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Limited Options: Symptoms as Expressions of Ambivalence

DAVID P FOURIE
University of South Africa

It was shown previously that symptoms could be seen as linguistic expressions of ambivalence at both an individual and a family level, resulting in conflicting discourses in the family. In this way everyone's options for action become limited. This article illustrates, by means of case examples, how the oscillation between the two opposite poles of such ambivalence limits the options for change available to all parties involved, including the therapist. It also shows how the concept of conservation of autonomy can be utilized to become aware of the limitations existing in the systems seen in psychotherapy, thereby enabling the therapist to avoid such limitations in treatment.

A man was sitting on a park bench, continually snapping his fingers. When a passerby asked why he was doing this, he replied that he was chasing away the lions. Said the passerby: "But there are no lions here." To which the man responded: "Shows you it works!"

Some time ago it was shown how, from the perspective of second-order cybernetics, (psychophysiological) symptoms could be seen as expressions of ambivalence both at an individual and at a family level (Fourie, 1996). The person who has to achieve but cannot, because of the debilitating effects of myalgic encephalomyelitis (ME) is a good example of this "stuckness." And the symptoms themselves, e.g., fatigue, pain, etc., can be seen as linguistic expressions of the ambivalence. These conflicting discourses in which both the symptom carrier and the family continually find themselves, can be seen mainly to reflect the two opposite poles of the ambivalence. In a similar way the ambivalence shown by the fictitious man in the park allowed only one of two possibilities, namely either the presence or the absence of lions. It is the aim of this article to illustrate, by means of case examples, how this oscilla-

Address correspondence to David P. Fourie, Department of Psychology, UNISA, P.O. Box 392, UNISA 0003, South Africa. E-mail: fouridp@unisa.ac.za

tion between the two opposite poles forming the ambivalence limits the options available to all parties involved, including the therapist.

CONSERVATION OF AUTONOMY; CONSERVATION OF AMBIVALENCE

The shift from so-called first- to second-order cybernetics in systemic psychotherapy embodied a shift from a focus on intra- and inter-systemic *interaction*, as if these could be "objectively" observed, to an emphasis on the *autonomy* of living systems (Fourie, 1993; Griffith, Griffith, & Slovik, 1990; Kenny, 1988; Kruse, Stadler, Pavlekovic, & Gheorghiu, 1992; Maturana, 1975). This autonomy is continually expressed in verbal and nonverbal linguistic ways (Anderson & Goolishian, 1988). From this perspective *all* systemic actions are seen as aimed at the conservation of the system's autonomy; if the system's autonomy is lost, it ceases to function as a system and is therefore destroyed (Fourie, 1993; Maturana, 1975).

The term "autonomy" is intended to be neutral, it does not necessarily refer only to something considered positive. A system could also conserve an autonomy of weakness; it is well-known in clinical work, for instance, that some clients conserve their identity as needy and dependent. To express this idea, Kenny (1988) uses a more accurate but unwieldy term in the place of "autonomy," namely "conservation of invariance."

Usually, and in the absence of a perceived threat to their autonomy, systems express the conservation of this autonomy through normal actions. But when there is the perception of a threat to their autonomy, systems might in desperation utilize symptoms to help conserve this autonomy. Because such symptomatic efforts are not ideal, they are uncomfortable, both to the sufferer and to others. Symptoms are stopgaps, non-ideal ways to keep the system from losing its autonomy, i.e., from losing its life as a system (Fourie, 1996). And probably because they are not ideal, symptoms can often be seen to express an ambivalence between the ideal, wished-for situation and the real, "necessary" situation. For instance, by means of depressive symptoms a person may express an attempt to conserve his/her autonomy as a sensitive, easily-upset individual in need of special respect and consideration, while at the same time these symptoms discourage the expression of real respect from others. Even if real respect is shown, the symptom carrier can never be sure that the respect is in fact real and not brought about by sympathy for his or her "affliction." In this way the particular depressive symptoms may be seen to express both sides of the ambivalence simultaneously, namely "I am worthy of respect" and "I am not worthy of respect." This looks like at least two possibilities, but on closer inspection it is clear that only one possibility exists in the system, namely not to be respected. These are limited options. In treatment these limitations are often

implicitly imposed on the treatment process itself. This is illustrated in the following cases.

CASE 1: JACK

Jack was retrenched from his job as a marketing manager at the age of 44. He desperately applied for every available position because he had a family to support. When, after three months, his applications were still unsuccessful, he sought psychotherapy for his depression, something he suffered from for a long time, but which was previously relatively well controlled by means of medication. The following is a history constructed by Jack and his therapist in an initial interview.

Jack came from a family of women. He had two much older sisters and a very manipulative mother. The father apparently took little interest in the family and was overinvolved in his work. Initially Jack was spoiled by the sisters, but after his father died (when Jack was 16), he was paradoxically expected both to be the man in the family and simultaneously to do the women's bidding. That means he had to do those things the mother and sisters considered to be the tasks of the man in the house.

When he left school, Jack was uncertain about further studies and a career. One of the sisters suggested that he study marketing, which he did even though he had little interest in it. He also did not enjoy the marketing career he subsequently followed, but by that time he had a family to provide for. His wife, Sue, and her elder sister admired their father who doted on them. He was a successful businessman who saw to it that his daugthers wanted for nothing. Sue did not prepare herself for a career, but married Jack when she was 18 and he was 24, and expected him to take over from her father in providing for her, which he did. In his marriage Jack therefore found himself in a very similar situation to that in which he grew up, namely one where he had to do the caretaking job expected by the woman in his life.

Quite early in the marriage, Jack found himself doing what his own father did, namely withdrawing from his wife and later also from the two daughters they subsequently had. He embarked on further studies, but merely as an excuse not to be home he said. When he lost his job, Sue was shocked and impressed upon Jack the necessity to find other employment as soon as possible. Every failed application increased Sue's anxiety and she blamed Jack for his lack of success. Her anxiety led her father and sister to help Jack look for jobs or business opportunities. This increased the pressure on Jack to perform as expected.

Most of the positions Jack applied for were in marketing, because he had 20 years' experience in this field. But never having liked the field, he did so reluctantly. He then blamed his lack of success in finding employment on this hesitance and on what he called his lack of communication skills.

Sue was unwilling to partake in conjoint therapy because she considered the problem to be Jack's alone and because she had lost interest in the marriage. However, she did consent to one interview alone. She reported having lost faith in, and respect for, Jack. She viewed him as weak, self-centered, and uncaring. Part of this weakness she saw as reflected in his frequent migraine headaches and the large amounts of analgesics he took. Whenever her family came to visit, for instance, he would withdraw with a migraine.

From the perspective of conservation of autonomy this case is interesting. One could see the ambivalence of Jack's position as reflected in his attempts to do as expected of him by the women in his life, but in such a way as not to be seen as obedient to them. For instance, he studied what his sister wanted, but did not enjoy it. He applied for many positions as his wife and her family expected, but did it in such a halfhearted way as to be unsuccessful by botching interviews, for instance. In so doing, he managed to defy his wife, but also clearly and strongly defined himself as uncertain and weak. Instead of saying openly that he did not want to see Sue's family, for instance, he would get a migraine, which gave him an "excuse" to withdraw, but which also defined him as "weak" in Sue's eyes (and in his own eyes).

One could therefore say that Jack's whole life was a history of doing what was expected of him, but in such a way as to be unsuccessful. He therefore managed *not* to do what the women in his life wanted, not because he was defiant or disobedient, but because he was incapable. His "incapabilities," as reflected in symptoms such as depression, migraine, communication problems, lack of confidence, social withdrawal, and overmedication, can be seen as ways to conserve his autonomy as a man who was not under female control. That these "strategies" were not effective is clear because they also simultaneously defined him as weak and unsuccessful ("I am too weak not to defy you"). This was the ambivalent position continually being conserved: defiance dressed up as involuntary disobedience, an option of one.

Two things need to be noted here, though. First, the above view does NOT imply that the symptoms, such as depression, migraine, etc., were not real. There is no implication of faking or deliberate misleading here. Jack really suffered from these symptoms.

The second aspect of importance is that it is not only Jack who should be seen as involved in the conservation of the particular ambivalence. By insisting that Jack find new employment, by withdrawing from him in disappointment and disgust, by getting her sister and their father involved, and by refusing conjoint therapy, Sue actively partook in the process of simultaneously pressuring him to do as expected, and defining him as unsuccessful, as a disappointment to her, as less of a man, and as an incapable caretaker. She continued to set the standards and to show how he failed to meet them. Even the normal, demanding teenage behavior of his daughters can be viewed as contributing to the cocreated "reality" that Dad was an incapable caretaker and not "there" for them.

Now consider the difficulties of therapy. Jack's request was that therapy should help him to be more confident and less depressed so that he could be successful in finding employment. It should be clear, though, that any attempt to do so would have been unlikely to be successful as it would have constituted merely a further demand Jack had to fail in order to conserve his ambivalent position in the family. Loading the demands would not bring Jack to fulfill them, rather it would intensify the system's need for him to fail. Seen from this perspective, the therapeutic possibilities were as limited as those in the family: the therapist could not afford to unwittingly let himself be defined as Sue's ally in the dynamics of this family.

What had to happen in therapy was to get out of the limitations imposed by the system. In practice this meant that Jack had to be confirmed as a person, i.e., taken seriously, while his ambivalent ideas had to be simultaneously disconfirmed (Fourie, 1996). This entailed a particular reframing of the situation. While it was understandable that Jack and his family considered his retrenchment a disaster, in fact it embodied a rare opportunity for him to start fresh, this time doing what *be* wanted. Every time Jack would complain that he was not "doing enough" to find a new job, he was congratulated on "not rushing things," on waiting until he found exactly what he wanted to do. For instance, he was interested in speculating on the stock market and the therapist encouraged him to enroll for a practical course in this regard. This was his golden opportunity, an opportunity not available to many people his age, to find that which he would spontaneously enjoy. He was warned against "indiscriminately" applying for jobs he knew he would not enjoy. He was reminded time and again that he had enough money to spend a year without an income and that this year should be used to the best possible effect. This kind of "restraining" is an old and well-known therapeutic technique (Watzlawick, Weakland, & Fisch, 1974).

Apart from the stock market course, Jack was encouraged to "look around idly" to see what kind of work he might enjoy. In this way he eventually came across a business opportunity which he hesitantly thought might be interesting. He took a risk and bought the business. He found, almost to his surprise, that he felt challenged and that he was capable of buying and selling successfully. In this process his self-confidence improved, the depression lifted and he found himself actually enjoying the business. His marriage, though, is still not satisfactory. Sue does not like the idea that Jack is not in some secure employment with a large and stable company. She doubts his ability to succeed in business.

CASE 2: LINDA

Linda grew up in the shadow of her very capable older sister. Being six years younger, Linda has always been "Little Sister." She emulated her sister in everything and at age 12 she put in such an effort and partook in so many

sporting activities (the sister was an extremely good sportswoman), that she was hospitalized with "nervous exhaustion." After this episode, Linda had to curtail her participation in sports, but still did very well, both in sports and academically. Eventually, both sisters became high-achieving professionals, but Linda always felt that, especially in the eyes of their mother, she was not as good as the sister. Even at the time of therapy, the sister still communicated with Linda in a condescending and patronizing way.

When she applied for psychotherapy, Linda (27 years old) had been married for three years. She thought herself very fortunate to have found such a handsome and wonderful man. The marriage was good, but Linda was becoming extremely jealous of her husband, Bill. The more he tried to reassure her and convince her of his fidelity the more anxious she became. She interrogated him regularly about his actions at work and at his sports club and she went through his cell phone records. Although he was generally patient with her, he increasingly lost his temper on such occasions. Linda realized that her anxiety would eventually drive Bill away. Also she felt embarrassed about this "weakness." Logically she said she knew that Bill was faithful to her, but she saw "dangers" everywhere. She was also becoming upset that his increasing anger about her interrogations indicated that he was becoming as domineering as his father, a man she disliked for this reason.

Linda strongly defined the problem as an individual one in which marital therapy was inappropriate. In fact, initially she did not inform Bill that she was coming to therapy, thinking that he would see that as a confirmation of her "weakness."

Linda was a high achiever. She worked very hard at a demanding position of employment. She was extremely attractive and very stylish, but with a charming humility. She seemed, in fact, to be continuing to do what she did as a child, namely to do her very best in all arenas of her life, while doubting that she was doing well enough. This could be seen as the ambivalent autonomy she was conserving: striving for excellence while never quite succeeding in her own eyes. Through her uncertainty, which manifested both verbally and in body language, she also seemed to communicate to others that she was tense and feeling insecure, probably leading them to underestimate her and to treat her in a patronizing way. The limitations this posed in her life, were clear: she was probably not taken seriously, which confirmed to her that she was not "good enough," leading to even stronger efforts to achieve.

These limitations also existed in psychotherapy. The therapist felt inclined to be gentle with her and to reassure her of her worth as a person. This was probably counterproductive as it embodied the "usual" social response of condescension toward her, confirming yet again that she was not taken seriously. The therapist had to avoid this trap by confirming the "positive" side of her autonomy (her capabilities), while simultaneously disconfirming her ambivalent ideas. For instance, she was asked why such an attractive woman would want to "drive her husband away," which was

clearly what she seemed to be doing. Her initial response—that she did not want to drive him away—was not accepted in therapy and she was questioned around her motives for wanting to end the marriage, leading to a much more fruitful discussion of her anxieties about herself and about her marriage, anxieties that were taken seriously by the therapist. In this way her definition of her jealous behavior as involuntary was not accepted and it was implied that the behavior, while based on legitimate anxieties, was in fact deliberate, meaning that she had voluntary control of such behavior. Such control rapidly became evident in that the jealous behavior diminished after two sessions of psychotherapy. Her general demeanor became more self-confident and relaxed. She even had the first open disagreement with her sister. This whole change was further defined as voluntary by qualifying it as a successful effort by Linda to overcome what could be seen as a "bad habit," called in therapy the "Little Sister Way of Acting." See White's (1989) externalization of the problem in this regard.

Only by recognizing, and then actively countering the limited options brought into the therapeutic situation, could the therapist go beyond them. This went so far as a respectful insistence to involve Bill in the later stages of psychotherapy. At that point care was taken not to define the problem as Linda's alone, but as one of marital communication.

CASE 3: CHERYL

Cheryl requested hypnotherapy to find out where her depression came from and, if possible, to treat it. She was referred by a marital therapist who helped her and her husband improve their relationship. Although the marital relationship was considerably better, the depression lingered. According to Cheryl, the depression originated 17 years before, with the birth of their son. At that time the depression was considered postpartum, but it never really disappeared.

"Coincidentally" the marital problems also dated from about the time of the birth of the son. Cheryl reported that Bob, her husband, never liked the son and thought that Cheryl paid too much attention to the boy. He felt that she was too close to the boy and not strict enough with him. This, according to Bob, would make the boy "soft" and effeminate. Cheryl was of the opinion that Bob was simply jealous of the attention she bestowed on the child. One of Bob's complaints was that Cheryl did not talk enough (to him) and this confirmed for her that Bob resented the time she spent with the boy. One of the effects of the depression was that Cheryl became quiet and withdrawn and spoke less when she felt depressed.

In hypnotic age-regression, which was carried out in the presence of Bob, Cheryl "relived" an episode where Bob took the son to task about some matter. During this occurrence Cheryl was looking on and wanted to protect the boy against the father's unreasonable (according to her) aggres-

sion. However, she could not bring herself to say or do anything and she felt helpless and depressed.

In a subsequent discussion, it became clear that the depression could be seen as an expression of the usual single option in this family, namely not to upset Bob. It kept Cheryl from coming to the boy's aid against Bob, which Bob viewed as disloyalty to him. By being depressed Cheryl could not defend the boy, nor could she spend much time with him. In this way she did not go against Bob's wishes. But she also could not relate to Bob in the way he wanted. This clearly illustrates the stopgap nature of the symptom. It did not please anybody, but it kept the system relatively stable.

This limitation was also evident in the therapy situation. The request to the therapist was to deal with Cheryl's depression, but not to focus on the couple's relationship, because ostensibly the relationship was already much improved. Bob insisted on being present at the hypnosis, thereby ensuring that the same limited option was present here: not to upset Bob.

If the therapist had accepted this limitation, the therapy would have been bound to fail. In fact, to focus on Cheryl's depression, as requested, would implicitly have defined the therapist as Bob's ally. Rather, by ostensibly focussing on the depression, the age-regression was used to highlight the power imbalance in the family. Bob's presence at the age-regression and the subsequent discussion was utilized to lead him to an understanding of his intimidating role in the family and how this linked to Cheryl's depression. Both in the age-regression and thereafter Cheryl was led to express openly for the first time her fear of Bob's aggressive and intimidating attitude toward her. This came as quite a shock to him and the therapy moved to a discussion of how the couple as a team could formulate and carry out a consistent policy regarding their son. In this way the limitation imposed on the therapy was circumvented. Also, it paved the way for a different option to be available at home, namely for the couple to act toward the son in a coherent and agreed-upon way, per definition obviating the need for Cheryl to be depressed.

CONCLUSION

These case discussions illustrate how the concept of conservation of autonomy/conservation of ambivalence (Fourie, 1993) can be utilized to become aware of the limitations existing in the systems seen in psychotherapy, limitations that are invariably brought into the therapy itself. They also show the kinds of pitfalls faced by psychotherapists when they do not have such awareness. It is all too easy for a therapist or other treatment agent unwittingly, and with the best of intentions, to allow the limited options of the system to become also the limited options of therapy. In so doing the therapy at best becomes ineffective and at worst it helps to entrench the presented symptoms even further.

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