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**OBSERVING SIMILARITY OF ANOREXICS' SYMPTOMS.
A CONSTRUCTIVIST EXPLORATION**

Abstract

Observing for a long time the ambulatory patients with diagnosis of anorexia nervosa being visited by a psychiatrist in a eating disorder clinic it is possible to be amazed at the incredible likeness of their "psychopathological symptoms".

They seem to manifest their disease according to a default script. How can we explain this similarity? This work tries to find an answer consulting some authoritative voices of the international psychiatric and psychological panorama.

While psychiatry derives such phenomenological similarity from the presence of the same "internal problem" ontologically present "inside" the patients (same problem, same behaviour), Devereux's analysis on the ethnic disorders brings it back to a cultural aspect: anorexics manifest their suffering through a script that shows the typical contradictions of the western culture: they will show their psychological problems in similar way cause of their belonging to the same culture.

Culture is an event that acquires an essential existence separated from any individual interpretations and that determines a detailed psycho-symptomatology, according to a logic very similar to the stimulus-answer one.

Kelly's ideas about this subject are very prolific: with the individuality, commonality and sociality corollaries the constructivist author shifts the attention from the similarity of the behaviors to the similarity of the constructions.

He also proposes to consider culture in terms of similarities of expectations according to a spiral model of mutual anticipations: PCP mainly faces the problem of the similarity of the behaviors from the point of view of the person as an individual that anticipates. The individual anticipates not only the behaviour of the other people but also the other's expectation of him. (KELLY G. (1955). *The psychology of personal constructs*, Vols. I. New: W. W. Norton.)

If Devereux derives the similarity of symptoms from the cultural context, Kelly derives it from the similarity of anticipations. The process of anticipating the anticipations brings us to the concept of role. Any behavioural manifestations cannot be studied if the role relationship between the two subjects is not considered: in these terms the diagnosis of anorexia nervosa is an event that takes place inside a relationship and so it belongs to the patient as much as to the psychiatrist. So it is possible that any diagnosis tell us much more about the psychiatrist's construction system than about the patient's system.

Perhaps the typical relationship between the psychiatrist and his patients is related to the similarity of symptomatological manifestations. If the relationship is studied like a mutual anticipations storm we can understand why the eating disorder clinics could become not only untherapeutic places but also "anorexics' factories".

The question

Living indirectly, with few involvement, looking at ambulatory patients coming and going – being aware that psychiatric help can only monitor the evolution of the disease without leaving enough time for further analysis – makes me feel like a naïve observer that looks from the psychiatrist's chair at a brand-new show.

Some questions arise: why do all these girls look alike? Why do we mechanically classify them according to their similar behavioural patterns? They seem to act following the same script. How can we explain this similarity, and where does it come from?

This question is crucial if we consider that it is just because of this similarity that specific medical-psychological help is legitimated. Not only: according to this similarity, professionals choose standard therapeutic practices that are expected to work for all the individuals sharing a diagnosis.

In this work, I would like to find out where this similarity lies: in the symptoms? In the behaviour? In the personal constructions of experience? Or maybe in the context?

Let's consult some authoritative voices in this field.

The DSM and psychiatry

The psychiatrists' teams that diagnose eating disorders according to the symptomatology, mainly use the official criteria listed in the DSM-IV-R and in the ICD-10.

Somehow, the psychiatrist aims at recognizing – and not at analyzing for the first time – the disorder in the population of his/her territory, by trying to find in the patients' symptoms that s/he knows being part of a diagnostic category. Diagnostic systems are used to evaluate a similarity or a difference, creating each time a double equivalence: symptoms that correspond to the script = Eating Disorder, symptoms that diverge from the script = non-Eating Disorder. Only by formalizing the similarities, adequate therapies can be chosen. As a consequence, a clinic can be considered as a place where similar people can be healed together with the same therapeutic practices.

Such an approach to this problem assumes the important belief that similar symptoms correspond to a psychopathological similarity, the latter being a set of psychological dynamics, personality traits, psycho-physiological reactions. Therefore, the symptoms are external manifestations of an internal disorder that is ontologically present inside the patient. Whether the disorder is there or not, when it is there, it is ontologically the same in all the affected patients.

I heard very often colleagues telling stories about patients who in the end turned out to "pretend" to be anorexic. It is as if during the diagnosis the professional had been cheated by some relevant symptoms that made him/her wrongly think the illness was there where it actually wasn't. It goes without saying that for the psychiatrist the symptom described as "obsessive fear of gaining weight or becoming fat" is not relevant from a qualitative point of view (he is not interested in its meaning and source), but only from a quantitative point of view: its presence/absence indicates the presence/absence of a psychopathology.

To sum up, the answer psychiatry gives to my question is: all the patients look so similar because they HAVE the same disorder. For example, the symptoms of yellow fever are: chills, headache, muscle pain, deep depression, nausea, vomiting, jaundice, haemorrhage. Similarly, the symptoms of anorexia are: "refusal to maintain body weight at or above a minimally weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected), intense fear of gaining weight (even though underweight), amenorrhea (the absence of at least three consecutive menstrual cycles)". The DSM-IV-TR lists some criteria that have to be fulfilled to diagnose this disorder, such as: low mood, social withdrawal, moodiness, insomnia, decreased interest in sex, obsessive compulsive disorders about food, fears about eating in public, low self-esteem and self-efficacy, obsessive need to control the environment, mental rigidity, low spontaneity in interpersonal relationships, perfectionism, repressed emotional expressivity.

The concept of Ethnic Disorder

The concept of Ethnic Disorder was first used by the ethnographer Georges Devereux, who was very interested in the bonds between culture, individual and mental disorders. He analyzed the so-called "folk diseases", that are psychical pathologies discovered in non-western societies, such as: *amok* in South East Asia, *latah* in the South Pacific area, and *koro*, mainly spread in South China.

In his work of 1991, Gordon remarks that Devereux tried to apply the concept of Ethnic Disorder also to Western culture, using the word "ethnic" with the meaning of: "peculiar to a culture". The core of his work is that these disorders come from the fears and the unsolved problems deeply rooted in each culture.

A concept that is very similar – or maybe even identical – to that of Ethnic Disorder is that referred to in the DSM-IV-TR as *culture-related syndrome*. Culture-related syndromes manifest recurrent symptoms, are peculiar to certain geographical regions, are marked out by aberrant behaviour and disturbing experience [...], and usually are restricted to particular societies and cultural areas. Furthermore, in the manual you read that there are also some syndromes that are specifically bound to western culture. Among these: anorexia nervosa and the dissociative identity disorder.

The seven criteria a psychopathology must fulfill in order to be defined as Ethnic Disorder are:

1. the disorder occurs in a peculiar culture much more frequently than other psychical syndromes;
2. if there is a coherence between the symptoms, their dynamics, and the elements perceived as "normal" in a certain culture, the disorder manifests itself in different scales of intensity with borderline and "subclinical" forms;
3. the disorder expresses the basic conflicts and the psychological strains regularly spread among the population. Yet, for some subjects, these strains can develop into severe anxious forms and can activate defence mechanisms;
4. the disorder is the common final stop of the manifestation of both the psychic unease and a great variety of personal problems and idiosyncrasies. Affected people can manifest different seriousness levels of the disorder considered;
5. symptoms are both the result and, at the same time, the grotesque exaggeration of normal and frequent attitudes. Nevertheless they often also include those behaviours that are considered as highly positive in normal situations;
6. the disorder is a high structured and widely boundless form of unease expression: it is a deviance pattern, that is a model of misconduct which provides individuals with the possibility to manifest irrationality, deviance or madness inside acceptable boundaries;
7. Finally, since the disorder is based upon well-considered behaviours while at the same time posing an expression of deviance, it generates ambivalent reactions among the others: these range from fear and respect to punishment and control. As a result, the disorder becomes somehow notorious inside the culture and develops its own "policy".

Reconsidering the Ethnic Disorder issue, Elena Faccio (1999) clarifies that, according to this logic, it is the context itself which suggests and carves out the peculiar shape taken by the deviance. The definition process of the disorder's phenomenology is all but accidental. The suffering manifestation's script is inspired by those behaviours which catch the cultural contradictions.

From this point of view, according to Gordon, anorexics use a language typical of the western culture, (based on diets, thinness and nutrition control) in order to defend themselves from an internal unease connected with female identity role. Anorexia is a trendy possibility of being noticeable and standing out through a deviance which simultaneously generates fascination and revulsion. Finally, the psychopathology embodies the political issue of female body's control and of the conformity with the beauty patterns typical of the contemporary society. Therefore, the answer Gordon gives my question is: they are similar because they belong to the same cultural context.

Kelly's perspective about the question

My question could be sufficiently answered by all these possible explanations, which have pre-eminently been supported by official figures of the international psychiatric outlook.

Unfortunately, Kelly's contribution to the similarity and difference question seems to make things even more complicated. As a matter of fact, our intellectual father moves the attention from the phenomenology to the construction.

The individuality corollary, indeed, asserts: subjects differ each other in the way they construct events. At the same time, the community corollary underlines how the psychological processes of a person are similar to those of another one. Indeed, the first builds the experience in a way similar to the one of the second person.

Thus, the similarity does not have to be searched in the events lived by the patients or in their behavioural manifestations, but it should be searched into their constructions, that means their own experiences. Inasmuch as these constructions will be similar, the psychological processes will be similar as well. That is that two subjects may act in the same way even if they have experienced completely different events.

By moving the attention from the event to the construction, Kelly suggests a different conceptualization of the similarity and analyses the behavioural similarity of groups of people by introducing a new meaning to the idea of "culture". In contrast to who, as Gordon, defines it as a particular kind of environment and education, Kelly suggests considering "culture" as a similarity in expectations.

To be more precise: according to the Ethnic Disorder logic a person, while expressing his/her unease, has necessarily to deal with the culture-event –and that is the same for everybody- that will provide him/her with the script through which manifest the unease.

This mechanism –Kelly highlights- is very similar to the stimulus-response one, where the stimulus *cultural context* determines the response *similarity in the psychopathological manifestation*. According to this logic, anorexia presents very similar developments and dynamics since it is a disorder that embodies the contradictions of Western culture that all the patients belong to.

Culture is an event that acquires an existence that is separate and inherently linked to the individual interpretations. Moreover this event determines a precise psychophenomenology.

According to the psychology of personal constructions, instead, the cultural similarity (and no more cultural belonging) may be defined in terms of similarity in the way people anticipate someone else's expectations of them.

Thus, may the development and phenomenology of an anorexic disorder be explained in terms of similarity of expectations? My hypothesis is that the actions of a person are shepherded by his/her ways to construct the world.

But it is exactly his/her existence into the world that offers a variety of possibilities and limits within which is possible to perform. This enlightens us also about Ethnic Disorders.

Even without agreeing with a contextual determinism on the forms of psychopathological manifestations, it is possible to accept the idea that the anorexic behaviour might be spread (i.e. similar for many) because it has already been contemplated as a possibility, because it has already been done by somebody, because it as already been thought.

I would like to highlight that this possibility is not determined in a causal sense by a cultural context, meant in constructivist terms. Instead it is determined in a causal sense by a cultural context in Kelly's terms. That means that the anorexic may limit her food if she identifies herself with the anticipation that the others may consider this eventuality possible; that the others may expect that from her.

In these terms, the patients will act according to anticipations of anticipations. Psychiatric diagnosis may in this sense prove counterproductive just because it represents a complete description of the expectations which are linked to the manifestation of the unease: a prelative, constellatory program of how an anorexic is supposed to appear.

If the patients internalize and anticipate such an expectation as likely to occur, they may behave similarly to those who received the same diagnosis. Moreover, referring to the famous metaphor of the dog biting its tail, it is important from my point of view to reflect

on the combined intervention of two anticipations, better to understand the cultural similarity. On the one hand psychiatry anticipates the similarity between symptomatologies, expecting to find patients who are phenomenologically very similar, it diagnoses anorexia and carries on with therapy; on the other the girls anticipate that psychiatry is expecting them to behave in a certain, consistent way so as to meet the expectations. The fact that the psychiatrist has expectations of the patient (like in the Ethnical Disorder) does not suffice: in fact the latter should internalize such expectations and make them part of her own experience. It is only by anticipating her psychiatrist's expectations that the patient will make some progress within her construction, either accepting or opposing it.

The encounter between these two anticipations strengthens the perception of the alimentary disorder's ontological existence. Therefore psychiatry reveals itself as a self supporting system. Which is also true for any other system.

Beyond the similarity: the role

In addition to that, similarities are always perceived by a discriminating system. Knowledge itself consists in finding out similarities and differences. How can we discriminate if not through a criterion (construct) which allows us to do so? Our constructs point out similarities among the events through a mutual relation according to which these similarities among the events are exclusively due to our elementary discriminating units.

So I will now answer my question with a further question: why do I perceive those girls as similar one to the other? I do so because my system allows me to generate such similarities. The similarity itself lies in my discriminative criteria.

I realize in fact that the psychiatrist's constructive system, which is based on constructs such as disorder-symptom, internal-external, healthy-ill, cannot help identifying similarities only as far as the phenomenological manifestation is concerned. A constructive system of different kind might therefore perceive these girls as very different or very similar in some other respect.

Just like the most devoted patients, I have tried to partially identify with the psychiatrist point of view as well, in search of an institutionally permitted and legitimate similarity: the symptomatic one. It is not by mere chance that within a system whose functionality is based on the analysis of symptoms, patients are perceived as similar precisely on the grounds of symptoms. In some way the patients, immersed in an institutional system that gives meaning to their suffering, which represents a key to the interpretation of their disorder (by referring to a system of original meanings based on solid and authoritatively supported constructs) will easily end up making the system's expectations and anticipations their own expectations and anticipations, and will start a sort of community by elaborating their experience in similar ways. This process is by intuition amplified within the institutions.

All this has to do with the concept of role. Kelly suggests that in order to play a role in the social processes involved in relations it is not really necessary to construct the events in the same manner the other does, but rather to construct the other's way of seeing the events.

Besides, argues Kelly, the subject plays his/her role according to his/her comprehensions of the other's perspective. The anorexic patient who trusts her psychiatrist, in an attempt to build her constructive system (as it usually happens in the relation therapist/patient) absorbs a whole series of prelativ, constellatory constructs thorough which she clearly realizes her capacity of movement and its limits.

Along with this point of view the patient, within her relation with the therapist, will make her choices according to her comprehension of the psychiatrist's constructive system. By doing this she will keep on playing a social role with him/her.

Since the psychiatrist roots his/her comprehension and intervention on a symptoms based diagnostic system, the patients will shape their role by intervening on the symptoms: the symptoms will represent the fundamental criteria in the therapeutic relation, and any change will concern symptoms.

Theoretically speaking the patients, while playing a social role in their therapeutic relation with the psychiatrist, will end up shepherding their psychological processes in the field of the constructs which are shared within this relation.

In this sense the relation with the psychiatrist may end up being anti-therapeutic, because it will underline and confirm the disorder proposing the movement along the major dimensions as the only recovering perspective: psychopathology on the one hand, health on the other (not to eat/to eat, underweight/standard weight, mental rigidity/flexibility), without chances of experiencing different dimensions. Therefore, as far as anorexics are concerned, the unique opportunity for a change is to become former anorexics.

Kelly writes that in such relationships there is only one possible change: to shift from one pole of the disease's central constructs to the other - and not to work out an alternative construction.

So, the psychiatrist will have a hard work in trying to have the patients do all the things they cannot do, like to eat, to observe a high-calory diet or to put on weight. Demanding anorexics to eat means to stress the importance of weight-construction: it is like showing the patients that their weight (no matter if under or over the norm) is an aspect that must be kept under control and that plays a major role inside the relationship.

According to Kelly, an effective therapy does not consist in shifting from one pole (underweight) of the disease's central construct to the other (normal weight), but in proposing inside the relationship an alternative and orthogonal construct. Kelly points out that there must not necessarily be the same constructions between people involved in a social role process. For example, the psychiatrist and his/her patient do not always construct mental disorder in a similar way. Yet, this is often the case during the treatment.

Salvini (1998) writes that, during the therapy, the patient can even anticipate the therapist's point of view. Using the language, the narrative techniques and the interpretations of the therapist, the patient can redefine, control and reorganize his/her own problematic sides.

For the psychiatrist, a patient can change only by shifting into the professional's constructs (like absence-presence of menstruation, underweight-normal weight, etc...). In this case, different therapeutic relationships based on the same professional constructs could in the end turn out to be very similar.

Along with this point of view the similarities among anorexics have their roots in the similarities among role-relations which usually occur between psychiatrists and patients. The standardization of symptomatic manifestations lies in the same medical-psychiatric praxis which provides a standard therapeutic process based on similar assumptions.

Where is anorexia then?

Bibliography

AMERICAN PSYCHIATRIC ASSOCIATION (2000). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. The American Psychiatric Association, Washington (trad. it.: *Manuale diagnostico e statistico dei disturbi mentali*. Masson, Milano, 2000).

FACCIO E. (1999). *Il disturbo alimentare. Modelli, ricerche e terapie*. Carocci, Roma.

GORDON R. A. (1991) *Eating Disorders. Anatomy of a Social Epidemic*. (trad. It.: *Anoressia e Bulimia. Anatomia di un'Epidemia Sociale*, Raffaello Cortina Editore, Milano)

KELLY G. (1955). *The psychology of personal constructs*. (trad. It.: *La Psicologia dei Costrutti Personali*, Raffaello Cortina Editore, Milano)

SALVINI A. (1998). *Argomenti di psicologia clinica*. Upsel Domeneghini, Padova.