COSTRUTTIVISMI, 11: 24-33, 2024
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ISSN: 2465-2083
https://doi.org/
10.23826/2024.01.024.033

aippc
ISSN 2465-2083
COSTRUTTIVISMI
Rivista semestrale edita dalla
Associazione Italiana di Psicologia e Psicoterapia Costruttivista

The Opposition Between the "I" and the "You": Intersubjective Imbalance and Personal Disorders[1]

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ABSTRACT
The concept of psychological disorder should be a fundamental question for any psychotherapeutic approach based on an adequate psychological theory. When the question "What can be understood by disorder" is asked, the answers are different depending on the theory adopted. For example, they can refer to learned maladaptive habits, irrational beliefs, dysfunctional relationships within the family, repetition compulsion, and so on. In illustrating the assumptions of personal construct psychotherapy, Kelly proposed a clear definition of disorder as "any personal construction which is used repeatedly in spite of consistent invalidation." However, such definition does not look like it has been used throughout the volume dedicated to psychotherapy nor in Kelly's subsequent writings. The aim of my paper is to show how the personal construct view of disorder has been further developed by some of his followers and to suggest the possibility and usefulness of elaborating further their proposals by referring to the phenomenological notion of intersubjective imbalance. In my opinion such a notion, which is mainly used in some relational psychoanalytic approaches, can be convincingly translated into the language of personal construct theory as I did in the hypothesis of uncompleted paths of mutual recognition.

Keywords: personal construct theory, personal construct psychotherapy, psychological disorder, intersubjective imbalance, narrative-hermeneutic psychotherapy, uncompleted paths of mutual recognition.

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[1] Paper presented at the 24th International Congress of Personal Construct Psychology. Padua, 13th-16th July, 2022

Received 12 2 2023, accepted 6 6 2023
www.aippc.it/costruttivismi

It is my opinion that the way in which the disorder is conceptualized should be fundamental to any psychotherapeutic approach based on an adequate psychological theory. When the question "What is understood by disorder?" is asked, the answers differ depending on the theory adopted. They can, for example, refer to learned maladaptive habits, irrational beliefs, dysfunctional relationships within the family, repetition compulsion, a lack of insight, and so on. In any case, a view of disorder should steer the course of therapy.

In illustrating the assumptions of personal construct psychotherapy, Kelly (1955) proposed a definition of disorder as "any personal construction which is used repeatedly in spite of consistent invalidation" (p. 831) or—in a little vague form—as "any structure which appears to fail to accomplish its purpose" (p. 835). So, basically, a psychological disorder is traced to characteristics of a person's construction system, not conceived in terms of a disease entity. It is a pity, and somehow puzzling, that this view was not being consistently used by Kelly throughout the volume dedicated to psychotherapy, nor elaborated or even re-presented in his subsequent writings.

Luckily, some of Kelly's followers took up the theme. I think I can divide them into two main areas, depending on the emphasis they place on the processes entailed in the block of experience resulting from the disorder: nonvalidation or conflict. I will briefly review them. In the last part of this presentation, I will introduce a proposal that has contact points with both and in some way unites them. The disorder is traced back to particular courses in that process of individuation which permits the emergence of an "I" and an "You" from the original undifferentiated, symbiotic relationship between mother and infant. This entails starting from the view that in the beginning is relation, that commonality precedes individuality as contended by the sadly missed Trevor Butt (1998): a thesis familiar to most of the phenomenologists but rarely adopted by personal construct theorists and practitioners.

Validation vs nonvalidation

The works of the first area are overtly intended to speculatively elaborate further Kelly's view of disorder focusing on the notions of validation and nonvalidation. They date back to the early 2000s, when Walker and Winter have begun to critically analyse and overhaul Kelly's definitions, at first separately and then as co-authors.

Walker's (2002) contribution consisted in having examined in depth the concept of validation in terms of the validation cycle, the process whereby construing is put to test. This cycle is closely linked to Kelly's metaphor of the person-as-scientist. She highlighted the possibility that people sometimes engage in neither validation nor invalidation by their action, coining the term nonvalidation to indicate the opposite pole to validation in cases of noncompletion of the ideal validational process. For each stage of the processes implied by the scientist metaphor and the validation cycle, Walker suggested as many nonvalidation strategies (such as endless circumspection, loosening, hostility)—meaning them not necessarily consciously adopted or controlled.

Walker (2002) argued that "because of Kelly's stress on people being effective scientists… the non-completion of experimentation is undesirable". Nevertheless, "nonvalidation strategies can have positive effects… by protecting the status quo from change and its associated distress" (p. 60). Kelly (1955) himself argued that "even an obviously invalid part of a construction system may be preferable to the void of anxiety which might be caused by its elimination altogether" (p. 831). It is now easy to relate a disorder to a breakdown of one or more

stages of the validation cycle and consider it as "any nonvalidation strategy that is repeatedly used to apply to either much of what we construe or to core/superordinate areas of our lives" (Walker, 2002, p. 60).

In his elaboration, Winter (2003) referred to a formalization of the metaphor of the scientist after the validation cycle used by Walker: that is, the experience cycle, that Kelly (1966) introduced in his manuscript A brief introduction to personal construct theory. This unit of experience embraces five phases: anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision.

Kelly's definition, Winter (2003) highlighted, implies that a disorder involves failure to complete the experience cycle, but "it can be regarded—just like the constructions of non-disordered people—as the individual's attempt to make the best sense of his or her world and to cope with or avoid invalidation" (pp. 201-202). To this end, people adopt the strategies which Kelly described in his diagnostic constructs: for example, tightening and loosening, and constriction and dilation. But while the "optimally functioning" person (Epting & Amerikaner, 1980) is characterized by a cyclical and balanced interplay of contrasting strategies, "disorders tend to involve the almost exclusive use of a particular strategy" (p. 202). This is why Winter suggested imbalance as a more appropriate term, given that disorder "carries mechanistic implications, is suggestive of a state rather than a process, and its dictionary definition includes such words as ailment and disease" (p. 209).

In their co-written work, Walker and Winter (2005) discussed in greater detail the problematic nature of Kelly's view of disorder and re-presented their suggestion in terms of the imbalance in the use of non-validational strategies, the result of which is that "we remain stuck, immobile, unable to move forward, and unable to reconstrue" (pp. 27-28).

I discovered the above contributions only after the publication in 2010 of mine and Nuzzo's book titled Constructivist Psychotherapy: A Narrative Hermeneutic Approach, in which book the view of disorder shows both significant similarities and some differences from that of Walker and Winter. Looking at personal construct theory in the light of Maturana's theory of autopoiesis (Maturana & Varela, 1987)—a comparison I elaborated further some years later (Chiari, 2016)—personal change was seen as "the expression of the continuous structural changes the system encounters in its dialectical relation with the environment... Being organisationally closed, the system necessarily subordinates any change ('becoming') to the conservation of its organisation ('being')" (Chiari & Nuzzo, 2010, p. 138). In this view, the diagnostic constructs relative to transitions are seen as intimations of a disintegration of the organisation of self, and the diagnostic constructs relative to the structure of a personal construct system (the "strategies" in the terminology of Walker and Winter) are seen as processes aimed at permitting its conservation or restoration. The attempt can be successful, but it can be a partial solution, allowing the prevention of disintegration but not a continuation of movement: the person chooses to stop changing—what we indicated as "not-becoming" (Chiari & Nuzzo, 2004). It is the very suspension of movement in the person's relation with the social environment that can be seen as a disorder. In mathematical terms, the conservation of the person's adaptation through recursive changes is replaced by repetitive processes. The psychotherapeutic process should be aimed at restoring a recursive movement.

Cognitive conflicts and dilemmas

The other series of works empirically addresses from a PCP perspective the role of cognitive conflicts in psychopathology.

Feixas and collaborators (Feixas, Saúl, & Ávila-Espada, 2009) have been working for many years on the verification of the hypothesis that people with mental disorders show a presence of cognitive conflicts higher than nonclinical samples. While they might not seem to be explicitly interested in elaborating Kelly's definition, they pursue their research within a rigorous PCP framework making an extensive use of the repertory grid technique, and their results shed light on a particular aspect possibly implied in disorders.

Starting from the observation that the notion of cognitive conflict has a long tradition in psychology, they see in personal construct theory the most elaborate framework for an understanding of conflicts and their relevance for personality and clinical psychology, given its emphasis on human freedom and choice, allowing in turn a view of human beings as susceptible to personal dilemmas.

The pioneer in this field was Hinkle (1965) who, in his Ph.D. thesis written under Kelly's supervision, coined the term implicative dilemma to refer to a particular form of implication between two constructs and related it to the notion of conflict:

> A and B imply X, and B implies Y; also A implies Y, and B implies X and Y. One subject, for example, when relating desirable-undesirable and realism-idealism, said that realism and idealism both implied desirable and undesirable aspects for him. Conflict theory and double-bind theory relate to these *implicative dilemmas*. (pp. 18–19, emphasis in the original)

In the PCP literature you can find other contributions to the theme. Based on Feixas's et al. (2009) review, I limit myself to pointing out those I consider to be the most significant.

It was observed by Adams-Webber (1970) that new structures evolve to accommodate an event that is ambiguous according to the person's existing structure, that is, that "becomes the focus of expectations which are inconsistent with one another in terms of the specific relationships between constructs which articulate the 'logical' structure of an individual's system" (Adams-Webber, 1981, p. 55).

The attempts to reduce conflict, according to Space and Cromwell (1978), may give constructs idiosyncratic meanings so that "looseness and instability occur as the final effort for conflict resolution" (p. 188).

Tchudi's (1977) ABC model drew on Hinkle's thesis. Here, three constructs—one describing the symptom or problem, one its disadvantages and the third its advantages—make up "an implicative network of a special type, an implicative dilemma", whereby "the system is blocked, the person is stuck or 'forced to' run in circles… the symptom solves the problem, but the price is felt to be too high" (p. 325).

Ryle (1979), who proposed a cognitive analytic therapy that incorporates some features of PCP, specified that "dilemmas can be expressed in the form of 'either/or' (false dichotomies that restrict the range of choice), or of 'if/then' (false assumptions of association that similarly inhibit change)." For example, "in relationships I am either close to someone and feel smothered, or I am cut off and feel lonely", or "I feel that if I am masculine then I have to be insensitive."

In his studies with clients with social anxiety, Winter (1989) linked the conflict to the core role. He found that in 80% of them constructs related to social competence (e.g., social, outgoing) carried negative implications (e.g., selfish, inconsiderate, bossy).

> The treatment which these clients were understandably resisting was therefore one which they appeared to construe as training in selfishness, contempt, and deceit, characteristics which were inconsistent with their core roles. (Winter, 1989, p. 4)

For these clients a hypothetical change would generate guilt, and resistance can be explained as a way of retaining personal coherence in order to avoid massive invalidation.

Feixas' research program makes use of repertory grids aimed at obtaining measures relating to three possible types of cognitive conflicts: (1) Triadic Conflicts (TC), where three constructs correlate between each other negatively, or where two correlate positively and the third negatively; (2) Implicative Dilemmas (ID), in which the pole of a construct representing a symptom or problem is associated to a positive pole of another construct which might be at a higher level in the system's hierarchy; (3) Dilemmatic Constructs (DC), where both construct poles are deemed undesirable and a middle point rating is given to the "ideal self".

One of the first studies (Feixas, Saúl, & Ávila-Espada, 2009) showed that the only type of conflict that differentiates significantly between the clinical and the nonclinical samples is ID. Although IDs are common in the general population, they are found in over half of the clinical and in a third of the nonclinical samples. Also, the participants with IDs presented higher levels of symptom severity than participants without such dilemmas.

Subsequent studies (see review in Montesano, López-González, Saúl, & Feixas, 2015) have explored the significantly higher presence of IDs in a variety of specific clinical conditions such as eating disorders, depression, dysthymia, and fibromyalgia, finding confirmation of the hypothesis.

Intersubjective imbalance and dilemmatic relationships

My suggestion arises from the numberless conversations I have had with clients as a personal construct psychotherapist, and the debates with colleagues and students as a psychotherapy teacher. As a result of those experiences, my way of practising and teaching psychotherapy has gone progressively toward an elaboration of Kelly's original formulation, enough to make it appropriate a new name for our approach: that of narrative-hermeneutic psychotherapy. In this way we intend to emphasize our interest in the narrative organisation of personal experience and the view of the psychotherapeutic process as a continuous hermeneutic conversation aimed at revealing the most core aspects of the clients' narratives favouring at the same time a reconstruction. On closer inspection, our way of joining a series of conversations with our clients has striking similarities to the clinical method as conceived and illustrated by Kelly.

Besides, our approach shows an interest in hypothesising developmental trajectories to which people can be tentatively traced back in order to anticipate the content of the clients' narratives on the basis of the observation of similarities in the construction of relational experiences. In other words, the "ultimate objective" of such enterprise is not, to quote Kelly (1955), "a log of [the client's] past navigation", but "the anticipation of actual and possible courses of events in a person's life" (p. 185). Already 30 years ago, we described what we called "dependency paths", supposedly channeled by the major transitions that children experience in their

early relationship with their caregivers (Chiari, Nuzzo, Alfano, Brogna, D'Andrea, Di Battista, Plata, & Stiffan, 1994).

In this perspective, the understanding of where the disorder arises and resides is central. To this regard, while retaining the view of the disorder as a nonvalidational choice as described above, I found the newest source of inspiration in the recent elaborations of the issues of intersubjectivity and recognition, situated at the intersections of philosophy and psychology. Among others, I refer to the philosophers Honneth (1995) and Ricoeur (2005), and to the relational psychoanalyst Benjamin (2017). I believe that the theory of recognition can account for important clinical questions. For brevity's sake, I shall limit myself here to describing the essential elements of my hypothesis. For in-depth reading, my last article was published in the Journal of Constructivist Psychology (Chiari, 2023).

Schematically, my suggestion is that clinically significant disorders are related to core role structures whose origin can be traced back to early relationships. Such relationships are characterized by an intersubjective imbalance deriving from complementary (as opposed to reciprocal) relations. The reciprocal interactions are characterized by the mutually influencing quality of interaction between subjects, whereas in the complementary relations one person is subject and the other object. In PCP terms, the distinction is between role relations and dependency relations. Complementary relations are supposed to give rise to dilemmas which permeate the relational life and generate suffering.

The main issue is the process by which both mother and child extricate themselves from a state of symbiosis and the child proceeds toward a progressive individuation, emerging as a person with a distinct role. The completion of such a process requires—in the words of Honneth (1995)—the willingness "to mutually recognize one another as persons who are dependent on each other and yet also completely individuated" (p. 24).

This mutual recognition leads to an intersubjective balance between contrasting poles: that of fusion (that is, symbiotic dependence), and that of self-affirmation in solitude (that is, egocentric independence), resulting in relationships of relative dependence. By using the conceptual tools of PCT, the possibility for the child to accomplish a developmental path of mutual recognition arises from early reciprocity relationships characterized by an acceptance by the caregiver, who values what the child does, recognizing and favouring his or her rising subjectivity. This is a kind of interplay that facilitates the establishment of role relationships, a high dispersion of dependency, and the development of what Kelly (1961) called an awareness of role, the feeling that "one has ordered one's life by understanding the outlooks of others", while "to sense that one's role has been lost" corresponds to guilt (p. 273). I called this path the completed path of mutual recognition in the form of acceptance.

Unlike the previous case, my guess is that an intersubjective imbalance is signalled, in PCT terms, by a low dispersion of dependency, where people tend to allocate their dependencies either to a few people or mostly to themselves. All this can be seen as connected to the children's experience of a want of reciprocity in their relationship with the caregivers. The incompleteness of the process of mutual recognition entails the feeling of a lack of confidence in the place one occupies in the social domain, that is, the lack of a sense of recognition, a lack of awareness of role in my interpretation of Kelly's term. Complementarity relationships are formed, in which the child is treated by the caregiver who disregards his or her subjectivity as an object rather than a subject contributing to shape a co-created reality.

I described three forms of uncompleted paths of mutual recognition.

I will briefly dwell on one of these paths because the disordered people related to it rarely ask for a psychotherapeutic treatment in a private setting and I have little direct experience of

it. Here, the mother-child relationship is such that children are deprived of the possibility of adequately construing the mother, whose participation in the relationship is limited to nourishing the children, her possibility of having a wider relationship being likely limited by the threat of affectional bonds. Children see the formation of new constructs hindered by the unavailability of validating data. Therefore, they experience anxiety. As a protection from anxiety, the children loosen their constructions—loosening is their preferred "strategy", to use Walker and Winter's (2005) term. Unfortunately, the children's social experimentations outside the family are likely to generate anxiety in others who experience difficulty in understanding their loose construing which results in odd behaviours. As a protection from anxiety, others avoid the child who, in a progressive spiral, "has less and less access to validational material of an interpersonal nature" (Kelly, 1955, p. 856). I called this path the uncompleted path of mutual recognition in the form of negligence.

Sometimes the intersubjective imbalance tends toward the fusion pole. Here, the mother regards the child as a resource for her and therefore discourages his or her social explorations by threatening to break the relationship on which the child depends. This results in the child's—and later the adult's—undispersed allocation of dependencies to the very few and familiar people who have acted as caregivers. The person chooses to live in a constricted world, being constriction the preferred "strategy" to avoid the threat implied by the anticipation of a separation. But here a conflict also appears. Proximity—being close with someone—implies security but at the same time restriction of one's freedom of action, and separateness implies freedom from such restriction but at the same time solitude and bewilderment: a dilemma well expressed by Ovid's verse, "I can live neither with you, nor without you." I called this path the uncompleted path of mutual recognition in the form of fusion.

In other cases, the intersubjective imbalance tends toward the pole of the self-affirmation in solitude, that goes along with an undispersed allocation of dependencies to oneself, given the experience of a lack of availability from caregivers. The above is the result of the children's construction of their mother as a figure happy and accepting them provided that they succeed in complying with her expectancies, and suffering and rejecting otherwise. But their repeated attempts are destined to fail, due to the hostility of the mother who holds them in contempt in order to absolve herself. The children feel responsible for the mother's unhappiness and experience recurrent feelings of guilt, which they try to prevent resorting to a kind of constriction consisting in the progressive exclusion from the relational field of all the expressions of themselves supposedly incompatible with the possibility of playing a role of care with her—and later, as adults, with other people. Consequently, their attempts at avoiding the evidence of being wrong and unworthy of being accepted since a source of suffering for others go along with the awareness of being different from how they appear to others. Hence, the disorder: they are threatened both by acceptance from others—which requires self-denial and losing themselves—and by expressing themselves—which implies guilt, rejection and definitive loneliness. The dilemma is "either a relationship requiring a self-abasement, or a self-affirmation entailing solitude" or, ultimately, "you or me." I called this path the uncompleted path of mutual recognition in the form of disrespect.

Conclusion

In the unsolved conflicts present in the last two paths I see the root of the disorder in many people. They can be more or less evident but manifest themselves in many ways since

childhood and inform the person's relational life, sometimes in a rather limited and sometimes in a very limiting way. My wild guess is that many of the conflicts that can be found in many people are subordinate implications of one of these two "ontological" conflicts pertaining to the social life.

This view also allows to interpret some behaviours traditionally understood as "disorders" as instead the expression of attempts to solve dilemmas. For example, the anorexic behaviour can be seen as a choice aimed at regaining some sense of agency. Thanks to it, the person does not submit herself to the other by eating, nor feels to assert herself over the other by not eating. The loophole she finds can be concisely expressed in this way: "I can not to do what you want only by not doing what I want."

If we share Kelly's (1955) idea that "the ultimate objective of the clinical-psychology enterprise" is "the psychological reconstruction of life" (p. 187), I think that we should join our clients in devising better ways to dissolve the relational dilemmas in which they find themselves. Feixas and collaborators suggest a series of steps aimed at solving the conflict. They are indeed appropriate methods likely to favour a therapeutic change. In addition, the view of disorder in terms of intersubjective recognition I am proposing here suggests that the psychotherapeutic relationship can be the first and the most important environment for a reconstruction. I am talking about the importance of construing a reciprocity relationship in which the therapist takes part in a relation with the client instead of acting therapeutically on the client. Once again ahead of his time, Kelly's presentation of the therapist-client relationship is in line with such an intersubjective view. Acceptance, the credulous approach, the metaphor of the two as "shipmates… who embark together on the very same adventure", are the prerequisites for the construction of a relationship able to favour an experience that frees the client from the limitations and the conflicts deriving from complementary relationships.

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Reference (APA)

Chiari, G. (2024). The opposition between the “I” and the “You”: Interpersonal imbalance and personal disorders. *Costruttivismi*, *11*, 24-33. https://doi.org/10.23826/2024.01.024.033