

CONTROL IN BULIMIC EXPERIENCE AT THE BEGINNING AND THE END OF THERAPY

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This qualitative research examines the question of control within bulimic experience and how it varies from the beginning to the end of the therapy. We used two self-referral tools (self-definition and self-characterisation) with 42 patients, 24 at the beginning and 18 at the end of the therapy. A comparison between the two groups suggested that patients at the beginning of the therapy anticipated that the solution of the problem was improving the ability for individual control while patient ending the therapy more easily broke free from the confines of the control/lack of control dichotomy.

Key words: *Bulimia, control, eating disorders, personal construct psychology, self-narratives*

INTRODUCTION

Alimentary control is not only an important issue in contemporary society, but is also a key theme in restrictive or repeated vomiting behaviour. That is why control is a construct used in many theoretical writings on eating disorders. Anorexia nervosa is frequently described as a syndrome of pathological self-control (Bruch, 1962; Crisp, 1972; Slade, 1982; Lask & Bryant-Waugh, 1993). Many authors pointed out the presence of a battle for keeping control within the family context (Bruch, 1962; Ma, 2008; Ugazio, 1998, Castiglioni & Faccio, 2010). Control behaviour and attitudes are prominent in clinical assessment tests, for example, the *Body Checking Questionnaire* (Reas, Whisenhunt, Netemeyer, & Williamson, 2002) to assess control behaviour, the *Body Image Automatic Thought Questionnaire* (Cash, Lewis, & Keeton, 1987), which analyses automatic and obsessive thoughts about food, or the Appearance Schemas Inventory Revised (Cash, Melnyk, & Hrabosky, 2004), which measures body image investment. However a clear definition of the construct of 'control' is not always given in the literature, either with regard to the original theory, which

proposes it, or with regard to the methodology used to analyse it.

The term 'control' can occasionally refer to a behaviour, a compulsion, a cognitive attitude about themselves, others, and situations, or to a modality to construe and replicate experiences. This last definition drives into the field of Kelly's personal construct psychology, which many authors consider a particularly fruitful and appropriate way of studying eating disorders (Mottram, 1985; Jarman, Smith, & Walsh, 1997; Winter & Button, 2010). In this perspective constructs related to eating and weight best allow eating disorders patients to predict and control their world. Consequently, the more important weight is, the more "resistant to change" the person is (Crisp & Fransella, 1972; Fransella & Crisp, 1970). Other constructs are strictly linked to control. Constriction allows persons to avoid anxiety, which derives from unpredictable situations: when persons are not able to deal with the uncertainty and the variability deriving from an area of their life, due to not having control on it (for instance, in the relational field) they contrast the lack of control avoiding the situation (Button, 2005; Winter & Button, 2010).

According to Mottram (1985) "anorexics [have] a prevalence of segmented and monolithic

structures when compared to non-clinical groups, characterised by a prevalence of articulated structures” (p 291). Button (1983, 1985, 1990), investigating self-constructs involved in anorexia nervosa, concluded that clinical subjects manifest more extreme constructs than non-clinical ones and emphasised the need to articulate the relationship between ‘rigidity of constructs’ and existent difficulties with food (whether psychological or of a general nature). Indeed, even if much evidence can be found in the literature supporting a polarisation of construct systems associated with psychopathology, this does not mean that health can be associated with immense flexibility and change. It rather depends on the stability and continuity of self. Extremely unfavourable and favourable judgments of self might make a person more vulnerable to psychological disorder (Cipolletta, 2011; Faccio, Centomo, & Mininni, 2011). Moreover, “self-perception seems to be closely linked to the perceptions of others, so that extreme construing may also extend to the perception of others, such as parents and other important figures” (Button, 1993, p.215).

At a first sight anorexics might also be characterised by tight construing and bulimics by loose construing (Faccio, Castiglioni, Veronese, Mosolo, & Bell, 2011), nevertheless the research findings are controversial about this point: tight constructs have been already observed in an anorexic sample (Mottram, 1985), restrained eaters (Neimeyer & Khouzam, 1985) and female students showing disordered eating (Heesacker & Neimeyer, 1990), but not in a mixed sample of anorexic and bulimic students (Batty & Hall, 1986). However, Dimčović and Winter (2011) found greater severity of eating disorder in those bulimic clients whose construing was tighter and more polarised. Researches indicate more one-dimensional construing in anorexics than in bulimics and the use of fewer constructs in anorexics than in normal controls (Button, 1993).

Russ-Eysenschenk (1998) has concluded that eating disorders patients exhibit greater construct integration and lower differentiation. Comparing two clinical groups (low and high eating disorder), the author observed that the high eating-disordered group tended to associate a weight

increase with a consistent and implicit change in their personal, interpersonal and vocational relationships. Thus radical changes in those very important areas, which together make up a sense of personal identity, would be associated with control or loss of control (Romaioli, Faccio, & Salvini, 2008).

RESEARCH AIM AND HYPOTHESES

The present research aimed to identify constructs linked to control in bulimic experience, assuming the existence of two opposite phases: control and lack of control. We wanted to explore the role of these elements in maintaining an identity system, and the destabilisation of the sense of worth and meaning in personal identity implied by a change in weight, if such change means ‘loss of control’.

In line with the results of previous research, we hypothesised that the control/lack of control constructs might be essential in the bulimic experience, since they tend to organise thoughts and anticipations in a dominant way. From a Kellian perspective the dominant modality of construing experience in bulimic subjects can be described as the effect of persistent attempts to face and resolve situations or experiences anticipated as uncontrollable. This is accomplished using the only repertoire of behaviour and anticipations (in the field of food management) considered appropriate, because they have already been used many times, and are believed practical and effective (Button, 1993). The bulimic experience is characterised by a cyclical alternation of periods of extreme dietary restrictions (during which control functions, operating on self and relationships, predominate) and bingeing episodes (characterised by feelings of powerlessness and inevitability). These are often followed by compensatory measures such as vomiting, use of laxatives, intense physical activity or food restrictions. Herman and Polivy (1975) were amongst the first to define this process as a form of dichotomous cognitive restriction based on the ‘all or nothing’ principle. “Every deviation, however minor, from the rigid norms which the individual has set for them-

selves, every transgression of the *veto* placed on particular kinds of food, gives rise to the phenomenon of alimentary inversion” (Apfeldorfer, 1996, p. 22) and leads to bingeing episodes. These moments, so feared and at the same time desired, seem to go beyond the willpower of the individual, who often feels torn, and the episodes of binge eating are experienced both as proof of failure and moments of complete abandonment and freedom to enjoy at one and the same time.

We can identify two superordinate constructs: ‘lack of control’, which deals with the self-narrations and self-perceptions regarding psychological mechanisms involved in excessive eating, and ‘control’ which deals with those involved in the mastering of psychological processes typical of the restrictive phase. In the first system, lack of control, persons feel distanced from their core self-constructions and their uncontrolled actions, do not recognise themselves in the actions carried out - bingeing - and avoid taking responsibility by not acknowledging them (“I didn’t do that”, “I couldn’t help myself”), so that they feel guilty. The second system, the control one, brings the self closer to how people wish to be (“I always want to be in control”, “from tomorrow I’ll succeed and everything will be different”) and they stubbornly cling to an action plan (the compensatory or restrictive behaviours) destined to fail. Keeping to a diet becomes a means to control and resolve every problematic or equivocal life situation. Becoming more important in the hierarchical system of constructs, this alternating between control-lack of control turns into a constellatory loop: every uncertain, inept experience or action will be perceived and described as a replication of the dichotomous situation of “control-lack of control”, thus preventing any kind of progress and movement being made.

This hypothesis may be viewed in the light of Fransella’s (1970) suggestion that the way that symptoms are organised eventually become more central components in the construction system of identity (Winter, 1983; Ng, 2002): “Even an obviously invalid part of a construction system may be preferable to the void of anxiety which might be caused by its elimination” (Kelly, 1955, p. 831). Feixas and Saül (2004)

agree with this analysis: in their studies of dilemmas and cognitive conflicts preserving a symptomatology serves to maintain identity coherence and relational stability, thus making change threatening.

On the basis of these premises, the present study explored how people described themselves in relation to control and how their self narratives changed at the beginning and at the end of therapy. Specifically, we investigated:

1. The modalities of anticipation and replication of the bulimic experience, their implications, and the role of control in maintaining personal identity.
2. Individual ‘beyond problem’ anticipations, how people beginning therapy might visualise a different reality to their present one (themselves beyond problem). It was anticipated that they would not have seen themselves freed of the problem (expecting phrases like “I can’t imagine what it’s going to be like” or “I don’t know how to answer this”). The opportunity for re-narration, offered by the therapy, was predicted to facilitate alternative solutions to those offered by control-lack of control dichotomy.
3. Narrative differences between the two groups of people at the beginning and at the end of therapy. Would the self narratives of people at the end of the therapy have supported the hypothesis of a greater flexibility and fluidity compared to those of the people beginning the therapy?
4. Whether the self-referral tools were useful to an exploration and illumination of differences amongst the participants.

METHOD

Participants

42 people (41 females and one male, all between 18 and 40 years old) undergoing psychodynamic psychotherapy for bulimia-related disorders (23 of whom also presented with vomiting symptoms) took part in the research. The participants were recruited from two institutes in

Northern Italy: the Clinical Institute for Anorexia and Bulimia in Mestre and the Napoleon Park Villa Care Centre in Preganziol (Treviso).

Inclusion criteria were that the diagnosis provided by the healthcare institution was 'bulimia nervosa', and no other eating or psychopathological disorder, that the Body Mass Index (BMI) was between 18 and 23, corresponding to the normal weight bulimic patients, and that the patients were at the beginning or at the end of their first treatment.

The decision to exclude patients with double diagnosis, with minor psychopathological comorbidity and with more than one psychotherapeutic treatment, was restrictively applied in order to minimise the risk of including individuals with potential different addiction problems, so as to avoid the production of 'spurious' narratives, which could be influenced also by previous therapies.

Participants were informed of the research aims ("an investigation of whether the problems of bulimia and identity systems might be interrelated") and methodology (using "two self-referral tools" and by "writing a short story about your experiences"). They gave their informed consent and were assured that their real names would not be used and that any information given would be treated in accordance with confidentiality laws. APA guidelines on how to conduct research using human subjects were followed.

Participants were divided into two groups: the first composed of 24 people beginning their therapy (12 from Mestre and 12 from Treviso); the second of 18 people (9 coming from the Mestre centre and 9 from the Treviso one) who had finished their therapy.

Only subjects who had specifically sought treatment from a healthcare institution for an eating disorder were included in the research; in addition, only patients at the beginning of the treatment (at maximum one month after admission) and patients at the end of the therapy were recruited at one month after conclusion of psychotherapy. Treatments duration was minimum nine months, maximum one year with weekly sessions.

The socio-demographic characteristics of the subjects in the two groups were as similar as possible.

Data collection

The research aimed to understand people in terms of autobiographical 'story systems' (Mair, 1987), in which individuals speak both as narrators and actors, therefore two self-report tools were used. The first of these, the self-characterisation, although less well-known than repertory grids, is perhaps the technique that best allows freedom of expression, and meets Kelly's criterion that the best way to find out what other people mean is to listen to the words they use. Mair (1987), paraphrasing the fundamental postulate of personal construct psychology, suggests that people's actions are psychologically governed by the stories they experience and by the stories they tell. Crites (1975) also maintains that anticipations are expressed by means of story telling and by the descriptions of the causes and consequences of the events. Fireman and McVay (2002) state: "We narrate our lives and live the narratives that result" (p.167).

Self-characterisation was used in a modified version: both groups were asked to write "a story about a man or a woman who had problems with food" (in problem situation) and a story about a man or a woman "who however had succeeded in overcoming them" (beyond problem situation). This invitation to describe themselves "as if" they were a character in a parallel story enabled participants to reveal "a theory" about themselves. Following the principles of Vainger's (1924) 'as if' technique, they were given the opportunity to fantasise beyond the problem (Merton, 1949), thus tackling the transition from the problem through to solution.

The second tool used to explore the identity system and its structure was a set of self-descriptions, which included a modified Twenty Statement Test, first developed by Kuhn and McFarland (1954) and successively revised by Giovannini (1979) and Lorenzi-Cioldi (1996). Participants were asked to write down 10 adjectives or short sentences describing themselves in

two situations, “who am I when I don’t control myself” and “who am I when I control myself”. The tools were completed in an individual interview session, in presence of the researcher.

Data analysis

While one researcher interviewed all the participants, two independent judges analysed the narrative texts without being aware of the origins and to which group the texts referred to. The level of inter-rater agreement, measured by Cohen’s kappa coefficient, was 0.87. For the doubtful cases, the two raters had mutually agreed the final version here presented. The narrative texts were analysed to extrapolate topic subgroups (clusters) which could facilitate the identification of the most common and recurrent areas of meaning.

The characteristics of the self-definitions related to the two situations (elements to which personal constructs were applied) “who am I when I don’t control myself” and “who am I when I control myself” were compared and their organisation (the relationship between the constructs, the dimensions and the dominant themes) was explored. We used three-phasic analysis, consisting in the observation of the type, number, and relationship between elements and constructs (inter-constructs), traditionally used to analyse repertory grids (Armezzani, Grimaldi, & Pezzullo, 2003; Kelly 1955), and theme analysis to identify inter-constructs arising from the pattern of self-constructs in the lack of control scenario, and within personal constructs in the control scenario. We followed Landfield’s guidelines on pyramiding interviews (Landfield, 1971; Landfield & Epting, 1987) to examine the dimensions extrapolated from the two scenarios. Assuming that constructs first elicited are *product* attributes, which are followed by consequences and finally become *end states or values*, we used the laddering procedure (Hinkle, 2010; Bannister & Mair, 1968) to discover the implications governing hierarchical systems within the constructs.

Two kinds of analysis of the self-characterisations allowed the identification of

individual processes of anticipation and validation of one’s own self: first, how the texts were structured and organised, and second, how the anticipation processes functioned and what was their extension. Kelly’s (1955) classic interpretative model consisting in tackling the main themes, organisations and perspectives in the text was used, and then the process of anticipation was analysed (focusing on sequences of events, repeated transitions and the prevalent style of construing).

The two ‘stories’ suggested to the participants to write (one concerning “a man or a woman who has had problems with food” and the other concerning “a man or a woman who however succeeded in overcoming them”) were treated as elements to which they could apply their own personal constructs: self in problem and self beyond problem. Using a series of traditional techniques of interpretation, the intention was to compare stories in order to measure narrative similarities or changes. Because of the modifications to the task asked from the participants, i.e. transferring transitional passages from the in problem story to the beyond problem story, it became essential to analyse those relevant sentences (in terms of narrative style) which might reveal modalities of anticipation, and the opening and closing statements. A careful analysis of the syntax and style of the stories enabled the identification of the main transitions, roles and identities. The anticipations of self beyond problem were compared with those of self in problem ones, retracing the core matrix. We investigated whether participants’ processes were characterised by loose, flexible, or propositional constructs, and the structure of their construct system noting the frequency of incidental, constellatory or pre-emptive constructs.

Finally, the self-characterisations of the beginning therapy group were compared with those of the ending therapy group and the self descriptions in the lack of control situation with the self-characterisation in problem situation. The aim of this last analysis was to compare the two self-referral techniques and to test the presence of the construction processes involved in the two systems of lack of control (prevalence of transitions of blame, constriction and loose constructs)

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and control (mostly transition of hostility, incidental and tight constructs).

RESULTS

The range of meanings in bulimic experience

It has been clearly identified a contrasting of polarities of constructs in the self-definitions and in the stories of self in problem. In the stories of self beyond problem anticipations seem to be less structured, with vaguer and less defined

frameworks, particularly in the stories of the ending therapy group.

Three main 'inter-constructs' were extrapolated from the self-descriptions, superimposed on the "who I am when I'm in control" and "who I am when I lose control" (*table 1*). They represent three main fields of meaning, together forming a core role: the field of ability (weak/insecure vs. strong/secure), the relationship field (isolated/distant/free vs. extrovert/lonely/controlled) and the moral judgement field (mistaken/ashamed of myself vs. perfect/proud of myself).

Table 1: *Fields of meaning found in the self-definitions*

LACK OF CONTROL "who am I when I don't control myself"	IN CONTROL "who am I when I am in control"
weak/ lacking confidence "incapable", "frozen", "still", "I waste time", "weak", "lack of confidence"; "empty"	strong/confident "strong", "powerful", "capable", "confident", "proactive", "someone who plans", "makes choices", "commits to something", "a doer", "confronts situations", "fulfilled"
without limits / unrestrained "lost", "excessive", "without limits", "irrational", "thoughtless", "vulnerable", "fragile", "liberal", "without restraints", "nobody can take away the only thing I have"	strict/controlled "rational", "strict", "hard", "motionless", "bound/obligated", "artificial", "others control me", "others want to take away the only thing I have"
wrong/ shy "rotten", "selfish", "liar", "bad", "I'm shy", "it isn't me", "wrong", "i deny myself", "dirty", "ugly", "careless", "a beast", "a fury", "not worthy", "an addict", "mistrusted", "disappointed"	perfect/ proud "perfect", "bold", "proud of myself", "satisfied", "I'm my ideal", "I love myself", "clean", "careful", "deserving love", "good"
isolated/ distant "set apart from others", "other people's opinions don't count", "I isolate myself", "lonely", "distant", "abandoned"	extrovert/ lonely "I go along with others", "extrovert", "always available", "altruistic", "pleasant", "nice", "kind", "I can love as well", "sweet and feminine", "I'm involved with others", "isolated", "lonely", "uninvolved"

Although core constructs were organised at opposite extremes, both in the 'self-control' and the 'lack of control' situations, their implicit meanings were similar: people compared themselves

with others to validate their expectations. Whereas isolation was the end result of wishing to avoid relationships with others in the lack of control situation, in the in control situation

avoiding others resulted from feeling involved or obligated within relationships (participants described themselves as "false" and "obligated" because "others control me"). Moral judgement regarding their behaviour ("wrong" vs. "correct") was the criteria the participants used for measuring how distant/close they were to others, and led to "the right" to be loved and esteemed by others as just "reward". This same construct also applies to more or less adhering to a diet and to self-control (in other fields besides food as well). As predicted, the participants felt "capable", "sure" and "worthy of being loved" when they felt in control and when they were not in control they became "powerless", "weak" and "unworthy".

The same themes were in self-characterisations, both in the self in problem stories and in the self beyond problem ones (*table 2*). The participants recounted a reality filled with problems described only in terms of their relationship with food: the "story of a woman or a man who has had problems with food", "her life style is body-centered and food-centered (...) not only is she a safety net but also a truly stable personality", "food had become a daily obsession", "she was always famished and needed to fill her stomach".

Others, often meaning other family members, were perceived as oppressive, demanding, compelling, who take without giving and judge without understanding ("her brother became stronger by weakening and denying L.", "she didn't feel she was understood", "nobody ever asked her what was wrong", "she could never confide in anybody", "she believed others overestimated her", "her mother kept her under surveillance"). In these stories others "abandon", don't pay attention, don't love "unconditionally" ("there was no room for her in her mother's life", "she always got less food than her brother", "she felt abandoned", "she was left to her own devices").

This interpretation is very similar to Button's (2005) theory that invalidation is a central ex-

perience in the stories of people with eating disorders. He states that "people with eating disorders are deficient in their ability to construe other people: they have difficulties in understanding, controlling or interacting with people. Their constructs about other people may be very limited or they may have restricted expectations of other people, the resulting effect of which is that they are unable to successfully engage in other than limited relationship with others. Restriction in social activity, staying at home more, keeping to familiar places" (p.4), all derive from lack of interest in relationships and at the same time perpetuate it.

In the absence of an external perspective with which to confirm their worth and personality, their self-esteem entirely depends on their own self-discipline. It is no coincidence that the expectations of those who had left their problems behind (those telling the story of the character "who however succeeded in overcoming them") were anchored in their relationship with others, in dialogue and exchange, and thus all references to food disappeared. The central themes of these stories were faith, and, above all, "love", sometimes rediscovered ("her father learnt to believe in her"), sometimes discovered for the first time ("the love of a man with who you can plan a life together") and others again imagined ("calmer relationships", "confidence in others").

Individual "beyond problem" expectations

Analysing the differences in the ways that expectations and future outcomes were experienced by bulimics in the two groups at the beginning and at the end of the treatment, and in the two situations (into and beyond problem), it was possible to observe that narrative constructions of the group at the end of treatment were fixed, in some cases, and fluid and open to redefinition, in others.

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Table 2: *Main constructs from self-characterizations*

<p style="text-align: center;">INTO-PROBLEM SELF “a story of a woman or a man who has had problems with food”</p>	<p style="text-align: center;">BEYOND-PROBLEM SELF “who however has succeeded in overcoming them”</p>
INTER-CONSTRUCTS	
<p>Me and food (isolation) Stable identity: “her life style is body-centered and food-centered [...] a real, true, stable identity”; “she lives in a chaotic world, designed to control her life” Abandoned child: “she is growing up feeling she was abandoned”; “she was a very lonely child, abandoned” The world’s lies: “the ideal world is made of lies”; “she has hidden her feelings [...] behind a mask of self-control”. Social prostitute: “she always asked herself what the others wanted of her”; “she didn’t know who she was”, “she seemed a social prostitute”; “in her opinion life was what others wanted her to be”</p>	<p style="text-align: center;">Dimensions</p> <p>Me and others (relationship) New and real life: “a new life, based on trust”; “the previous girl didn’t know about life” Aware woman: “she’s a woman who doesn’t hide her fragility, she’s able to face her fear”; “now it’s her who decides”; “she’s starting to feel more a woman”; “it’s the time to make adult choices” Confidence: “today she’s a more mature and aware woman”; “the anger’s no longer there”. Relationship: “she’s learning to love, without relying on others’ wishes [...] thanks to reciprocity!”; “she allowed love into her life”</p>
IMPLICATIONS	
<p>Lack of ability “She’s left it to chance”; “this fear of growing up has held her back a long time”; “food was often an anaesthetic for difficulties”</p>	<p style="text-align: center;">Ability</p> <p>Ability “She’ll succeed in taking back control of her life”; “she’s a woman able to live her life in the first person”</p>
<p>Isolation “She was stand-offish, she isolated herself, she spent hours by herself [...] away from everyone, distant even from herself”; “she was a lonely girl, but with an affected solitude”</p>	<p style="text-align: center;">Relationship</p> <p>Relationship “She feels that she’s free [...] without fearing being overpowered / hurt”; “she’s starting to live with others”</p>
<p>Shame “She didn’t think she deserved happiness”; “she was never on one level”; “deep guilt feelings accompanied A”</p>	<p style="text-align: center;">Moral judgement</p> <p>Worth “Now she can exist without others’ approval”; “now she’s learning to defend herself, to carve out her life, because she deserves it”</p>

There was a major difference in the matrices, in the ways that roles were construed in these stories. In many of the stories characters had singular names and personalities, and existed in relational constructs, which permit interdependence (or a more distributed dependence). Many self beyond problem accounts, although differing in terms of how identity was defined (“a woman who doesn’t hide her vulnerability, but who ‘fesses up’”, “a much more aware and mature woman” who has succeeded in “taking control of her life”, “who wants to live her life making first person choices” “without relying on the approval of others”), were similar, constructs were constellatory and punctuation was more structured than that used by the group at the beginning of the therapy.

We can hypothesise that the bulimic constructs of the beginning therapy group were nurtured by expectation belonging to both the lack of control self and the in control self. The wide-ranging and lacking structures of the lack of control self were largely sustained by guilty periods (it is “others’ fault”, “lack of love”, “being abandoned” which “causes bulimic crises”, other people who “over-impose” or who lend “their support” to needs which make these young people feel “crushed” or “overwhelmed”). Hostile expectations sustained the more stringent self in control processes. In these cases people continually were looking for confirmation of their own preconceptions (“you can’t trust” others, because “they abandon”, “they always take without ever giving in return”, “they suffocate with their demands”, “they don’t understand”). “Happiness isn’t possible” because individual attitudes are considered “all wrong”. Isolation becomes the only choice remaining (“because others want to take away the only thing I have” (food), “they take away all your love”, they’re not interested”, “they do nothing but make demands”). Both in control and lack of control modes confirm the

implicit and controlling role of the bulimia construct in the self perception of the person.

Narrative differences between the two groups

The self beyond problem narratives in the group beginning therapy (*table 3*) contained expectations characteristic of the bulimic way of thinking concerning control, particularly in the relational field. In their hypothetical future, an individual problematic situation was seen as an expectation that “food is a substitute for love” (“false hunger”, “avoid to be filled”, “nourishment when feeling abandoned”, “can love make you feel as full?”) or it was converted to “others as substitutes” (“love is rediscovered through others”, and it is others who “get [them] to believe in themselves”, “encourage trust” and “teach [them]”). On the contrary, when food was perceived as dependence on/overwhelmed by others (“antidote”, “safety net”, “safety valve”, “escape route” to/ from problems, “frustrations” and “other people’s needs and expectations”), alternative solutions were centred around independence from others (“first love yourself” and “defend your personal space” and “personal gains no matter what”). The future was seen in an opposite way, but preserved a similar structure.

In the narratives of the group at the end of the therapy there was found an increasing range of alternative constructs. An awareness and a reading of their own past life made up of “gradual deformities”, mistaken attitudes, longed-for ideals (“vowing to look at things in a different way”, “to better [...] understand others and improve”, “to understand other people’s needs”, “choosing for [your]self”) pervaded these stories. This view was fundamental to the “decision to change” and developed alongside a renewed possibility to plan and act different things, if they worked, and to confront problem situations.

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Table 3: *Self beyond-problem narratives of the two groups of participants*

BEGINNING THERAPY GROUP	ENDING THERAPY GROUP
TRANSITION: INTO-PROBLEM SELF → BEYOND-PROBLEM SELF	
GUILT: “doctors [...] and [...] friends helped her”; “trust came when she travelled” HOSTILITY: “she learned that you have to do as others do: first think for yourself, then for others” AGGRESSIVENESS: “reconstructing the blocks in her life, she understood”, “choosing in the first person”	GUILT: “she dismissed the pain and allowed love to enter”; “her father’s love helped her” AGGRESSIVENESS/ANXIETY: “so she understood” AGGRESSIVENESS: “she decided to observe her world and the world around her, but in a different way”; “to understand others [...] and to improve herself”

The usefulness of the self reports

Regarding the choice of self-report tools, it is possible to state that self-definitions produced larger and more understandable data, compared to those normally produced with provided definitions, and ensured greater transparency and flexibility. The range of meanings and implications found with the two tools coincided: in both cases the most common themes were ability/lack of ability, relationship/isolation and shame/worth (see *tables 1* and *2*).

The self-characterisation, which allows the imagination to go beyond the problem, can be used not just for feedback, but also as a module to interpret and potentialise individual and relational resources, by making the individual responsible for undertaking a new initiative or activity, whether creatively or in reaction to circumstances. Perceiving and bringing to a conclusion allows people to build up narrated realities which may trap them (Dimaggio, Semerari, 2001), but which may also suggest them alternative interpretations while preserving the continuity of their meanings (Neimeyer, 2000).

CONCLUSIONS

The results of this research suggest that it is possible to reconstruct a very complex phenomenon which is implied in the bulimic experience departing from a matrix of expectations and ex-

periences of control and excessive self-monitoring, mostly in a protected situation such as psychotherapy is. The protagonists of this change reconstruct things in different ways, out of the control/lack of control blind alley. These people have succeeded in changing their own systems of meanings, modifying their properties and making them more transparent. These changes are breaks in the interpretative mould, which allows the individual to understand that experience should be subordinate to their own anticipations rather than a one-dimensional interpretation of reality. This finding confirms Button’s consideration of constriction (2005) as the most useful personal construct concept in understanding eating disorders; the restriction of the perceptive field is also an attempt to make life more manageable, in contrast to the lack of control and invalidation experienced in relationships with other people (Winter et al., 2010). On the other hand a construction process characterised by dilation is typical for people raising their perceptual field in order to organise it at a more comprehensive level, a condition that we could observe in narratives at the end of therapy. At that point, construing processes were less tight and less polarised, confirming what Dimčović and Winter (2011) observed comparing people with great and little severity (or absence) of eating disorder.

Additionally, the outcomes of this research suggest that therapists, as facilitators of possible new versions of self (Mair, 1987), can play an

important role in helping other people to reconstruct their stories. The self-characterisation, prompted by the beyond problem situation, can be a very sensitive tool for documenting and undertaking possible directional changes. This technique, following Grice's (1975) definitions regarding the principles of cooperation which govern people's conversations (quality, quantity, relevance and narrative style), appears able to sustain and promote people's ability to get into the role of different actors and tell their stories as characters in different stories (Dimaggio & Semerari, 2001). Interactions between the therapist and the patient thus become a "two heads are better than one" interpretation of new imagined scenarios and possible future plans (Mair, 1987). Suggestions to change the narrative genre of individual biographies may offer viable alternatives and permit new stories to be told. Additionally, negotiating a meta-narration can permit an already expected version of the self, which has not yet been experienced because it is considered incompatible with the main narrative system, to be included and analysed (Dimaggio & Semerari, 2001).

To sum up, the results of the research largely confirm the hypotheses being examined and still they leave room for further investigation. For example, the analysis pointed out that adhering to a diet and maintaining self-control (in other situations besides food, too) become a personal moral judgement. As a result, controlling oneself makes the person feel "capable", "secure" and "worth loving" whereas losing control makes him/her become "powerless", "weak" and "unworthy". The same principles govern the relationships with others, construed in terms of distance/proximity, which makes self-esteem a "right", derived from others' love and respect. We investigated whether individual attributes in the self-esteem realm had similar extreme values: positive self-esteem and self-worth coincided with periods of self-control and negative ones with perceived lack of control. Thus self-esteem depended on the situation and the phase in which the person was. This 'situational' interpretation of the meanings and value of individual identity should help researchers to understand why clinical groups are characterised by "a

greater negativity of self-construing". Requests for therapy occur when individuals try to resist to loss of control (which has damaged their sense of identity), and therefore recognise their more negative self-representation (Button, 1990). It has also been investigated how other means of identity and individual worth constructs are arranged, once a person's worth and value are no longer organised by and dependant on an ideal control as, according to the results of our research, happens at the end of therapy. In this regard, the research might be carried out by evaluating psychotherapeutic changes also through a measure of self-esteem, as suggested by Button (1990), and repertory grids might be useful for this aim. Rethinking recovery from eating disorders may also open the way for new treatments (McIver, McGartland, & O'Halloran, 2009).

With regard to the methodology adopted, the self-definitions might be used also to investigate another hypothesis. Since self-definitions correspond to constructs elicited by the persons, the same descriptions might be used as constructs on a repertory grid in order to analyse the domain of personal relationships. This would enable us to draw up both consistent and inconsistent solutions by using the imaginative ways persons perceive themselves when compared to how they construe other people and relationships. In fact, as researchers and psychotherapists alike know, analysing expectations and outcomes in the field of interpersonal experiences represents an essential component of the therapy, since relationships with others in such cases are very often accompanied by difficulties which range from lack of understanding to control and denial of experience.

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