In other words, the greater the complexity, the better the tolerance of the person at the time of undergoing a stress experience.
- Second, if the stress increases, a significant detriment is expected at some point, regardless of the initial complexity level, in the operations of the conceptual system.

Both aspects are important to clinical considerations. On the one hand, the promotion of conceptual alternativism, that is, the ability to gradually increase abstraction in phase entry[6], seems to be central to the intervention. And on the other hand, it highlights the care and clinical attention required by a detriment in many processes when the stress experience is very high. As discussed below, in our approach this detriment to performance is called «simplified integration» (Díaz Olguín, 2022).

The threat construction and stress behavior

In understanding stress behavior it is essential to study interpretations, beliefs, expectations, learning history and other elements of personal experience. For example, Richard Lazarus (1984) suggested that perceptions at the onset of the stress experience can be ordered in terms of their personal or subjective appraisal: irrelevant, positive, challenging, threatening, and harmful perceptions. Careful not to view these categories as isolated from one another, and setting aside *irrelevant* and *positive* perceptions, *challenging experiences construction* will involve attempts to increase the potential for dominance and control, personal growth, or gain.

[5] As we suggested in page 7, the notion of "openness" implies opening to refutation, constructive alternativism, search for alternative concepts, creativity, exploration, etcetera. The opposite defines "closedness".
[6] See page 18

The other forms of construction —*threatening* and *harmful concepts*—imply some kind of danger, something important to the person is at risk, or a risk himself.

From our constructivist approach, the construction of the threatening experience is specified by the individual's narrative orderings —the form of the previous integration of references to corporeality/world, self-image and alterity—. A sense of identity presupposes by definition that which can undermine the sense of coherence that sustains that identity. In other words, by specifying the rules of "what one is", the forms and guidelines that allow "ceasing to be" are specified. The reader will then be able to characterize the nature of the threat through the degree of differentiations, valence changes, control assignments and the way in which the experience is comprehended —qualitative/descriptive appreciations regarding the articulation of concepts, their openness, degree of directivity and level of abstraction—.

For example, for a man with homophobic beliefs, a possible homosexual orientation of his son may be threatening to the extent that he presents few differentiations referring to the area in question, is a highly central ordering, experiences little assigned control and in terms of understanding does not achieve articulate your child's orientation with other aspects of the parent-child experience, is part of beliefs with little openness and a tendency to avoid refutation, is expressed in an unclear way and interferes with the expression of other concepts, or that represents a set of highly specific concepts or arranged in such a way as to favor closure.

The stress experience can be related to conceptual closure through three general, non-exclusive ways: hysteresis, lack of conceptual differentiations, and high structuring of conceptual applications. The first refers to "material fatigue" or the accumulated set of epigenetic changes, sleep disturbances or physiological detriments, negative changes in others, economic losses, etc., which are equivalent to a detriment and a gradual perception of greater difficulty. The second form refers to the absence of expertise or necessary concepts for integration, because the person is very young, or an important aspect of conceptual refutation has been avoided in the experiential course, or the constructed experience is very novel. The third way is that the construction of threat and the tendency to closure are related by the high degree of coherence in the conceptual applications available, making integration difficult due to the *inadmissibility* of the threatening experience, in terms of the large costs of conceptual reorganization that their integration entails. Through these three ways, the person can increase the tendency to closure, which is defined as the repetitive application of the same conceptual applications, a process in which they can be distinguished (Díaz Olguín, 2022):

Closure to refutation and search for threat confirmation.

In the stress behavior, organisms gradually display less openness regarding possible alternative conceptual applications, at the same time that confirmatory concepts are applied.

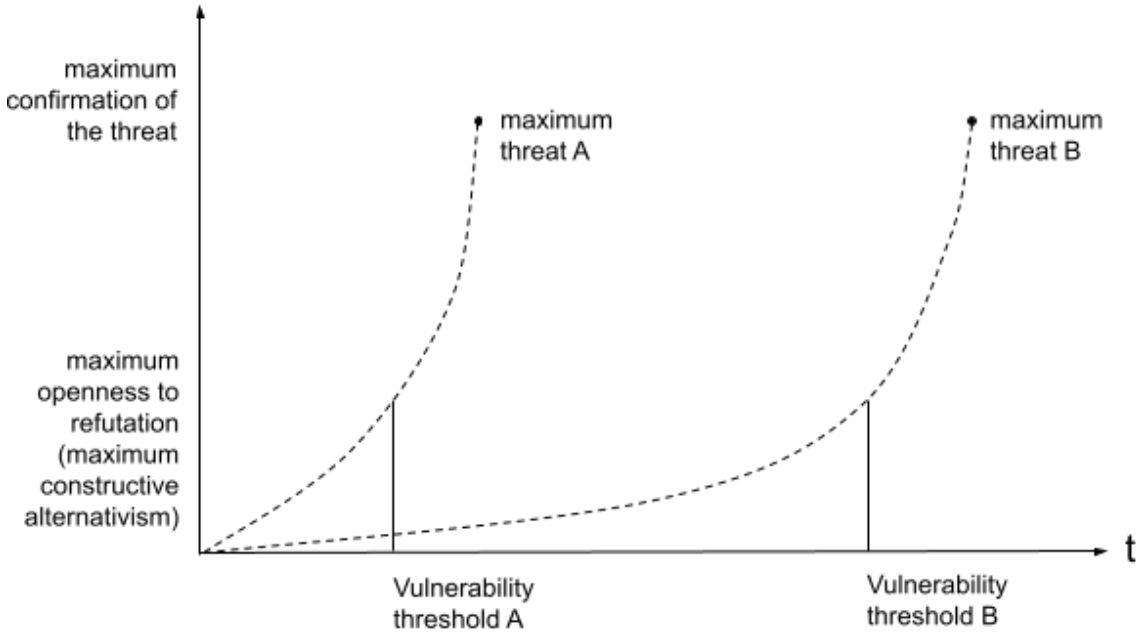

Figure 04. Vulnerability Thresholds and Threat Confirmation

As the threat represents a process of meaning construction, its maximum openness to refutation does not refer to avoid a confrontation with a independent content, it's not a denial or defense with respect to an a priori, pre-existing threatening content that has an "inherent meaning", as in other psychotherapeutic approaches —for example the *Verleugnung* and *Verneinung* of the Freudian tradition— but is related to the application of alternative concepts regarding the possibility of threat. In the same way, the threat confirmation is a constructive process and is also not related to some "inherent meaning" in the experience referred to as threatening, but rather to a gradual process of building certainty and closing off the possibility of constructive alternativism[7]. The time required to cross from open conceptual applications to an orientation of threat confirmation and conceptual closure, can be considered an indicator, among others, of the threshold of vulnerability to stress with respect to the specific threat that is being constructed.

[7] At this point it can be remembered that conceptual applications in no case refer to only cognitive actions (thought), but rather include the integration of perceptual activity as differentiation. In other words, examples of this search for confirmation of the threat include both the imaginary anticipatory anxiety regarding a supposed job dismissal, with all the bodily, contextual and interpersonal changes that it involves, such as physically approaching a strange noise source, again including the associated thoughts, feelings, and behaviors.

Closing and reiteration.

The advantage of a closure process is that the rules of narrative viability that have been upheld up to now are ensured. Apparently the execution of conceptual applications may be diverse, but a careful evaluation may discover that as stress increases, the type, sense and level of conceptual applications tend to increase in similarity: the person repeatedly applies the same concepts or the same type of concepts, hoping in vain for different results. It is important to note that each reiteration does not occur from the same experiential point, because each applied concept modifies the following application –hysteresis or allostatic changes–. This can take the favorable path of directing resources and energy towards what represents a possible way out of the closure process, persisting in the actions or defining the baseline to make slight changes, or it can "make the situation worse" by generating a gradual decline in behavior—if we compare current behavior with past behavior. Detriment pathways can include actions such as substance use, sleep disturbances, interpersonal isolation, etcetera., actions that were often helpful coping for the person.

Increased concreteness.

In simple and complex living organisms, the stress response is an innate, stereotypic, adaptive response that has evolved in the service of restoring the non-stressed homeostatic set point (Chu, Marwaha, Sanvictores et al., 2022). Faced with a sustained threat, this fast and stereotypic behavior involves, in individual or transgenerational-epigenetic terms, changes in the way energy is dispersed. In other words, the stress behavior can be understood as an entropy increase with respect to the previous energy dispersion pattern (Bienertová-Vašků, Zlámal, Nečesánek, Konečný & Vasku, 2016). From this point of view, if the most abstract differentiations are considered as increased forms of entropy reduction and energy dissipation[8], the stress response evolutionarily guides conceptual applications that are increasingly direct, concrete, with high energy dispersion, in order to maintain viability[9]. It is to be expected, then, that in the construction of threat, the stress-closure response gradually involves more concrete conceptual applications. The maxim limit to this course of processes, primarily tacit, can be defined in terms of viability: biographical death, physical death or conceptual disaggregation —disintegration, dissociation and psychotic reference—.

[8] Through structural changes, not a simple accumulation of energy. Review Erwin Schrödinger's notion of “negative entropy”, or “negentropy”.
[9] Premise that would also be valid for allostatic adjustments.

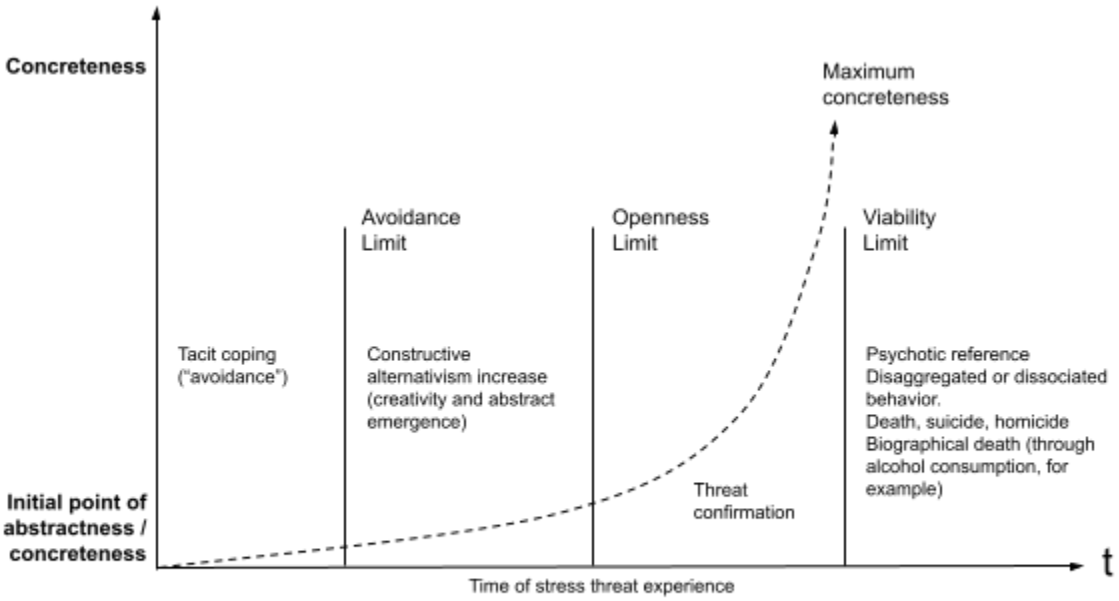

Figure 05. Structuring of avoidance, openness and viability limits, regarding changes in abstraction-concretion, during the course of the stress experience.

Valence changes.

It could be established that the threat construction processes and the course of stress are in direct correspondence with those concepts or groups of concepts central to the subject, but this is not a precise assertion[10]. In a stress construction course, and given that the behavior of organisms is dynamic, it is expected that the parameters that define the field in terms of centrality-periphery are the ones that change in the first instance. On this redefinition of the parameters field, the new valence changes must be studied. This notion is fundamental in psychotherapy, supporting effective actions on the one hand and –for example, the "intersession" approach in addiction psychotherapy–, on the other hand, explaining to a great extent some difficulties of "access" that therapists and patients have in session, outside of an experiential course of stress. In addition, the lack of clarity of the relationship between a course of stress and valence changes could support stigmas, guilt, and adverse judgments from the patients and treating professionals themselves. Our approach suggests that evaluative changes in stress allow us to define groups of central conceptual applications in their maximum concreteness, which probably —despite their importance— do not achieve an articulated expression of greater abstraction outside the course of stress. From this perspective, the psychopathological forms "contain" broad and favorable personal development possibilities for the person, if their most abstract deployment becomes possible.

[10] Part of this confusion can occur when pain processes are equated with stress processes, which, although they may overlap, are different.

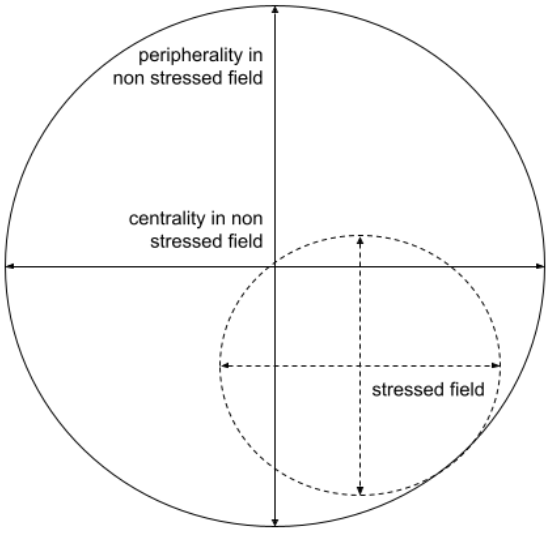

Figure 06. Valence changes with respect to more general field changes during the stress experience

Sensitization.

During the course of threat and stress construction, the person is likely to increase sensitivity to closed concepts. In this way, small differentiations can be referred to in the construction of relevant discrepancies. This change summons multiple processes, in the physical-body response, attentional changes and cognitive rumination, among others. It may be relevant, not only from a strictly epistemological point of view but also from a methodological one, to consider the increase in sensitization according to the discrete structural changes of the experience, and not to the supposedly objective changes from the patient's point of view, which from that perspective might represent continual changes in intensity perception —for example, "I can't stand the noise of my relatives' voices anymore."

Generalization.

Another gnoseological change expected in the construction of the stress experience is concept applications outside the usual range, compromising other applications —for example, a job failure can increase awareness of the construction of failure in other areas of development, such as sexual or romantic—. The first effect of generalization is the gradual increase in closure in other areas. The more central the threatened concepts, the greater the generalization to previously peripheral areas. In this process, the more abstract applications in other areas may also decrease, while fewer applications in other areas of the vital space are used. The second effect is related to the reorganization of these generalized clusters, which is often carried out through diffuse conceptual applications, poorly differentiated, with unfavorable control assignments in the event that the stress experience is sustained for a long time. For example, the feeling that "something bad is going to happen to me, everything is going wrong" can show both

effects and, if sustained for too long, lead to unfavorable behaviors. From this approach, however, they should not be considered in isolation or as "causal factors" of a behavioral alteration, generalization processes such as hopelessness, for example, should be considered as part of a stress course.

Compensation.

The above changes —closure to refutation, confirmation seeking, reiteration, increased concreteness, and valence, sensitization and generalization changes—may be paired with a greater likelihood of making more extreme compensatory conceptual applications unusual for the prior behavioral style. These compensations are concrete, trying to compensate by direct opposition in the same type of conceptual applications. For example, a person who increases her intake of sweet foods after a unusual demanding day at work, an academic who experiences little peer recognition and who dreams of writing the "best book in the world", a young man who he experiences his sexual desire as threatening and that he tries to be “pure in thought and action” after masturbating, etcetera. In time-limited stress courses, compensation can be a very useful strategy, allowing effective compensation from the subjective point of view for the changes that occurred during the stress course. However, in some cases it can be counterproductive, in terms of euphoric or manic behaviors, drug use, sleep disturbances, etcetera.

Allostasis.

Given some complexity, the stress course is expected to exhibit *hysteresis* and *nesting* or –for an equivalent term in the area of stress study– *allostatic load*[11]. This notion alludes to the quantity and quality of the adaptations in the conceptual applications carried out. Although the changes in the course of stress can take various directions, such as the increase in the propensity to apply certain concepts and the consequent closure through changes in the articulation[12], or the high increase in congruence within that group of concepts, the gradual loss of differentiation due to closure could be associated with a detriment in global functioning if the stress course is maintained. We have established that a conceptual application not only alludes to a thought, but to the global activity of knowledge, for which psychological, biological, contextual and interpersonal allostatic modifications are expected. From our constructivist perspective, these decreases in conceptual capability, or reduction of «constructive alternativism», referred to the construction of corporeality, world, self-image and alterity, must be carefully considered in the therapeutic formulation. For example, the person may—through epigenetic changes—gradually show different ways in his construction of corporeality/world, or through frequent rumination, may facilitate the construction of a

[11] Sterling and Eyer, 1988, coined and defined *allostasis* as the change that points to flexible variability to anticipate requirements more quickly (Sterling, 1988, 2020). *Allostatic load*, coined by McEwen and Stellar, 1993, refers to the "wear and tear” and other changes on the body and environment that accumulate from repeated stress, in long term effects (McEwen & Stellar, 1993; Sterling, 2020).

[12] A discussion regarding the *nature* of the articulation, which should not be considered a form of associationism, exceeds the limits of this work. However, the reader can review Piaget's notion of *unfolding* or deployment, which in our terms refers to the process of differentiating concepts through the application of previous conceptual differentiations, in an *organized* way.

negative self-image, or may promote changes in the construction of their otherness with the probable alterations in the behavior of the other close ones, among many other possibilities. One of the challenges of a highly complex clinic is to consider the adaptation phenomena in all these areas, as a "stress load" susceptible to change and clinical intervention.

Stress and phase behavior

The construction of threat and closure usually takes the form of change in a significant group of gnoseological processes, called in this approach *phase change*. It is a common, non-restrictive characterization in highly complex clinical case formulations —for example, addictions, suicidal experience, etc.—, in which the therapeutic problem that is treated generally does not present itself in a linear and progressive way, since it would imply the biographical or biological annihilation of the person in a short time.

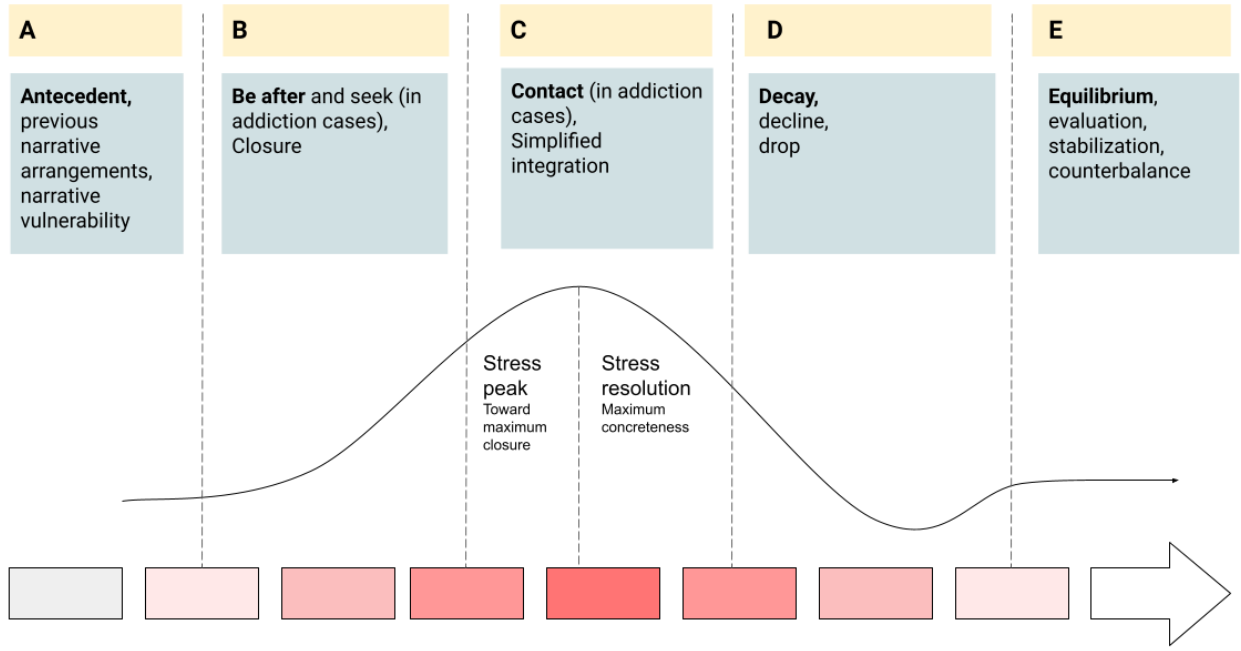

Figura 07. Characterization of distinctive moments in the tonic-phasic change (Díaz Olguín, 2022)

The «tonic-phasic» notion points to the ostensible change, included in a stress course, in the organization of the conceptual applications involved in the therapeutic problem[13] (Díaz Olguín, 2022) . This characterization can be done after the patient and the therapist make observations together, regarding the focus of psychotherapeutic work, in discrete periods of time.
The tonic aspect considers the behavior organization prior to the phase —the "*A moment"* in the diagram above—, and in this relationship it is a more stable behavior, generally outside the

[13] It is a notion similar to the more generic one proposed by Beck (1996) with his theory of modes, although with obvious differences.

therapeutic focus, at least in the initial moments of the work. Regarding the tonic behavior, it is important to record who the person is outside the therapeutic focus, what their interests, hobbies, etc. are, historically disposed aspects, with probable thematic and identity deployments. In contrast, the phasic characterization considers limited periods of time, it is a description of the changes involved in the construction of more acute stress-threat. In the diagram above, one can also distinguish a *B moment* —of progressive closure, a *C moment* —of contact or simplified integration— and *D and E moments* —of decline, stabilization and gradual opening—, discrimination that favors a processual register of the experiences treated, increasing the patient's ability to predict and promoting the application of concepts with greater assignment of control, among other methodological advantages.

Depending on where the patient is in the phase, they can take very different subjective viewpoints of their own experience, with narrative reintegration being most difficult at times D and E—moments when the experience becomes incongruous, painful, empty, guilty, etc.—. This suggests that the therapist-patient team should focus the investigation on the B moments of each phase, given that they present better recording possibilities, a greater possibility of paying attention to behaviors that favor the patient's integrity, a better possibility of remembering because the difference relative experiential has not been much, a possible increase in controllability as a result of the attention on precipitators in the closure construction, and so on. Of course, the self-concept discrepancy in phases D and E, and the possible increase in suicidal risk, must always be addressed, even though the perception of stress, both by the patient and by their environment, is lower.

c. Narrative arrests in the referential instances integration

From a gnoseological perspective, criteria for characterizing the psychological problem are defined and agreed upon, to be studied together with the patient —demarcation, valence, control and understanding criterias—. Then, it is possible to carry out an ontological analysis regarding the psychotherapeutic problem: this **ontological analysis** —regarding "things" or "objects" and their meaning relationships—- it is carried out in a narrative perspective. In this approach, the term *narrative* refers to the referential ordering in the concept application, both in their tacit and explicit or conscious forms, and not to the notion of narrative as explicit discourse, speech or story. This notion is supported by the thesis that meaning can be better studied through the way in which the person integrates it simultaneously —from an identity point of view, self-referentially— through arrangements between three referential instances or classes: alterity, self-image and corporeality/world.

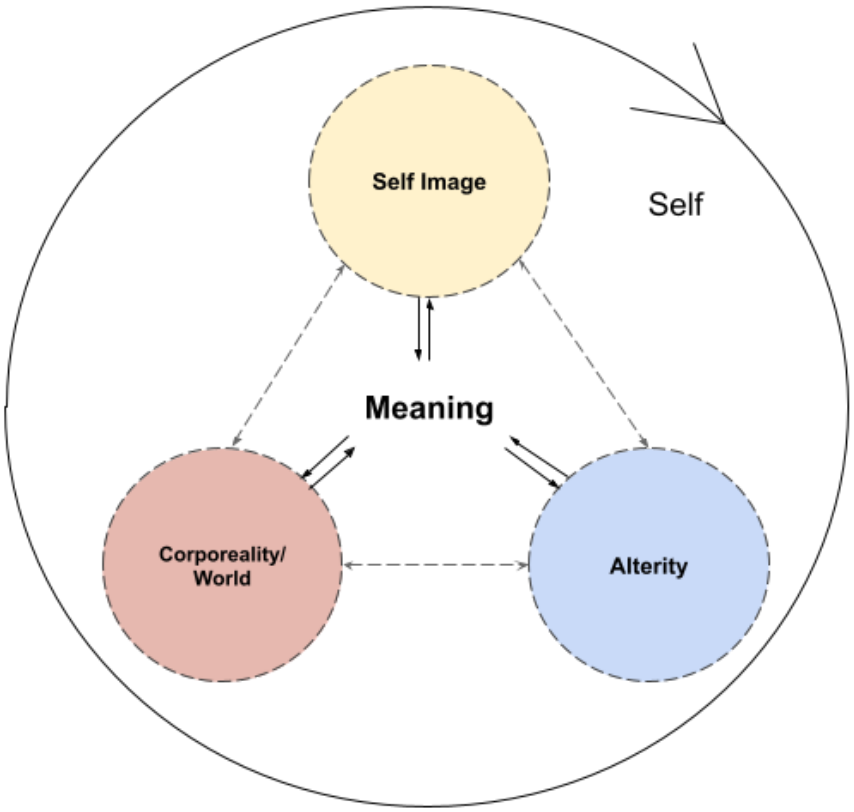

Figure 08. Reference instances in the narrative integration study (Díaz Olguín, 2022)

This formulation differs from other constructivist approaches mainly on two points. The first consists of the emphasis on bidirectional ontological determination in the construction of meaning. The notion of «concept» is transactional, in the sense of being defined as a

differentiation in the subject-object relationship, therefore the ontological reference not only defines the demarcation of objects, but at the same time the experience of the subject. The second aspect is that it is not a model that proposes a vision of meaning as an interpretive system of an event independent of the conceptual applications made by the person. In this approach, of a radical constructivist nature, the discrepancy is not an inherent characteristic of the environment, of the interaction or of the environment, with respect to which the individual must direct assimilation efforts to maintain the sense of identity, but is determined by the specific type of anticipations —conceptual applications— executed.

Reference instances

The definition of the three categories of reference is based mainly on the restriction of *intentionality* attribution in the meaning construction, which makes each category of ontological reference irreducible with respect to the other. In this way, the references in the construction of the self-image do not include the configuration of an intentionality other than one's own, as do the references to the instance of alterity; on the other hand, the absence of intentionality will characterize the instances of corporeality/world. The particular combinations between these instances and the notion of "cross-reference" (Díaz Olguín, 2016) can be heuristics in psychopathological understanding. Below is a brief description of each instance:

Alterity.

The reference instance of *alterity* is constantly constructed and rebuilt in the stabilization of references with respect to human beings or other entities involved in nutrition, protection, expressions of love and appreciation, generation of pleasure and behaviors of reproduction. This instance considers the distinctions or experiential actions that are referred to a subjective other to which mental states, personality and intentions other than their own are attributed. Of course, given the evolutionary development of the subject and the culture in which it develops, the multiplicity of otherness referents far exceeds one other as an individual, referring as otherness to persons, spiritual entities, physical objects to which intentionality is attributed, groups of people that are built with a single intention, among many other possibilities. Some biological and evolutionary aspects of humans —high altriciality, group protection and sustenance, sexual reproduction, etc.— could explain the centrality of this instance. In our approach, it is the first instance considered in deconstruction activities.

Corporeality/world.

From our narrative perspective, the person is situated not only as an object that wanders and acts in a world of other objects, but also builds in its activity what it perceives as the world, experiencing an emerging space and time with respect to its own knowledge operations. The corporeality reference instance, like the other instances, can consider discrepancies determined by the type of conceptual anticipations made, which lack inherent meaning. In its integration with other instances in which meaning occurs. For example, the meaning constructed by an injection of caffeine in a blinded experiment can vary from a panic attack, to "seeing" irritability and experiencing anger towards a nearby subject, or to build sexual desire and interpersonal attraction towards a person

who is part of the experiment, among other possibilities of meaning, depending on the variations of the experimental device. In all cases, the world as such, in its unfolded meaning, occurs in the process of interactive engagement with it, with specific anticipations and implications of the applied concepts.

Self image.

The instance or category called «self-image» groups the references that make up "what I am", the phenomenological organization of the experience referred to the self-image, (Abramowitz et al, 1984; Offer et al, 1988). References in this instance may include body image, partner, car and other material objects, alleged character attributes, trades or occupational performance, events, etc. Two notions are different from the most commonly used notion. In the first place, the self-image instance includes non-reflective or also called *tacit* conceptual differentiations (Gawronski and Payne, 2010; Greenwald, and Banaji, 1995; Musholt, 2015). Second, the processual understanding is emphasized over states or structures, understanding this instance of reference as a process of intentional course, with respect to which the supposed structures or static states are observation artifacts.

Narrative instance arrests and cross references.

The notion of «arrest» alludes to the fact that in the procedural exploration of the therapeutic problem, both the patient and the therapist can observe that the reference in one instance is difficult, without variations, with an obvious impossibility to carry out alternative conceptual applications. This can be explained by a lack of expertise and possibilities of development —for example, children and young people who have had to show an accelerated autonomy, for subsistence reasons or some form of parentification, to the detriment of the explorations common to the evolutionary stage—, by training that turned threatening integrative poles into specific conceptual systems —for example, negativization or censorship of concepts related to sexuality in certain families—, oversimplification of references to an instance —for example, due to very constrained routines or drug use—, and by inadmissibility —for example, a high coherence in the references already existing in an instance, with little possibility of innovation or admission of discrepant concepts.

The therapist may consider in his evaluation the characterization of special narrative arrangements or «cross-reference formats» observed with the patient. These crossover arrangements are ways to defocus discrepancies at the lowest possible cost to the person, and can often represent problems in the design of psychotherapy if they are approached without their compensatory character.

	Articulated discrepancy, is referred to	Not achieved articulate at the instance of	It articulates in a deferred way with changes in the reference in
A	Alterity	Corporeality/world	Self image
B	Alterity	Self image	Corporeality/world
C	Corporeality/world	Self image	Alterity
D	Corporeality/world	Alterity	Self image
E	Self image	Alterity	Corporeality/world
F	Self image	Corporeality/world	Alterity

Figure 09. General cross-reference formats (adapted from Díaz Olguín, 2022)

For example, a person could experience suffering for perceiving that other people want to harm him or are in collusion for this purpose —deferred articulation of alterity—. The therapist and patient can assess in the deconstruction whether these references in alterity would covary with integration difficulties with respect to instances of self-image or corporeality/world —for example, frustrations in sexual "performance" in marriage, in which case it might be C or F cases in the table above, depending on how him give meaning to the situation–-.

III. Clinical case formulation

To exemplify the formulation of a clinical case, a clinical vignette made with segments of two similar clinical histories will be reviewed below[14]. In addition to the explicit consent of patients and therapists, for reasons of social responsibility and professional ethics, relevant information has been changed, so that none of the exposed background allows the identification of any particular person. In addition, understanding that this is a text aimed at discussion among therapists, its use with discretion is suggested.

Overview

In the vignette the patient was given the fictitious name Caroline. Anna, the therapist who worked with her, supervised the process from the first session, alerted by the work team that the patient was very aggressive during a brief hospitalization prior to the start of psychotherapy. Despite previous behavior with other therapists, during the course of the process she and Caroline developed a loving and respectful working relationship.

In the first session, Anna asked Caroline about the expectations she had about the therapeutic relationship —not about the results of the psychotherapeutic process, but about the working relationship between them—. Caroline explained that she had the fantasy that the professional was involved with a "high level of energy", which, according to the therapist, allowed her to restructure expectations and thus take care of the alliance. Due to the fact that they worked in a hospital context, the provision of consents and expectations of all the interveners was left in writing.

In retrospect, when commenting on the general process, Anna mentions that one of the difficult aspects was that in the first sessions she was more stable than what was written in her clinical history. This happened mainly because, a few days before the first session, Caroline ended her relationship, feeling very relieved since romantic relationships were a problem area for her. According to the therapist, the two previous “attempted relationships”[15] —relationships that lasted less than two months each—were associated with increased instability and frequent “crises.” So this romantic rupture, which occurred between hospitalization and the start of psychotherapy, had the advantage of generating a more stable work context, but the disadvantage of avoiding precisely deploying the most threatening conceptual applications for Caroline and being able to review them in session more directly. What they did in this regard

[14] Before exposing the cases that make up the vignette, in 2020 the therapists received explicit and written authorization to use these records and publish them. In addition to the fact that the therapists were careful not to provide data that would allow identification, specific information has been changed in this transcript, in order to fully ensure the protection of the sense of confidentiality, respect and ethical care in psychotherapy. In terms of social responsibility, it is expected that the reading be used with discretion and seeking the goals of professionally discussing help strategies in this type of clinic. If in any way the reader feels that he/she requires therapeutic support because they have identified with an experience or feeling similar to those reported, there is a wide network of help and support in each country, which they can consult by internet searching or through contact with the nearest health system, among other sources.

[15] In Caroline words

was to relate the current uncomfortable moments addressed in therapy with the difficulties they recorded in these previous "couple relationship attempts".
To frame an overview of the clinical case, after the third session the therapist's notes in her supervision documentation included the following observations:

- Caroline pushes herself to enter into romantic relationships motivated to correspond to the supposed expectations of other people, with concrete imagery –critical and adverse– about how the rest would see her without a partner, or how she would see herself in front of others with a certain type of partner. She then wishes, by establishing a relationship, to fulfill the image that she assumes the rest expects, she does not use many criteria of dependency or effective interpersonal mutuality. Due to this situation, after the break there are no significant learning processes.
- Caroline shows an increased sensitivity –constructed in terms of closure and threat– towards concrete concepts in the self-image reference. For example, specific clothing and weight, matching your appearance to specific standards and models, academic qualifications, and so on.
- It presents certain difficulties in constructing diverse and relative mental states in its reference to alterity/partner. For example, if his ex-partner George looked at a woman on the street, he would build the image that George's sexual desire for her had been completely lost, he had stopped desiring her, in a supposed confirmation of a global state of rejection/approval in the significant other.
- Other specific references to significant alterity: when she is in a room alone, she feels that the rest does not exist. If it is not seen by others, those others do not exist. It experiences its beauty if it is seen and if other people react with specific behaviors, and in the absence of these indicators, the constructions of corporeality are either carried out through intense movements, such as exercise, or become diffuse, non-existent.
- It establishes very specific anticipations regarding the roles involved in couple relationships. It “decrees”[16] the behavior of the other, through “contracts” or concrete agreements on relational behaviors that could be spontaneous and without an explicit structure –for example, developing a friendship with someone—.
- Autonomy over-compensating behaviors: Caroline tends to represent or act excessive independence, excel with respect to indicators of autonomy, presume autonomous behaviors, etc.

The therapist noted that under stress, some of these conceptual applications were shown in their most concrete formats, with an experience of high anguish, what Caroline called a "*psycho behavior"*, alluding to limited segments of behavior analogous to psychopathy: imaginations of how manipulate, threaten, obtain desired results at the expense of the integrity or discomfort of the other involved. According to the therapist, Caroline made great strides in experiencing stress, particularly due to the patient's vast amount of cognitive and creative resources. An example of this is that, approximately six months into psychotherapy, Caroline shows the therapist that she has tried to anticipate stressful situations by making stories and stories about

[16] “To decree” can be roughly defined as fully consciously affirming what a person wants for their life and thereby “attracting it”. It is a common belief and suggestion in belief systems close to magical thinking.

couple situations, based on her stories, those of her friends and some imagined. The therapist had noted that through anticipation she could develop more abstract conceptual applications, but Caroline took it to a very creative and sophisticated level.

Towards the year of psychotherapy, given the degree of well-being and fulfillment of the objectives defined together, Caroline and the therapist began to distance the meetings, in a "follow-up" mode. About two years after the first session, Caroline exceptionally requested to take four sessions[17]: she had started a relationship, this time with much more criteria of mutuality, but she began to experience intense fears to having sex, avoiding them. Joking about it —"I'm wasting myself, with this body that I have"—, she requests to resume support. In that period, Caroline clearly observed that she lacks models of mutuality that are not "terrifying", that her parents "did not serve as positive models". This time Anna gave her a direct suggestion, to discuss this with her partner and look together for models of mutuality, and talk with other couples who could serve as models to see different ways of relating more intimately. Caroline states that after these actions, the sexual life between them began without major problems. After that period, she has communicated sporadically with the therapist, through emails, expressing a good level of subjective well-being.

To analyze the formulation of the clinical case used by Anna and the supervisor, part of the audio transcripts of the first two sessions will be used and the discussion will be organized around the following scheme, adapted from Díaz Olguín (2020)

[17] Caroline specifies the number, considering that they would suffice to solve the problem.

NARRATIVE-ORIENTED CONSTRUCTIVIST CASE FORMULATION	
1. General background and patient description. A profile of the person who comes to consult is defined, including data such as age, current close people, schooling or work, recreational activities, how the patient describes their current family and relational environment, etc. It does not focus on the deficit or problem, but also points to the person's lifestyle, resources, life orientations, hobbies, level of work and time demands, spirituality, concerns, etc.also includes: a. Relationship of the therapeutic problem with the available evidence, "state of the art" and valid therapies. b. The consideration of risk factors and mechanisms possibly involved c. A prospective of situations of potential danger/risk to integrity	**4. Psychotherapeutic relationship and alliance** A description of the characteristics of the relationship, its resources and possible breaks, the representations that both build regarding the other and the relationship, the relationship styles, etc. **5. Psychotherapeutic hypotheses** Based on the previous points (from the general background, relationship with the more general clinic and the "state of the art " in the therapeutic problem, the diachronic gnoseological evaluation and ontological integration, up to the characteristics of the therapeutic relationship) therapeutic hypotheses are made, which must be clear, operational and verifiable by both
2. Reason for consultation and therapeutic demand The motivations for requesting help and the construction of demands are dynamic and constant processes, which are recorded insofar as they allow defining roles, setting, etc.	**6. Work objectives** Recording the objectives built with the patient and communicating them explicitly allows organizing the general formulation, maintaining the alliance with the patient and clearly evaluating the effectiveness of the intervention.
3. Descriptive study of the psychotherapeutic problem In a mainly descriptive study, with an idiosyncratic, qualitative, diachronic and constant emphasis during the therapeutic process, both participants attend to the changes in the conceptual applications that are components of the therapeutic problem. Through two evaluation formats (gnoseological and ontological), a characterization of three aspects is pursued: a. **Conceptual organization**. A characterization that uses the criteria of demarcation, evaluation, control and understanding (articulation-compartmentalization, opening - closing, direct - mediate, abstraction - concretion) b. **Closure-stress and phases**. A characterization of the construction of threat and the closure-stress experience, which allows (both patient and therapist) to understand the tonic-phasic changes of the therapeutic problem c. **Arrests in narrative instances**. A characterization of the ontological reference organization of the therapeutic problem, establishing the arrangements in instances that hinder the integration of concepts involved in the therapeutic focus.	**7. General strategies** The general strategy oriented according to the level of concretion and articulation is recorded of the most central aspects of the therapeutic problem. It is defined whether the strategy will consider the promotion of openness in a highly closed system of constructs, or the integration of subsystems of constructs of different levels of abstraction. It also defines the style or role that the therapist will adopt in terms of control perceived by the patient, to "anchor" the patient's style and promote gradual and comfortable changes for the patient (“matching” or “tailoring” setting strategies). **8. Valid evaluation** It is suggested in the formulation the design of a qualitative evaluation (for example, stages of change, coherence and flexibility in the narrative ordering) and quantitative (for example, comparison of records, use of valid and sensitive scales, etc.), in addition to a critical and constructive review of the entire process

1. General background

Caroline is a 23 years old medical student. According to Anna, her therapist, she is a good-looking young woman, fashionably dressed, with pretty features and a "flashy, well-groomed body appearance". In session she behaves appropriately most of the time, except for some comments that may be disparaging, although she does not seem to notice them. She is eloquent and energetic in the way she speaks and communicates.
Caroline mentions a history of panic attacks, especially at night, before going to sleep. He experiences them, according to his story, once or twice a month, 16 years ago, since he entered first grade. She mentions that when the light goes out and there is too much silence, she begins to experience herself "empty", as if she were "disappearing" or "fading out" in those moments. According to the therapist, it was a psychopathological history ignored by her family and undertreated.
Regarding other areas, mentions that in elementary school she managed to form a group of friends and feel protected by them. Caroline mentions that studies have never represented a problem,

> "*I always had excellent scores, very good performance, far above the rest of my classmates, even in the career* [medicine]*… my problems have been on the other hand, on the emotional side. I'm just studying a little bit, but I'm doing excellent in my degree. I have a very good memory, although the truth is I've never felt very intelligent, it's weird, isn't it? Maybe it's because I clearly know my strengths and weaknesses… I'm not sure*".

She has experienced pseudohallucinations a couple of times. Once at the age of 14, after a heated argument with his mother. And the second after an argument with his last partner.
Her mother is a 64-year-old woman whom Caroline describes as "*very devoted, one of those old-fashioned Catholics, very correct as well*"[18]. Her parents are separated, he is a 75 years old well-known architect in the country. Caroline describes him as "*an expert* [skillful in his performance]*, he must be the smartest person I know, he's always traveling, now they just gave him an award in New York*". She mentions that her parents separated when she was in fifth grade:

> "*It was hard, I mean, before it was sad, I still remember the fights between my parents and me there trying to make myself invisible so as not to increase the tension. I remember that I imagined that I was an actress or* [an] *alien and thus pretended that everything was fine while they fought. Later it got more hard, when they separated, I had to take care of my mother, she became very depressed. Sometimes I found her lying on the bed, I cooked, it was very heavy* [difficult]*. Everything was very crazy, I think the*

[18] After receiving emergency care, Caroline's mother obtained, through personal contacts and unusual steps, the continuity of outpatient treatment in the public health hospital system, although for administrative reasons it did not correspond to her —in Chile, the public health system is aimed at people of different economic levels—. However, she did not participate in the therapeutic process, excusing herself the two times she was summoned to collect general information.

> *strangest thing was that although they separated, they had the habit of always having lunch on weekends. It was like stage acting, I saw my mom crying all week and on Sunday she dressed and put on makeup as if nothing had happened and we waited for our dad to have lunch, very creepy* [strange and terrifying]*. I think that caused the food problems that I had afterwards. Even now, that remember affect me, I still feel rancid when I think about it"*

Caroline attends the first interview after a suicide attempt with cuts on one of the wrists. According to her, her intention was never to kill herself, but "*I was very confused*". This was three weeks before the first interview, she had a discussion with George (a 21 years old psychology student, with whom she had been in a relationship for a month and a half):

> "*The truth is, I don't know how we got to those levels in the discussion, it was heavy.* [difficult]*. I'm going to be honest here, that is, I've told this story to other people, but I've changed some details to make it look a little better for me, I don't know if you understand me, I kind of made up things a bit. But here… I'm going to try to focus on the facts. It's just that in this story I will not be very well off… Anyway, we were discussing something very trivial with George, it was nonsense, before that we were fine. We had eaten sushi and there was a Suicide Squad commercial on television, and I thought that he… I really imagined… I don't know, it was quick, I thought he liked the actress, Margot Robbie… and I got jealous. But I think he was so sleepy he didn't even notice her. The point is that I got angry, I told him why he was lying to me, that you can't have a relationship like that with such small lies, and that he should go away. And he was super cold, so he got up and left. So I followed him to the garden and started yelling at him asking how he was doing that to me, that I wasn't going to allow it, that it was abuse. Then my neighbor and a friend of his* [the neighbor's] *came and went after him, because they thought he had done something bad to me... I mean, something bad like physical abuse, I don't know. I got desperate there, it scared me, and I told my neighbor to get out of there... My neighbor is a big guy, he plays rugby at the university, it scared me that he did something to him. Then everything turned... and George... well, there... there, the truth is that he didn't say anything, but he looked at me as if I were a lunatic, daft, 'a bit lacking upstairs'* [a derogatory slang expression]*, and gave me a look of disappointment. That was what hurt me the most. He left, but super cold, he didn't react, indifferent. I called him on the phone, but he had it turned off. After that I don't remember much of what happened. I only know that other times I would get into the tub to calm down, without the water, I just got into the dry tub and snuggled up alone... I liked this idea of being in a little box, like cats. And it burdens my bedroom, so I got in the tub, but this time it occurred to me to break a razor, I took the blade out and cut my skin under the water. I remember worrying about washing the blade first, because I didn't want to get infected, so I don't think my intention was as suicidal as my mom thought".*

Her mother found her in the bathtub, she was unconscious, drunk. She had emptied a 750 ml bottle of vodka, she probably did not drink all of it and spilled some of it in the tub, but she must have ingested a large part due to the blood indicators recorded in the emergency room.
She was hospitalized in a short-stay psychiatric unit for five days. According to some staff members, she issued critical comments regarding the staff work. She began with a pharmacological schema to which she adhered irregularly, under the charge of a psychiatrist who referred her to psychotherapy with an interconsultation that mentioned “uncooperative patient, with a severe underlying personality disorder”.

First Interview

After gathering all of this general background, the therapist uses the rest of the session to ask you what was the last uncomfortable or unpleasant moment you experienced before the session. Caroline mentions a situation the day before the interview.

- Therapist: My intention is that we first review these uncomfortable moments, the most current ones, the ones that are most present to us. My idea is that if we review them calmly, perhaps we can see which are the most sensitive issues or the habits that generate the most discomfort, do you think?
- Caroline: *Sure, obviously. Yesterday, Sunday... I remember that I arrived at the ‘mausoleum’... that's what I call my house, that place burdens me too much, well, I arrived at about three in the afternoon. I had gone to the gym. I spent four hours there, it relaxes me a lot*
- Therapist: Four hours exercising?
- Caroline: *Yes, it relaxes me a lot. Also, I look good. It serves to pass the time, it has several advantages. I have this thing that sometimes I look like a mannequin, a statue, and I can barely walk. Other times I feel hyperkinetic, I need to jump, move. So exercise helps me.*
- Therapist: And did you come home in good spirits?
- Caroline: *The truth is that I never come home in a good mood. What I want to say is that I don't like the house itself, it's old. It is a beautiful, large house, in a well-kept neighborhood* [affluent neighborhood, with a good economic situation]*. I don't know, I don't feel part of that house, that's why I call it 'the mausoleum'. It's like everyone is dead there, in fact my mom has this thing of asking her friends, when they go to Europe, to bring her these little ceramic figurines as a gift... it's atrocious, they're horrible, it's like being surrounded by statues. It makes me want to break them all*
- Therapist: I understand. Yesterday you arrived then…and what was the awkward moment?
- Caroline: *I had left the cell phone at home, on purpose. The truth is that I suffer with the telephone. I didn't want to be aware of him, it exhausts me. So I left him at home and went to the club gym. I think the worst moment was just before taking it. My worst thought was that I wasn't going to find any messages and when I checked it I was like 'holy shit I was right!' I didn't have a single message… I think I saw my last post on Instagram… I'm a little embarrassed to say this… and I threw the phone away. I think it*

came apart, but it didn't break. It bounced off a lamp or something. It made me laugh, but then I started to feel cold, just like those shitty figures of my mom. I think I was half frozen... between the bedroom and the living room... I don't know how long. Since I was a child, these things have not happened to me. I was 'parked'. Then I decided to shake that feeling, take my dog and go for a walk

- Therapist: Could you tell me what specifically bothered you?
- Caroline: *I could invent something now. But don't get me wrong, it's not that I don't want to answer the question, the psychiatrist got that impression, but he was kind of stupid. What happens is that they are voids that I always try to fill, many times I do things and then I have to invent an intention for them. My attention sometimes gets scattered, not always, but sometimes I'm not connected to the situation. So those times the things I do are faster than my intentions… I don't know if you understand me. These things that I do are not as well thought out, they do not have that background that other things do have. In simple words, sometimes my motorcycle escaped me* [slang expression for losing control of oneself]*. So I suppose, I imagine... that in that situation I wanted... I mean, I had the expectation before I got home, of having messages and being able to entertain myself a bit. It sounds daffodil, doesn't it?, but it's not so much. It's just that I depend a little on that, on seeing myself… on being seen. Not always, sometimes, I get well 'context dependent'... George told me that, but in the end it didn't help much that he understood me in those things, because it didn't make me feel good at that point either, I didn't feel seen by him . So we broke up*
- Therapist: I didn't know you had broken up with George
- Caroline: *Yes, we did it on good terms. On Wednesday I gave her a letter that I made while I was hospitalized*
- Therapist: A letter?
- Caroline: *Yes, while I was hospitalized I wrote him a letter, where I said that I loved him, but that I needed his commitment that he should forget about the discussion we had and also about the hospitalization, that we not talk about it. So we got together on Wednesday, we walked for a while… I passed him the letter, he read it… but right then I realized that I was hurting him. So I started crying and we talked. I felt a little pity for him, he's a good guy, but I… I don't know, I think it's better to give us some time. I am sure that in a couple of months we will be together again.*
- Therapist: You said you didn't feel seen by him, what do you mean by that?
- Caroline: *I don't know!... haha... no, I know. This Wednesday it was he who asked me to meet up to talk. With that typical tone of the movies, right?. I think he was upset, because I called him like twenty times in the morning. He didn't answer the phone, so I thought something had happened to him and I got upset, but he told me he had stayed late studying and had a test early in the morning. Then he told me to get together to talk... and I went a little crazy, but I didn't show it to anyone. I don't like being seen like this, so when I can control it, I do it alone, at home. I spent the whole day thinking about strategies to manipulate him, I called the psychiatrist to give me an online certificate, that was a possibility... tell George that I had a transitory problem and show him the paper, but the certificate he sent me had this personality thing, I did not like. I think I spent a lot of time devising a way to threaten him, that I was going to kill me or something if he let*

me. But some friends just before leaving contacted me by message, I told them a little, and they suggested that I be more transparent. The truth is that when I was going to meet him I went with a different 'wave' [with another intention]*, but I saw him and I felt sorry for him. I do not know why. I was sorry.*

- Therapist: And how are you now?
- Caroline: *Fine, fine. In other words, calmer. But I think I need to change some things, but I don't know how. Psychologists and psychiatrists, the truth is that they are not very useful, nothing personal, but I need to make a change. So I'm in the best mood… I want to see if I can get an idea or something. I don't know if talking can change, I also know that drugs won't do anything, because I studied it. So, I'm low on hope*
- Therapist: Perfect, I was going to ask you about that. What is the minimum we hope to achieve?
- Caroline:*The minimum?*
- Therapist: Imagine it like this, the first change, incipient, small, what would you expect to observe if things go well?
- Caroline: *I would like to have a brake* [curb]*. Something that in critical situations would make me think a little, to slow down in those moments.*
- Therapist: Ok, Caroline, then let's get to work. But I need you to keep giving me current information for the first two sessions, like you did today. So, we will see each other in a few more days, but while you are going to pay attention to the most uncomfortable situation or situations that occur these days, try to remember where you were, and above all how you felt before these situations occurred. Is that okay with you?

In the first session, the therapist already manages to obtain certain information, tentatively, regarding the conceptual organization —for example, the changes of demarcation in certain contexts, the changes in valuation in which some concepts become central, the degree of control assigned and experienced , and the level of articulation, opening, directivity and concretion of the concepts involved—, the main processes of closure - stress, and the difficulties of narrative integration that allow us to begin to characterize the psychotherapeutic problem. After the second session, the therapist's clinical formulation begins to define itself and basically maintains its structure for the rest of the psychotherapeutic process.

Second interview

Caroline arrives at the second session in a very good mood. She states that he would like to achieve some goals in the future, particularly *"to be less hurtful and less psycho*[19] *when I get stressed*". He mentions that something "funny" happened to her during the week, which she wanted to comment on:

- Caroline: *It was a strange week, I had never had such a peaceful week. I know it's a pause in my storm. But anyway. Something super funny happened to me the other day with you.*
- Therapist: With me?
- Caroline: *Yes, on Friday. It happened to me that I was 'parked' in my house*, *and I began stalking George* [search for information about him on social networks]. *But there I thought that it was super likely that later I would feel bad about anything I saw, because I imagined that if I came across a picture of him walking his dog, even then I would feel bad, because I would get the hell* [imagining things] *of 'ah, he's not sad and he's showing that he's happy to break up with me'. But then I thought that if I felt bad about it, it would be the only awkward thing this week, I'd have to tell you, and what the hell… the only awkward thing and it would be something silly like that… so I quickly closed the computer, and went to backyard to smoke a cigarette, Pia came to greet me, and we went for a walk listening to music*
- Therapist: Pia...?
- Caroline: *My dog, she is so pretty, like she feels when one is weird and starts doing cute things*.
- Therapist: So, if I understand correctly, you managed to stop a sequence of actions that would make you feel very bad. What do you think about that?
- Caroline: *I'm older* (laughs), *discharge me, I'm ready...*

After the second session, the therapist presented the clinic supervisor with a fairly defined formulation. First, the therapist made a profile of who is the person who comes to consult. She is a young woman, 23 years old, a medical student. She has a group of three close friends, with whom she discusses some of her problems, but in general she is very careful not to do so to "protect her image" in front of them. She likes doing physical activity in a gym that calms and relaxes her, an activity that also has the consequence that she keeps her body in a way that she likes. His parents, divorced, have high economic resources. His father has been oriented towards professional achievement, his mother was oriented towards social activities, such as participating in charitable activities through a foundation of which his family is a part. In general, Caroline experiences herself alone, she prefers to stay in activities that occupy her attention. Sometimes she shows a magical style of beliefs, she likes topics related to the "stars influences" and "crystals energy", beliefs that manage to coexist with his academic training in medicine. The current family environment defines it as very stable, there are no conflicts, they have family

[19] Manipulative and insensitive to other people's feelings, according to a later clarification of the term that the therapist asked Caroline

meetings with some frequency that she enjoys, although she maintains the impression that the climate of coexistence is "a bit false, a bit of acting".
According to the therapist —who was trained in DBT before her constructivist training—, some components of the dialectical behavioral approach allow us to characterize the clinical case in a general way: Caroline feels trapped in polarities, which she constantly expresses, and shows difficulties in achieving a synthesis from them. In some way, strenuous exercise and study routines may be serving as rudimentary forms of attention control, and outside of these routines she may find herself drowning or overwhelmed by her own thoughts or discomfort. She also shows difficulties in achieving interpersonal goals without transgressing his own respect or the integrity of other people, in specific situations.
In addition, Caroline shows some difficulty in tolerating discomfort, carrying out actions that tend to increase it. The therapist considers that some of these actions can lead to highly serious behaviors in terms of violating one's own integrity. Aware that self-harm and suicide attempts increase the probability of death by suicide, the therapist considers that it is important to intervene in a timely manner to promote a reduction in future suicidal risk.

2. Reason for consultation

Caroline's personal intention to consult was gradually built. Reluctant at first, the initial statements of a reason for consultation itself consisted of "*I would like to have a brake* [curb]*. Something that in critical situations would make me think a little, slow down in those moments"*. Considering the background exposed in the first two sessions, it can be hypothesized that this motivation is partly oriented to the preservation of the conscious image of herself in certain interpersonal scenarios —in the form of "I want to be more regulated to be better seen by others", in the therapist's words—. For the therapist, this first motivational north, although relatively volatile, gave rise to Caroline's construction of more articulated personal goals.

3. Therapeutic problem characterization

A first characterization of the therapeutic problem can be summarized in three elements: (a) characterize the organization of the conceptual applications, (b) study the therapeutic problem in terms of the stress-closure phenomenon, and (c) characterize the therapeutic problem in terms of possible arrests or integration difficulties in specific narrative instances.

a. Conceptual organization

Important changes in demarcation stand out in the therapeutic problem explored by Caroline and her therapist. In the absence of an audience or concrete observers, it feels empty and diffuse. These changes also occur with respect to variations in the construction of the physical context, with particular attention to her mother's ceramic ornaments, the size of her room —which for her is "too big"—, or the feeling of shelter that she experiences with perceived physical constriction in the tub. There are also significant changes for her in the construction of George's mental states. The perception quickly builds up that he no longer feels desire for her, and then she doesn't feel desirable herself. Related to this, there are difficulties in constructing his partner as present, when he does not answer a telephone communication, experiencing anguish

due to death imageries regarding him. Other demarcation changes in Caroline's story are registered by the therapist, but were considered less relevant in the therapeutic strategy.

In terms of valence criterion, the therapist's initial characterization pointed to an important change regarding whether Caroline was in or out of a relationship. Being in the relationship, previously peripheral themes became central: physical appearance, comparison with other women in terms of competition for attention, the role of jealousy and discomfort, among others. These valence changes, of an increase in the centrality of concepts that were previously peripheral, were coupled with a constant “feeling of being tested” —in Caroline's words— when starting a relationship.

At the same time, there is a gradual loss of subjective control in actions aimed at the couple's relationship. Behavior also becomes erratic in objective terms: control and agency begin to lose articulation in the relationship between expectations and the outcome of events. A good example is the situation in which Caroline decides to write a letter to George, trying to control his memory or the interpersonal memory of the hospitalization, which ends in a meeting with an outcome not planned by her, although it was executed by her at the last moment.

Regarding the understanding criterion used to characterize the conceptual applications involved in the therapeutic problem, the therapist recorded:

- Articulation-compartmentalization: some elements are compartmentalized, particularly those related to couple discussions. Perhaps it is related to the low articulation of similar experiences in their development, not being able to articulate the behavior of their mother and father during their own couple conflicts. In Caroline's story, the two episodes of pseudohallucinations occurred in the context of arguments with incipient couples

- Opening-closing: the most acute conceptual closures occur in similar concepts, observing herself alone or observed by others as abandoned, being seen by her partner as someone “failed”[20].

- Direct-mediate: in a high sense of mediation, the therapeutic problem is consciously hidden behind a hyper-adaptation façade, of appearing as a very effective woman, competent and accommodating on the first day of the relationship. The functions that are perceived as inadequate and psychopathological by Caroline are hidden, trying to show the rest the opposite, a person with a "high spiritual development", "compassionate", "cheerful and happy at all times".

[20] This was an important characterization in the therapeutic process. Caroline mentions towards the 6th session that her impression regarding her mother was that she was "discarded" by her father for being "failed", although that failure and its nature were imprecise ("*I don't know well, it's something very strange. Now that I think so, it's unfounded. I always felt it was her, because of her depression, although of course, her depression came after they separated and my grandmother died. So I don't know why I kept that explanation all these years. I imagine that when one is a child, explains things badly, in a way that is too simple…*")

- Abstraction - concretion: paying particular attention to concretion level, two types of concrete concepts are registered. One related to the specific dependence on the correspondence of external standards —for example, building general approval in social media as a regulation instance, or responding to the configuration of physical spaces in such a way that they are imposed on her, among other examples—. The other system, less articulated, appears in the attempts to apply these same concepts to the couple relationship, not meeting the abstraction requirements to organize the emerging complexities. For the first system, it is possible to hypothesize a transitional conflict between Stage I and II, with Caroline showing threatening applications to both Stage I and Stage II concepts. Probably in his life history, she experienced strong pressures to conform to the rules —Stage II— and at the same time few opportunities to explore the possibilities of self-control and autonomy —Stage I—, which could even be seen as threatening given the depression of his mother and the tense state of the family situation. The attempts of the second conceptual system to be able to function in a viable romantic relationship are shown to be unsuccessful, since better differentiations are required regarding the mental states of the other, to be able to better characterize the partner intentions —differentiations that are achieved through the opening of Stage II concepts—, having clear self-other and self-world attributional distinctions in order to better communicate —differentiations achieved through opening Stage I concepts— and so on.

b. Stress-closure and phases

Carolina shows closures in the application of two extreme conceptual poles.

The most concrete group is related to autonomy in Stage I, discriminations regarding one's own intentions, mental states, desires or thoughts that are articulated with agency in certain contexts. It shows difficulties with basic purposes, disassociating itself from dependency to the context or modifying the context within that dependency relationship.

The most abstract extreme is related to regulatory adequacy, Stage II concepts, which appear threatening. Being in a relationship, meeting external social or interpersonal standards are seen as imperatives.

Both ends appear partially closed. In situations of stress, Caroline begins with attempts to repeatedly apply concepts —more concrete than expected for her global development, such as writing letters to “erase” events from memory of her partner—, while increasing sensitization —the romantic theme is shown to be sensitized— and to apply concepts in an increasingly extreme compensatory way. In stress experiences, a lesser openness to alternative applications is observed, beginning to appear a format of suicidal experience that must be intervened.

Given that Caroline shows in her therapeutic problem the tendency to closure in concepts of different levels of abstraction, it is possible to explain the phasic nature of the therapeutic focus. It is observed that the greatest number of closures occur between attempts at hyper adaptation —Stage II— and emptiness experiences —Stage I—. In

exceptional moments, the attempts to make conceptual applications needed in a romantic relationship, related to mutuality and sentimental dependence, involve extreme concepts, characterized by hyper-dependence and the obligation to "let go" and "not harm" the other involved.

According to this formulation, the therapist prepared the therapeutic setting to promote the development of conceptual differentiations oriented to independence and autonomy, first in specific aspects. She asked Caroline to make arrangements in the decoration of the attention box, asking her to bring a decorative element that represented herself. The task, which Caroline performed with ambivalent feelings, served in the first stage of psychotherapy as a metaphor to guide other explorations.

c. Arrests in narrative instances and integration problems

In the therapeutic problem study, both Caroline and her therapist observed that some conceptual references were comparatively detained, hard, arrested —Caroline called them “my disabilities”, in a dark humor tone—. She presented, in the moments of greatest closedness, difficulties in referring concepts to a present, constant or existing alterity:

> “*It is similar to a horror movie, I don't remember the name, but what I see in my mind, if I try to focus on it, are blurred faces. I don't understand them, the truth is*… [referring to his parents] *I never understood them. It's like coming across a script, a libretto for a play in the street, and you begin to act that out, but without really understanding the play or the other characters, do you understand me? It's too heavy* [difficult]*, it's like... as if they had... they are not thinking about having a daughter, but an ornament, something...* [incomprehensible audio]... *It mattered to me, my mother did matter to me, that is, I felt that if I didn't move, if I didn't do something, she would die... so... so… well, it was a difficult time* ”

> “[regarding the phone calls to George] *it's not always, It 's sometimes. Other times it didn't happen to me, for example I went to the gym and hours could go by without him calling me or answering a message, and I didn't "play movies in my head"* [I didn't imagine things]. *But at times, I don't know... I get hysterical (sic), it's a strong feeling, very intense, that something bad happened, that the other person doesn't exist*”

In the first deconstruction activities, Caroline mentions that she experienced these feelings since she was a child, particularly when she went to open her mother's bedroom door in the morning.

> “*It was like Schrödinger's cat, but in a horror movie version. I didn't know if... it's hard to say it, the first time I've said it like that, it sounds rude... but I didn't know if I was going to find her alive or dead. In fact, it's easy to say now. I mean the anguish I felt at that time… it made me sick to my stomach. I have photos in which I am very, very thin, almost anorexic (sic), and it had to do with that, not with some image or that I felt fat. It was simply because of anguish, the fear was very intense. I think that at one time, when I was a child, my hair fell out and I covered it up, I have memories of that*”.

> "*Now I imagine it as a "box". I kept thinking about the last session. I realized that it is like a box, that if I tense up a bit, the same box opens again. There the rest disappear. But it draws my attention, because it has happened to me even with suffering that is not mental. A couple of times, I remember that I got a strong menstrual period, with a lot of pain, and the same thing happened to me. It is inevitable that the rest will disappear in my mind, and it distresses me a lot."*

Unlike other people in whom differentiations in corporeality drive uninhibited behavior when concepts referenced to alterity are not integrated, in Caroline the first consequence is a high body inhibition - movement restriction, perceived by her as "paralysis":

> "*When I was a girl I had this nightmare or dream, very distressing, I was desperate. I was a girl, a little child, but in the dream I imagined myself even smaller. And the dream was very atmospheric, I arrived at a soccer field. Everything was dimly lit, as if it were an hour after sunset. Enough light to see a few meters in front of me, but much darkness beyond. And the dream was that. I had the feeling that I was left in fear, paralyzed, without moving... I had no one to ask for help, I felt alone, not with sorrow, not with sadness, but rather afraid to move, to do something. If I did something, if I moved, something very bad could happen, something could come out of the shadows, I don't know... it was all a feeling. Oh, and a constant background noise. Or a sensation similar to a sound. Something like that. I called it 'the mill', because I imagined it was the sound of a great stone, a giant one, moving slowly over another".*

For Caroline it was also interesting to verbalize the difficulty of imagining states or variations in the intentions or mental states of other people. With humor, what she called "my disabilities", the inability to imagine internal states in other people that were different from one's own —especially those that were voluntary and evoked some sort of "ostensible feeling" for her–, in certain specific stressful situations, was an important finding. She assumed it as part of his own objective, in terms of investigating and attending to the symbolic processes of other people in moments of greatest stress.

From the point of view of the therapist and Caroline, the main changes in the conceptual applications referred to corporeality and self-image began first with difficulties in alterity references[21]. For example, referential changes such as "being an undesirable woman" occurred to make the references to self-image correspond to concepts referring to alterity in the first place.

According to the therapist, in the initial sessions they did not observe another more striking integration difficulty, for both of them, than the difficulties in alterity referring. As integration is a self-referential identity process, the deconstructions quickly referred to the conceptual arrangements that Caroline organized in her story with her mother, loaded with highly emotional scenes for her, which represented very high pressures for her stage of development.

[21] A "narrative arrest" in alterity: a group of references seem to be arrested, stopped, immobile, poorly articulated. The possible referential arrangements, cross-references, would be in corporeality/world and self-image (see page 21).

In a second moment of the psychotherapeutic process, Carolina and her therapist observed reference difficulties in the corporeality/world instance. In a very interesting way, the therapist observed Carolina's difficulties in the session, in the form of slightly derogatory comments, however they were discussed explicitly and consciously after several months of therapy. These difficulties consisted of lack of conceptual differentiation in terms of "own tastes, personal interests and not socially desirable". They noticed that it was necessary, in specific situations, to allow for the differentiation of tastes, predilections, more personal and “selfish” motives, in Caroline's words.

4. Therapeutic relationship and alliance

The anticipated notification of a possible insulting style in Caroline's communications with her therapists during hospitalization was contrasted by the therapist:

> “[my meeting was] *with a sweet but honest girl. That can be seen as aggressive, but I didn't understand her that way, but from her point of view she can express what she feels works or doesn't work, because she doesn't register that these comments can be liked or disliked. She is careful in the interaction, but not from personal empathy, from imagining the other with their personal, differential characteristics, but from the formal… She is an educated girl, who has an elegant way of speaking and behaving. When talking with her for a few minutes, one understands that she lacks the keys to build a certain kind of alterity. Without me being dismissive, it's like talking to my younger sister, she has that style, more novice in some things*.

The therapist states that the therapeutic relationship was framed in a structured, concrete framework at the beginning of psychotherapy:

> “*I did not feel that she generated a sense of dependency, of asking questions… of asking for advice, no. Other patients do that, quickly one feels that they develop an initial sense of dependency, but she doesn't. I considered it a false autonomy, an expression of accelerated autonomy. I imagine that this is related to the adaptation to the circumstances of her childhood, which were very adverse for her. So the setting was not like the one you do with a patient who shows a high sense of autonomy, but it was structured. Concrete tasks, very concrete exercises, directive, concrete results*”.

The therapist also mentions that she did not register any type of coercive behavior during psychotherapy:

> “*Unless by ‘coercitive’ we call oppositionalism, explicit or tacit, no. That requires greater differentiations in alterity. Her psychopathic revenge fantasies, as she called them, were quite childish and did not include a perceptual construction of the alterity's effective suffering, but were more akin to caricatures, cartoons*."

Regarding her feelings in psychotherapy, the therapist mentions remembering her impressions in the first interviews:

> "*The first thing I felt was weird, a strange feeling, because Caroline looks like a tall, regal girl from the outside, with a life that for many could be enviable. But without knowing its history, it also generates that feeling that something is missing, that there is an important lack. It is not sadness, but rather... I would call it a lack of trust, in her case it has to do with... well, that is how I imagined it, with that, with trust, with... it is as if in an orphanage one of the girls is hyper correct, from fear, from a deep fear*".

The therapist's imagery, explored under supervision, alluded to an image of a child experiencing abandonment or lack of family support with intense feelings of fear, but not conceptualized as loss of the loved object, a loss of an pre-existing affective relationship, but rather a more intense anguish based on the threat of basic survival.

5. Psychotherapeutic hypotheses

The hypotheses considered the psychotherapeutic problem sustained on difficulties in constructing a consistent alterity, a valid one and open to refutation. Regarding the therapeutic problem, Caroline hypothetically lacks the concepts and referential arrangements to build the intentions and other mental states in significant alterity —again, in a *very specific way* in certain areas within the reference instance and not as a global difficulty—. This difficulty points to experiences of high emotionality, partner decisions that deviate from simplified standards or romantic ideals —both in the history of their parents and in their own current romantic experiences—. Coexistence with her mother during the marriage breakup was a great challenge for Caroline, promoting an accelerated autonomous behavior, fulfilling functions beyond the evolutionary stage, giving her global behavior a high degree of practical effectiveness and resolution, but with a marked nuance of "faked performance", feigned, unnaturally.
Mutuality requires greater differentiation both about oneself, the world and others. And by the other side, Caroline' cross referential arrangements defocus suffering and lack, although they add a minus of modulation to the experience. Far from this need to fulfill roles and functions "expected" by others where one experienced being seen and recognized, one's own tastes, predilections and interests —differentiations that require exploration in an interpersonal environment constructed as trustworthy and comfortable— did not occur, did not existed as possible applications to refer. A high contextual dependency can be explained by this hypothesis.

6. Work objectives

The first objectives constructed and agreed upon between the therapist and Caroline consisted of creating differentiations —conceptual applications— aimed at discriminating tastes, predilections and defining and characterizing "mental states" in significant others during moments of their discomfort, but not hers. In Caroline's words:

> "*I want to be able to feel that there are others out there, I want to feel calmer with that*"; "*I would like to be able to bear it better when I argue with someone close to me. I despair, I feel it as something very distressing, I go to the extreme. It would be good to really understand that other people need time, that discussions need time, takes time. I understand that, but I can't feel it*."

The main requirements of the objectives definition was to assign them to changes out of phase. To do this, in the first place the characterization of "mental states" of the significant others was oriented to specific situations, which did not include Caroline in the conflict. In addition, imagery and training activities were included to achieve this objective. The other requirement when working to achieve these objectives was that the new conceptual differentiations to be trained were open —possible to verify or refute—.
With favorable relational conditions in therapy, Caroline managed to build concepts that allowed her to articulate, for example, the perception that her parents "love each other while lying to each other", a construction that even before psychotherapy caused intense feelings of anguish when not being able to integrate both perceptions.

7. General strategies

The main strategy was *self-observation*. Specific time periods were selected to select the main current discrepancies and then some of the referential elements were treated in a deconstructive way[22].
This required the achievement of a «lateral placement» attitude, where both could deal with the focused experience with the possibility of points of view changes. The main efforts were aimed at gradually making more abstract differentiations regarding the possible mental states of significant alterity.
"Construction" activities were then suggested. For this, favorable conditions for exploration and conceptual applications were created, where discrepancies with their own expectations of application were not punished or considered an "error", but rather they were encouraged to reincorporate discrepancies as useful information about themselves, their way of constructing context and alterity. Considering Caroline's awareness regarding the correspondence with external standards, the therapist took care to consider the "error" as useful, desirable, acceptable information, beginning in the first session where she asked Caroline to make a decorative modification in the box of attention[23]. That playful invitation, with the feelings that Caroline built up during the exercise, were used on several occasions to enrich and guide the coping with more complex situations.

8. Evaluation

The first formal evaluation conversation took place after 4 months of psychotherapy. Caroline felt much better, in terms of general subjective well-being, but the therapist wanted to check if

[22] For space reasons, the definition and exemplification of *deconstruction* was not exposed in this work.
[23] It is the type of task for which any result can be useful to generate exploration heuristics. They do not have a "correct answer", even if the person does not perform it, the feelings or imaginations applied in the avoidance of the task can be very useful.

Caroline perceived that she was reaching her goals. Together they observed that they were making progress, and in the words of the therapist this was explained by a noticeable decrease in vulnerability that was sustained in the therapeutic hypothesis. In that evaluation session, they agreed on “test tasks” regarding past and future situations, in order to evaluate the new constructions. Caroline presented more open, abstract answers, particularly in the reference to alterity. Between the fourth and sixth month of psychotherapy, the focus began to shift towards the exploration of more precise personal discriminations referred to in the corporeality/world instance[24].

Caroline's therapist used two scales, in the context of outpatient care in a hospital: OQ 45.2 and BSL-23. The first was applied five times —every 3-4 sessions, until the sixth month of psychotherapy, when the applications began to be spaced out, due to clinical improvement—, generally registering favorable clinical changes. The second scale was only applied twice, at the beginning of the process and at the eighth month of treatment.

About a year after the first interview, the sessions had already begun to spread out –decrease in frequency–, taking place approximately once a month. Around the year four months, they were suspended, maintaining sporadic contact through email. Around a year and 8 months, Caroline requests four sessions to “deal with a topic”. In this request, Caroline expresses difficulties in having sexual relations with her new partner. She mentions that it has been a different relationship, more "calm" but at the same time more intimate. She comments that her fantasies regarding sexual activity between them included general standards of "how to have sex" and "how to be effective as a lover", which led her to recognize these fantasies as those constructions that they dealt with in session, for which she decided to request aid. In three sessions, less than budgeted, Caroline and the therapist managed to reformulate what happened as "a return to a known pattern when the terrain is new" and were encouraged to make differentiations together with her partner and other people —more specific differentiations, situated and abstract regarding sexual desire and the confidence implicit in affective intimacy increase—.

[24] According to the therapist's opinion, both advances went in some way together. Better discriminations referring to alterity then allowed "having space" (in the words of the therapist) to explore new discriminations in corporeality/world. She also mentioned a process in the opposite direction: for example, understanding and articulating one's own satisfactions and frustrations allowed these processes to be included in the reference to alterity.

IV. References

1. Abramowitz, R., Petersen, A., & Schulenberg, J. (1984). Changes in self-image during adolescence. In Offer, D., Ostrov, E., & Howard, K., (Eds.), *Patterns of adolescent self-image* (pp. 19-28). Jossey-Bass
2. Beck AT (1996). Beyond belief: a theory of modes, personality, and psychopathology. In *Frontiers of Cognitive Therapy*, Salkovskis, P. ed., pp. 1–25. Guilford
3. Bienertová-Vašků J, Zlámal F, Nečesánek I, Konečný D, Vasku A. Calculating Stress: From Entropy to a Thermodynamic Concept of Health and Disease. PLoS One. 2016 Jan 15;11(1):e0146667. doi: 10.1371/journal.pone.0146667.
4. Bowers, K.S. Situationism in psychology: an analysis and a critique. *Psychological Review*, 1973, 80, 307–336.
5. Chiari, G. & Nuzzo, M. (2009). *Constructivist Psychotherapy: A Narrative Hermeneutic* Approach. Routledge.
6. Chu B, Marwaha K, Sanvictores T, et al. Physiology, Stress Reaction. [Updated 2021 Sep 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan.
7. Díaz Olguín, R. (2022). *Experiencia suicida: comprensión narrativa constructivista*. Ril Editores.
8. Díaz Olguín, R. (2016). *Deconstrucción, construcción y reconstrucción: integración entre instancias de referencia*. Retrieved from: https://cipra.cl/documentos/DeconstruccionConstruccionReconstruccion-IntegracionClasesdeReferencia-RodrigoDiazOlguin.pdf
9. Díaz Olguín, R. (2007). *El modelo narrativo en la psicoterapia constructivista y construccionista*. Retrieved from: https://cipra.cl/documentos/NarrativaPsicoterapiaConstructivistaConstruccionista-DiazOlguin.pdf
10. Endler, N. S., & Magnusson, D. (1976). Toward an interactional psychology of personality. *Psychological Bulletin*, 83(5), 956–974. doi:10.1037/0033-2909.83.5.956
11. Feldman Barrett, L. & Russell J.A., eds (2015). *The Psychological Construction of Emotion*. Guilford.
12. Gawronski, B. & Payne, B.K. (Eds.). (2010). *Handbook of Implicit Social Cognition. Measurement, Theory and Applications*. New York: Guildford Press.
13. Greenwald, A., & Banaji, M. Implicit Social Cognition: Attitudes, Self-Esteem, and Stereotypes. *Psychological Review*. 1995, Vol. 102, No. 1,4-27
14. Guidano, V. F. (1994). *El sí mismo en proceso. Hacia una terapia postracionalista*. Paidós.
15. Guidano, V. F. & Liotti, G. (1983). *Cognitive processes and emotional disorders*. Guilford.
16. Guidano, V. F. & Quiñones, A. T. (2001). *El modelo cognitivo postracionalista. Hacia una reconceptualización teórica y clínica*. Desclée de Brouwer.
17. Harvey, O.J., Hunt, D. E. & Schroder, H. M. (1961). *Conceptual systems and personality organization*. Wiley.
18. Harvey, O.J. (1963). Authoritarianism and conceptual functioning in varied conditions. *Journal of Personality*, 31(4), 462–470. doi:10.1111/j.1467-6494.1963.tb01312.x
19. Harvey, O.J. (1964). Some Cognitive Determinants of Influenceability. *Sociometry*, 27(2), 208. doi:10.2307/2785717
20. Harvey, O.J. (1965). Some situational and cognitive determinants of dissonance resolution. *Journal of Personality and Social Psychology*, 1(4), 349–355. doi:10.1037/h0021873
21. Harvey, O.J., Reich, J. W., & Wyer, R. S. (1968). Effects of attitude direction, attitude intensity, and structure of beliefs upon differentiation. *Journal of Personality and Social Psychology*, 10(4), 472–478. doi:10.1037/h0026813

22. Harvey, O.J. (Ed.)(1966). *Experience, Structure & Adaptability*. Springer
23. Kelly, G. (1955). *The psychology of personal constructs*. Vol. I, II. Norton..
24. Laughlin, C. D. (2017). Conceptual Systems Theory: A Neglected Perspective for the Anthropology of Consciousness. *Anthropology of Consciousness*, 28(1), 31–68. doi:10.1111/anoc.12065
25. Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. Springer.
26. McEwen BS, Stellar E. Stress and the individual. Mechanisms leading to disease. *Arch Intern Med*. 1993 Sep 27;153(18):2093-101.
27. Musholt, K. (2015). *Thinking about Oneself From Nonconceptual Content to the Concept of a Self.* Massachusetts: MIT Press
28. Offer, D., Ostrov, E., Howard, K., & Atkinson, R. (1988) *The Teenage World: Adolescents' Self-Image in Ten Countries.* New York: Springer
29. Pervin, L. A., & Lewis, M. (Eds.). (1978). *Perspectives in interactional psychology*. Plenum.
30. Richards, J. & Glasersfeld, E. (1979) The control of perception and the construction of reality. *Dialectica* 33 (1): 37–58
31. Rotter, J. B. (1975). Some problems and misconceptions related to the construct of internal versus external control of reinforcement. *Journal of Consulting and Clinical Psychology*, 43(1), 56–67. doi:10.1037/h0076301
32. Selye, H. (1976). *Stress in Health and Disease*. Butterworth
33. Schroder, H.M., Driver, M.J., & Streufert, S. (1967). *Human Information Processing.* Holt, Rinehart and Winston.
34. Schrödinger, E. (1944) (ed 1992). *What is life?: the physical aspect of the living cell, with Mind and matter & Autobiographical sketches*. Cambridge University Press
35. Sterling, P., & Eyer, J. (1988). Allostasis: A new paradigm to explain arousal pathology. En S. Fisher & J. Reason (Eds.), *Handbook of life stress, cognition and health* (pp. 629–639). Wiley
36. Sterling, P. (2020). *What Is Health?: Allostasis and the Evolution of Human Design*. The MIT Press. doi: 10.7551/mitpress/11472.001.0001
37. Witkin, H.A., Goodenough, D.R. & Oltman, P.K. (1979). Psychological differentiation:current status. *Journal of Personality and Social Psychology*, 37 (7), 1127-1145.

About the author

Rodrigo Díaz Olguín. Psychologist, trained in post-rationalist psychotherapy GIP Barcelona. Diploma in Addiction Treatment and Rehabilitation for the General Population, Universidad de Chile. Clinical psychologist in Hospital Las Higueras Psychiatry Unit, in charge of the Personality Disorders Subprogram. Author of the book "Experiencia Suicida: Comprensión Narrativa Constructivista", Ril Editores, 2022. Comments or queries about this work, write to ps.rodrigodiazolguin@gmail.com

Edited by Cipra, Círculo de Psicoterapia Constructivista.
Concepción. Chile.
Email cipra.psicologia@gmail.com
Website http://www.cipra.cl

October, 2022