Anorexia Tattoo

Part 1

Anorexia Tattoo I

Nick Drury 1998

Abstract

Gremillion (1992) has suggested that, what in this paper is referred to as "modernistic approaches" to the treatment of anorexia, may replicate the very conditions generating the problem it attempts to address. This is because modernistic therapy attempts to teach "rational control" over "irrational cognitions" and "constitutional weaknesses"; failing to appreciate that such self-domination is central to the discourses that generate anorexia. This first of two papers, explores an alternative context for therapy in some detail as it accounts for many features of an alternative approach – a treatment based on postmodernism. Gremillion goes on to suggest that an alternative to the traditional treatments (that for anorexia give emphasis to social isolation, constant measurement of weight gain, and reward for eating) may also serve as an alternative paradigm for psychiatric practice with a wide range of other difficulties.

The Interpretative Turn

We come into this world in the middle of this gigantic conversation, and when we go out it will still be going on. And we become participants in that conversation. Fred Newman (p. 154, Newman & Holzman, 1997)

The hegemony of the pharmaceutically induced biological deterministic discourse in that crucible of human difficulties known as mental health all but deafens us to hearing other voices. Our culture is equally ensnared, with regular media reports claiming genetic and

chemical bases for human difficulties of all sorts, including many, such as the so-called eating disorders, for which the evidence of cultural origins seems overwhelming. But other voices are more frequently being discerned by those with a generous ear, proclaiming the strange message that "bodies are not born, but are in fact made by culture". These are the voices of social or cultural constructionism, which claim that the biological body is a fiction as the body never presents itself in an innocent or "natural" form, but is always politically and historically "inscribed" by cultural discourse.

The idea of bodily inscription was introduced by Foucault and his contemporaries; a notion representative of the genre of postmodern discourse which is sweeping through the social sciences as it is gradually recognised that no one is privileged with direct knowledge of the world. At best, these postmodernists (Bruner, 1986; Bruner, 1990; Geertz, 1973; Gergen, 1995; Harre & Gillett, 1994; Rosaldo, 1992; amongst others) are saying, is that we can interpret the self-interpreted experiences of others through our interpretations of our experiences. In turn these interpretations structure experience as people situate their lives through their enactions in the narratives, texts, or interpretations they enter into or are entered into by others; and thus lives are shaped and bodies inscribed through the performance of text or stories. The most common way in which we perform meaning in our lives is by situating our actions and experience in stories; stories where the major themes are the dominant discourses of our historical present (Ricouer, 1983).

Foucault argued that cultural discourses 'discipline' the body via "a multiplicity of minor processes of domination" (Foucault, 1977a, p.138). And that the body becomes "the inscribed surface of events….totally imprinted by history" (Foucault, 1977b, p148). Cultural values, commercial messages, social expectations and standards of beauty are all inscribed on bodies, and "..just as a text in a book or a piece of film, ….they can be read by others, and rewritten.." (Fox, 1993, p26). In seeking to understand the cultural tattoo culling young women as 'anorexia', the diet mentality promulgated by the fashion and diet industry deserve our severest critical scrutiny; but in itself does not deepen our understanding. For as several feminist authors (e.g. Brumberg, 1988; Orbach, 1993) have argued, 'anorexia' is not simply a matter of 'super-dieting', but can be understood as a metaphor (Sontag, 1978) for the dilemmas created by more complex gender political discourses. By developing a discourse based around eating and food refusal, psychiatry, by and large, has in my view, failed to adequately address the conflicts and dilemmas of various cultural sub-texts. Sub-texts which are being performed on and through a large number of women and men; a far larger number

than just those attracting a diagnosis of anorexia nervosa (Eckerman, 1997). For as Place (1989: p97) suggests, "…any language that denies sub-texts must be diminished in it's capacity to effectively treat illness. Especially anorexia nervosa, which I believe is first and foremost a language problem."

Paralogy and Subjugation

Lyotard (1984) has described the postmodern condition as incredulity towards any metanarratives; be they those of Freud or Marx, or that of astrology. For the very simple reason that it is impossible for anyone to step outside of the universe of the human condition to survey the situation objectively, such incredulity allows us to remain cognisant that our own thinking is confined by such closure. Derrida's famous phrase that there is "nothing outside of the text" means "that one cannot refer to this 'real' except in an interpretative experience" (Derrida 1972, p. 148). Various endeavours to uncover the 'truth' about the human situation, whether they be the efforts of modernistic science or religious discourses, have given rise to a plethora of texts which are far from neutral and objective, for they actively shape and create the very communities and lives they purport to describe. As postmodern subjects we have no rationale way to evaluate the truth or morality of these texts. However, although there is no end point of interpretation, no final truth, it can be extremely useful to interpret the various texts or discourses, exposing their lack of innocence, as they impact upon our lives. One consequence of the recognition that such textual deconstruction allows for a multitude or surplus of possible interpretations, is that it invites us to listen generously to other voices. Lyotard (1984) calls such collaborative conversations, which allow us some way out of the closure of grand or metanarratives, 'paralogy'. Consequentially this has resulted in a radical shift of posture amongst those psychotherapists influenced by postmodern discourses as they endeavour to avoid the colonizing effects that logocentric practices (e.g. definitive diagnoses and prescribed treatment plans) stemming from particular metanarratives can have, in order to develop and maintain paralogical collaboration. Paralogy can be considered closer to the celebrity debate than the political debate, because the emphasis is not so much on winning point or counter-point arguments as it is upon providing a generous context that fosters the entertainment of new ideas.

Foucault's influence on psychotherapy has been via his efforts to show how various truth claims, which purported to describe the human condition, gradually seeped into everyday discourse and began to prescribe our lives. He was highly critical of the fact that our

discourses on political power are couched in terms of sovereign power, which is exercised by threat or brutalizing restraint and repression; allowing the 'power-knowledge' of what he termed 'bio-power', which functions through self-surveillance and 'knowledges' which encourage people to act in certain ways, to remain largely invisible. He wrote that power's "success is proportional to it's ability to hide it's own mechanisms" (Foucault 1978, p86). The mechanism that Foucault exposed was that of 'govern-mentality' which has gradually arisen over the past four centuries; where people are constantly monitoring themselves in the mirror of normalising judgements.

Although the disciplinary tactics of late stage capitalism may be more subtle than at the commencement of the industrial revolution when disciplinary techniques first began to be regimented, due to the later merger of these disciplinary tactics with pastoral power (the confession); we are all exposed to it's regime through our educational and other institutions, and through the texts and discourses that invite each of us to gaze upon ourselves in this mirror of normalisation.[1] Foucault describes our situation as 'demonic' (Foucault 1988, p.71). It is 'demonic' in the sense that the individual has little opportunity to directly participate in the discourses that define what an individual is, and what their proper relation to society might be, as these discourses are authored, by and large, by an army of semi-invisible experts. And further, most of these discourses which shape subjective experience, are couched in the rhetoric or 'language game' of positivistic science, creating an impression of being unassailable truths, or laws of nature. As Foucault says, at least the Christians stood a chance, because they entertained the idea that Satan could possess your soul and give you thoughts, and do it by pretending to speak with the voice of God (Foucault in Dreyfus & Rabinow, 1983, p.244).

In the process of subjectivization by bio-power certain bodies, certain gestures, certain discourses uttered by individuals, and certain desires, come to be identified and constituted as 'selves' in the organisation of self-consciousness. Within this social constructionist frame, the self is seen as relational, fluid, and existing in narrative. We create our minds 'ad hoc' in the course of carrying on our lives. In Rom Harre's terms the 'self' has the status of a vortex in the flow of a river, which is brought more concretely into existence by the confirming discourses we partake in with others (p.178, Harre, 1998). Liberation in the post-modern world involves coming to terms with the task of how we produce ourselves. This is because we live in a 'multi-verse' of discourses creating an instability that, as Nietzsche also saw, provides a possibility of change and liberation from a dominant discourse (Nietzsche 1968,

sec. 488). As Foucault put it: "From the idea that the self is not given to us, I think that there is only one practical consequence: we have to create ourselves as a work of art" (Dreyfus & Rabinow, 1983, p.237). Ironically, those operating in the human sciences, the psychiatrist, the social worker, the psychologist, the scientist, - all figures Foucault indicts for their complicity in authoring "normalizing discourses" - are presented in a number of his writings as having the greatest potential for enhancing such liberation (e.g. Foucault, 1988, p.107). Nikolas Rose has developed these ideas further, expressing his distaste also at psychology and psychiatry for positioning themselves, in response to culture's demands for expertise, as the judges of "correct selfhood" and "true meaning". He calls for a re-constituting of the power relations which will always exist in the psychotherapeutic relationship (Rose, 1990).

Collaborative Therapies

"if we are immersed in the supposition that we exist in a universe in which things are as they are, intrinsically independent from us ("the child is lazy" "the coffee is bad"), and if we are immersed in the belief that we can characterize them as they intrinsically are because we have privileged access to their objectivity, then we have no alternative but to correct the other for his errors, or to punish him or her for being naughty, appropriating to ourselves the power to do so through the right to be obeyed which objective knowledge gives. A claim to objective knowledge is an absolute demand for obedience."

(Mendez, Coddu & Maturana, 1988, p. 170)

Over the past fifteen years a number of schools of psychotherapy have arisen, all strongly informed by such postmodern ideas, which place primary focus on maintaining the client in the role of "primary author" of their preferred life (Hicks, 1998). These therapies include narrative (White and Epston, 1990), solution-focused (de Shazer, 1994), collaborative language systems (Anderson, 1997), and social therapy (Newman and Holzman 1997); and collectively are frequently referred to as the 'collaborative therapies'. Centered upon the competencies that clients bring to therapy, rather than deficiencies, these approaches attempt to maintain what Russian psychologist Mikhail Bakhtin called 'dialogical conversations' (Holquist 1991). By contrast, those therapies situated within the discourse of modernism, such as cognitive-behaviour therapy, can be described as 'monologic' in that they attempt to adjust the client to the therapist's theory of reality. Postmodernism proposes that reality, or meaning construction is a product of conversation, and only a dialogical conversation will keep the client in the role of primary author to the reality we co-construct (Anderson, 1990).

The postmodern therapist Kathy Weingarten (1991) takes the view that the imposition of meaning, such as occurs when modernism gauges the correctness of clients' meanings or 'cognitions' through the gaze of 'normalizing judgements', is conversational violence. This difference implies a change in the type of *expertise* the therapist brings to the conversation. Instead of being expert in defining what the 'good life' is and how to achieve it, the postmodern therapist's expertise lies in facilitating dialogical conversations that invite the client to become the 'author-ity' in hir construction of meaning or reality. As one of the pioneers of postmodern therapy, Harlene Anderson put it:

> *"The therapist does not talk with the client and determine new ways to envision and look at their lives that they hope the client will accept and find helpful. The therapist's expertise is to be in conversation with the expertise of the client."* (in discussion with Holmes, 1994, p. 156)

Noting the "physics envy" which characterizes modernistic endeavours in the social sciences to uncover the truth of objective realities in a world, where, as solution-focused therapist Steve de Shazer says, "we can't get to the bottom of things because there is no bottom to get to", Tom Strong develops Cooperrider's theme of Appreciative Inquiry (see for example, Cooperrider, 1998) to explicate the notion of 'constructive research' as the characterising method of the collaborative therapies. As research is just another language-based activity which elicits descriptions that people consider are their realities, why not ask questions which "invite clients into new perspectives on their experiences from which to consider their resources and problem-resolving competencies" (Strong, 1999, p.1)? The rigour Solution-focused therapists bring to this endeavour is to eschew the impotent despair that 'problem-talk' engenders, and instead ask, with a respectful insistence, about those moments when the problem doesn't occur so that clues about client preferred exceptions and competencies can be conversationally developed (de Shazer, 1994). White and Epston (1990) suggest that by "situating the therapist's curiosity in front of clients", especially through the use of what they term "relative influence" questions, we can begin to diminish the power of 'problem-saturated' stories as people map their own influence upon the 'life' of the problem, and thereby develop stronger senses of 'agentivity'.

Central to these therapies is the 'not-knowing' stance (Anderson, 1997). As the universe is not provided with a gallery where we can develop a 'gods-eye' view, our knowledges are relative, provisional, and local; as anthropologists such as Geertz pointed out (Geertz, 1973). Anderson and her colleagues have proposed an 'elicitive stance' stemming from this

recognition that we cannot know our clients objectively; instead suggesting we enter into their 'language games' with total curiosity to discover their preferences with regards to goals, their unique resources, and sense of self(s)[2]. This can be contrasted with some modern forms of therapy, which in the traditions of forensic psychiatry as bio-power, have questions which are so well laid out in protocols that computers may soon be able to duplicate, and generate what Strong has termed "rigged conversations" (Strong, 1999). Such rigid conversations rob therapy of the "discursive flexibility" which Rom Harre maintains is essential for the postmodern condition, and is obviously required for Bakhtin's sense of dialogue (Harre & Gillett, 1994).

Recently Miller, Duncan, and Hubble have published an extensive review of research identifying the significant variable in successful therapy, which is the therapeutic alliance, and not a specific technical intervention (1999). But this does not mean that all interventions are on a par, for clearly when the therapeutic focus is upon the client's perceptions of problem formation and resolution, as the central organising influence in therapy, then the therapeutic alliance is more likely to be enhanced. For collaborative therapists this means in practical terms being, what Michael White once noted, "as never more than an inch from the client's experience" (Hoffman, 1998, p.152).

Because collaborative therapists do not privilege themselves as keepers of objective meaning, searching instead for ways to expand clients world making, or meaning making *from within*, a new slant is offered to the notion of therapeutic resistance. With regards to the so-called 'eating disorders' this is of some importance. "Resistance" for collaborative therapists simply means that dialogue or shared intentionality has been lost, and is thus a valuable clue in maintaining discursive flexibility. The whole notion of resistance appears to stem, by and large, from the medical discourse, where non-compliance of what Foucault termed the 'docile bodies' that medical authority demanded, was problematized. Because collaborative therapy is a process of uniquely customizing our conversations in a client-led dialogue where new meanings are being performed by the client, the onus on flexibility lies with the therapist; and in this sense, there is no such thing as 'resistance', only the expression of client preferences. A number of collaborative therapists readily acknowledge Milton Erickson's maxim that each client requires a unique therapy to where they are and their circumstances; and their expression of their preferences guides the development of this. Morally, this is Bauman's 'aporia of proximity' (Bauman, 1993); where our actions remain within the relational conversational context and don't wander onto pre-scripted solution paths.

The objection might be raised that if therapy is based upon discursive flexibility where the client is the primary author, then it could be led in a direction that was dangerous either to the client or others. However the therapist brings to the conversation their own professional ethics and values, which act as boundaries to entering into certain 'shared intentionalities'; and in turn become part of the negotiation to discover 'shared intentionalities' which can become grist for the dialogue. The centre may not hold, but anarchy is not reigned upon the world.

In recent years the view has been developing amongst postmodern theorists that meanings are performed in relationships (Newman & Holzman, 1997; Shotter, 1996). This is the notion that meanings derive their significance not so much by pointing to some 'truth' beyond the relationship, so much as how language 'moves us' emotionally in conversation. Thus the meanings that we become attracted to are those that personally resonate and fit our life circumstances. 'Problems' from this perspective, can be seen as stalled conversations, or stalled research programmes, embodied in our postures. Newman and Holzman refer to these as "fossilized meanings". They also warn that because of the primacy of 'knowing' as the central feature of modernism, various postmodern discourses are at risk of being drawn into modernism as merely further forms of knowing. They propose that the knowing paradigm stifles human social creativity, and radically call for the "end of knowing". Drawing from Wittgenstein's later writings they note that the purpose of conversation is not to seek understanding but to perform ourselves in new ways so that "we continually become who we are not" (i.e. continually make ourselves anew.) They write: "We are seeking to complete and be completed, not to understand and be understood, not to get it right" (1997, p. 113). Or as Wittgenstein said in a Zen-like simplicity - "now I can go on".

Leaving No Footprints

Collaborative therapists may themselves measure their successes by the degree that the clients believe that they themselves created more satisfying lives for themselves. To paraphrase a Timothy Leary paraphrase of Lao Tsu, when the best therapy is over the clients will say "it all happened naturally; it was so simple we did it all ourselves". As solution-focused therapist Insoo Kim Berg has noted, this is the Zen metaphor of "leaving no footprints" (Berg, 1997). The challenge issued by the collaborative schools is to not only step off the throne of knowing what is needed by clients, but to do it in a way which leaves no footprints.

Footnotes

[1] This process of self-surveillance is sometimes referred to by Foucault as 'panoptism', being based on an architectural design of Jeremy Bentham where prisoners began self-observing as a response to a situation where they never knew whether they were being observed or not.

[2] 'Language games' is a term from Wittgenstein's "Philosophical Investigations" and refers to a genre of discourse.

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Part 2
Anorexia Tattoo II

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Abstract

This second of two papers, co-authored with those involved, highlights some of the 'sparkling moments' that occurred in a discourse with a young woman, who had attracted a diagnosis of anorexia nervosa, and her conversational partners following her hospitalisation. Her success was due to her discovery of her own strengths and special talents in overcoming this demon, to which she graciously allowed a therapeutic team to be an appreciative audience to. Those legally mandated under the Mental Health Act to prevent anorexia from ravaging her unduly also had a presence; but did not involve themselves in the therapeutic conversation. Gremillion (1992) has suggested that whatever approach we take to anorexia may also serve as a paradigm for a wide range of other difficulties encountered in psychiatry.

Nick: *"Eve, when we first met (some 8 or 9 years ago), you were in the Intensive Care unit of a hospital, and although I had been asked me to go and meet with you, I wasn't at all sure whether you wanted me to get involved. I introduced myself and told you I was from the mental health service (enough to scare many folks away!). What memories do you have of that first encounter that attracted you to wanting further conversation with me and my co-therapist?"*

Eve: *I remember being in ICU, naso-gastric tube up my nose, heart monitor, drip. I didn't feel sick, I didn't think I looked sick. I remember the carol singers coming in to the ward and singing a Christmas carol and I remember thinking "they'll wonder why I'm here, I don't look sick." But I was sick and I did not look well. In fact it wasn't really "Eve" at all, Eve had been lost a long time ago. I functioned, I didn't live as such, I was driven by the thoughts and voices in my head - the voices of Anorexia.*

I also have fragmented memories of the counselling and therapy I had experienced prior to our meeting. I had seen a private psychologist at the insistence of my parents

and basically went to keep them happy and told the therapist what I thought she wanted to hear. I finally made the decision to get some real help and admitted myself to another hospital for a month. The less said about this the better but essentially I feel that I could have died there. It was so awful, in fact it made it worse, not better. I am still struggling with the experience now, ten years later.

I felt comfortable with you from the very beginning. You talked to me on different level than my other caregivers. You spoke to me as an intelligent woman and our conversations were filled of history, philosophy, rites of passage, sociology. They weren't specifically about me and my eating and food which was what everyone else insisted on focusing on. You seemed to know that this was just the manifestation of something else and it was this that needed to be addressed.

Comment: Appreciative inquiry involves deconstructing the meanings clients bring to therapy to not only invite reflection upon the meanings the client has developed, but also to begin constructing new meanings for performance. Eve's comment about previous therapists insistence upon focusing on her eating and food is an example of Weingarten's conversational violence; and invites such therapists into unwitting complicity with processes of domination. The alternative, conversational intimacy, requires a collaborative conversation, which begins where the client is at in themselves. One way this can be commenced, is by simply asking clients how they came to understand themselves and their situation in this way. This process, which White and Epston call 'relative influence questioning' (1990), helps to separate the client from the problem. By inviting the client to review the effects of the problem on the client's life, space is usually opened for the client to reflect on those 'sparkling moments' when they have influenced the life of the problem. It is by this means that the problem is 'externalised' and the exorcism of the demon begun (Tomm, 1989). And we conduct this in total curiosity, for as Strong writes: "curiosity (not of the forensic kind) is our greatest incentive to turn to clients for: *their* understandings, *their* resources, *their* competencies, *their* evaluations, and *their* imagination" (Strong 1999, p 8?).

Nick: *Eve, when you began to describe some of the things that had been happening in recent years, like the previous hospitalisation, various therapists, hassles with your*

parents, and now being here in the intensive care unit, I detected a note of dissatisfaction, disappointment, or even anger at the way things had turned out. So we (my co-therapist and myself) asked you if you could help us understand this dissatisfaction a little more. During that discussion you sometimes referred to anorexia in the third person, but I am not sure you noticed yourself doing that. We picked up on that and began asking you a number of questions, which you now well recognise as 'externalising the problem'. As this theme developed in our conversation, we all started to talk about 'anorexia' as if it were some sort of demonic entity. We then began discussing your 'resistance' to anorexia, and you immediately identified that you had managed to drink a few sips of water from a glass, despite anorexia's voice imploring you not to. What do you recall of the first feelings you had as you entered into this 'externalising conversation'?

Eve: *I didn't realise that I myself verbalised Anorexia in the third person but that was the answer to my successful recovery. Knowing and recognising that Anorexia was the enemy, a distinctly separate entity to myself and with the help of others, the enemy could be beaten. I do remember the "teams" of staff - helping me to fight the enemy, some better than others. Once I grasped the concept of Anorexia being an external entity, I felt as if I had broken the hold it had over me and from that point, I actually fought to get well, I found that I now had a means, a method to get well.*

Therapy and Policing

Foucault identifies two watersheds in the development of bio-power – the first being the commencement of the confinement of the mad in the 17th century, and the second being when the pastoral power of the confession was utilised in the development of 'panoptism'. The first step in the development of 'panoptism' was when moral reformers entered the prisons, the army, the factory, the schools, and the hospitals (Pinel and Tuke entered the asylum not as doctors but as moral reformers), and began imposing disciplinary regimes. By observing prisoners, for example, comparative knowledges could be accumulated, and reform programmes administered. Such a system creates what Foucault calls 'docile bodies', "..the obedient subject, the individual subjected to habits, rules, orders, an authority that is exercised

continually around him and upon him, and which he must allow to function automatically within him" (Foucault, 1977a, p.129). Bend the body to one's will, and the mind will follow.

Although many mental health professionals may express a reluctance to accept the burden of being agents of social protection, they frequently cite humanitarian grounds for their acceptance of this burden. But as Haley noted "to be both a healer of the sick and a jailer is stressful and paradoxical, and the psychiatric profession suffers as much as it benefits from it's obligations. It is a mad world inside the ward for both staff and patients" (Haley, 1980; p.53). Indeed, it has been suggested by a number of writers that it may well be this paradoxical position, combined with the invitation to a negative self-evaluation that accompanies psychiatric diagnoses, that is accountable for the sad finding by WHO that the prognosis of an individual who experiences a psychotic phenomena is worse in the developed countries than in the developing (e.g. Gergen, 1994; Kleinman, 1988, Szasz, 1973; Waxler, 1977).

Because policing and therapy have been combined it becomes difficult for therapists to not engage in the kind of conversational violence which Eve alluded to above. The most pressing problem appears to be one of an individual near death, so the therapist focuses the conversation upon eating and food; which paradoxical as it may seem, is not usually the primary focus of the client at that time. This trap for therapists is considerably reduced when policing and therapy are separated.

Nick: *Gail, you were the Charge Nurse of the mental health in-patient ward when Eve was treated. As you will recall, even before Eve was transferred from the ICU ward, the doctors and myself had decided to split ourselves into two teams. The doctors took charge of the 'Pro-life team' and took upon themselves the responsibility of keeping Eve alive under the ethos of 'the least restrictive means'. They had minimal dialogue with Eve, and attempted to keep their measuring and interventions to a minimum. My co-therapist and I initiated the 'Anti-anorexia team', which engaged in the therapeutic conversation. This split was maintained on the psychiatric ward, with nurses being assigned to either the 'Pro-life team' or the 'Anti-anorexia team'. What are your impressions of how well this arrangement was received by the nursing staff and psychiatrists?*

Gail: *The split roles of the nursing team facilitated a 'no blame role'. Staff had clear boundaries and roles which enabled them to be objective in their approach and therefore reduced the conflicts within the nursing team. Nurses often experience the dilemma and conflict of being a police person and a nurse, and feel uncomfortable with this. (This I believe is often the basis of burnout - internal conflict). Some nurses fit the police role comfortably and others definitely feel more comfortable with a therapeutic approach. Staff self-selected for the roles.*

Nick: *Gail, in the therapeutic literature written by Narrative therapists (e.g. Epston, Morris, & Maisel, 1998; Madigan & Epston, 1995) concern is expressed that in asking clients whose lives have been taken over by a so-called eating disorder questions, there can be a sense that this very questioning is yet itself another way of measuring and weighing them. Questions themselves can become part of 'anorexia's tricks' so to speak, and lead to further entrenchment in anorexia's concentration camp. Do you have any observations about how this was avoided?*

Gail: *The approach of therapeutic questioning was sensitive and gradually increased over time. Apart from not overwhelming Eve with eating disorder questions, it enabled staff who were the 'anti anorexia team' to witness the dialogue and develop an understanding of the treatment.*

Nick: *Finally Gail, do you want to make any comments about how this split teams arrangement might function for other types of problems a psychiatric unit might face?*

Gail: *Utilising such a split with other disorders could be very useful, particularly with nurse experience i.e. often less experienced staff have difficulties with the policing role or the therapeutic role and this would enable them to develop excellent skills with clear boundaries - the split would help define the nursing role in psychiatry which is not so easily articulated in many nursing texts. Regarding the psychiatrists, some would be open to the split while others may not; but really if the nurse leader takes responsibility for developing a team then the possibility is there. Currently there is a lot of policing in my opinion and this concerns me.*

The other thing is that I think it would be very useful for staff and the client to have some closure upon discharge – especially for those staff involved in policing. A

discussion where client and staff can discuss their feelings about the staff who are cast in the policing role.

Deconstructing Anorexia

The task confronting the client and the therapist in discursively exposing the ideologies and discourses which tattoo individuals is doubly difficult in that the power of these discourses attain their power in their ability to remain hidden, and can only be deconstructed at the site of their power operations – the particular individual. Although various sociological treatises and feminist analyses of the social construction of gender and anorexia can sometimes be useful, they can at best serve as indicators of 'possible suspects'. For there is always a risk that the enthusiasm of the therapist towards particular ideas about gender may lead to an imposition upon the client of these ideas (Kraner & Ingram, 1997). Or as Kenneth Gergen warns us, the reification of any discourse can generate an identity politics with binaries of inclusion and exclusion that close us to more open conversations (Gergen, 1995). For the client, the 'unmasking of anorexia' from within the 'language games' (Wittgenstein) of the client is, as David Epston notes, primary and crucial (Epston, 1999). In order to promote such paralogical dialogue narrative therapists have found it more useful to share archival correspondence between narrative therapists and their consultants/clients in appreciative inquiry constructive co-research[1]; rather than the more authoritative and potentially colonising writings of sociological or feminist research.

Having said that, it should come as no surprise to those familiar with the feminist analyses of anorexia and gender, to recognise a number of sub-texts in the anti-anorexia/anti-bulimia leagues archives that have been voiced elsewhere. For example we may note that in many ways the label 'anorexia nervosa' is a misnomer, as what we witness is control over appetite and not it's loss; and as Foucault showed us with regards to the Victorians and sexuality, we see people who become masters at disguising and deceiving themselves and others in the very thing they are most fascinated by. As a number of recent writers have noted, those captured by discourses which promote self-starving, in their attempts to be invisible, have made visible some of the powerful discourses that invite women to be either docile subjects or rebellious subjects. For amongst many of these women it is possible to deconstruct both high degrees of conformity and high degrees of defiance to particular prescriptive discourses for normality (MacSween, 1993; Probyn, 1996; Eckerman, 1997).

Therapists seeking to unmask or expose the body thief that is situated in the nexus of entanglements of discourses and sub-texts about the female body and power, may well benefit from a review of some of the possible suspects. Amongst the myriad of writings on these discourses I (ND) have found the following useful:

- The vulnerability of early adolescence when young women frequently surrender their own interpretations of events for the sake of maintaining relationships (Gilligan, Rogers, & Tolman 1991).
- The dominance that 'virtue', as a measure of a women's worth, has occupied since the commencement of the industrial revolution, when it began to occupy the place previously taken by the size of the dowry. Indeed, according to 17th and 18th century 'wisdom', when a woman lost her chastity, she lost her 'purse' (Rowbotham, 1973).
- The ancient patriarchal doctrine that masculine desire is active and female desire is responsive; which in turn has given rise to the popular notion that women's desire needs to be harnessed as it is construed as being symbolic of 'mother nature's' voracious threat to overwhelm patriarchal order. This doctrine has been coupled with the gendering of the Cartesian dualism with it's implicit suggestion that the 'masculine' 'public' mind or 'spirit' needs to contain or control the excesses of 'feminine' 'private' emotion and bodily desire (Bordo 1993). (In the rhetoric of the league anorexia is frequently depicted as 'male').
- Bryan Turner's thesis showing that moralistic medical dietetics of the 19th century constituting 'virtuous' women as weak and vulnerable generated hysteria as the major mental health problem of that era (Turner 1984). In turn this discourse gave way, following the first wave of feminism, to the dominance of discourses depicting 'virtuous' women as belonging in the home, which generated agoraphobia as a symbol of the chastity of women and the virility of their husbands and fathers, for the first half of the 20th century. And since the second world war, with a shift from an oedipal producing culture to a culture of narcissism, as the central cultural contradiction of late stage capitalism has become more sharply focused – the requirements for an asceticism of production (work ethic) to be coupled with a hedonism of consumption – a new discourse on the 'virtuous' woman has arisen (Deleuze & Guattari 1985, Lasch 1979). With the massive increase in the numbers of women at the sites of production and consumption a cultural prescription for femininity has arisen centered around an asceticism of body presentation or representation in society (Turner 1984).

Thus in late stage capitalist culture a nexus of discourses have arisen around the representation of the female body in social space. In this climate obesity has become a stigma; for it suggests lack of control, and hence poor performance. So anorexia can be construed as a powerful invitation to women to regard their body as a 'phantom object' for male consumption, and for her to think of herself as the care-taker, which she maintains through cosmetic and dietary disciplines (Wolf, 1992). In doing so she achieves the markings of success in that she displays a level of self-control which keeps her safely on the right side of the madonna/whore divide. She achieves this by maintaining an ever-vigilant gaze upon the disgusting and fearful desires and appetites which threaten to overwhelm her at any moment. In a very real sense she is attempting to be the 'individualized male self' (mind) controlling the voracious feminine appetite which threatens to overwhelm the social order; this is her solution to the problem of female representation of self in a male world. Such women are achieving their 'success' by developing a phantom object body and distancing themselves from the desiring body. Morgan MacSween writes:

> *"The anorexic woman aims, through a ritualized eating pattern, to create the surface of the feminine body as an absolute barrier and the body itself as an absolute object… the aim is to eliminate it [external intrusion] completely and create a pure, empty and static inner space free from contamination by intrusion…. The anorexic 'shell', then, functions in two senses: to prevent intrusion and to contain emptiness…The ultimate aim of anorexia is the destruction of the desiring body in which dangerous appetite is lodged, and the ascendancy of the object-body."* (MacSween 1993: 195-196)

Eve's Deconstruction of Anorexia

Nick: *Eve, as our discussions progressed, we tried to be particularly sensitive to any phrases or metaphors that you used in describing your understandings of and victories over anorexia, and at the same time introduced a number of phrases and metaphors we had gleaned from the leagues archives. We frequently wrote you letters after those conversations so that we could make available not only to you, but also to other members of the anti-anorexia team, this 'languaging' as it developed. For example the Auckland league frequently used the term 'concentration camp' as part of it's description of anorexia's intentions, or the Atlanta league alludes to the feminist concerns by talking of being a 're-sister'. More recently this 'languaging' has been termed the 'social poetics' of therapy. With the hindsight you now have, could you*

say which particular metaphors and phrases resonated best for you? Do you recall any that particularly facilitated the turning you took against anorexia?

Eve: *Reading back through the letters you wrote I am reminded of how as I "battled" against a "deceitful robber" I began to find "my own voice", and was allowed to be angry again, and not feel I had to "fit in" to everyone else's schedule. Getting free from the "beauty myth" made it ok for me to "rock the boat".*

Nick: *As a result of your experiences in battling anorexia can you say a little about your thoughts on feminist politics?*

Eve: *As you know, I later got married, and then anorexia started it's tricks again, and part of breaking out of it's cage this time was to reclaim my maiden name. I think there are some very powerful but subtle invitations in the world for women to sacrifice themselves for the sake of fitting in. I think both man and women need to be quite mindful of how easily we invite women to these traps.*

Nick: *Now that you have 're-membered' who you are by breaking the spell cast by anorexia I wonder how you cope with the daily exposure it seems all women in our culture have to the discourses that are anorexia. Do you care, look after, or treat yourself in acts of self-appreciation more now? Do you share the story of your struggle with an appreciative audience? Do you get angry, or voice your disapproval to those giving voice to anorexia more freely now?*

Eve: *Yes, that's it. I'm now allowed to be what some people call "selfish". I take time out for me now, and treat myself, although I must admit that guilt still tries it's tricks.*

Nick: *Finally Eve, a number of the leagues have taken part in political activism, such as public demonstrating or letter writing campaigns to raise consciousness of how, say a particular billboard or advertisement is pro-anorexia. What thoughts do you have on this activism?*

Eve: *I don't think it is my thing, but they certainly have my support. I now have a husband and a few close friends who share my disgust, and are wary towards the voice of anorexia.*

Nick: *My thanks for your help in writing this paper with me.*

Footnotes

[1] Some archival material can be obtained from the Vancouver Anti-anorexia/anti-bulimia league's website - http://www.rpl.richmond.bc.ca/youthbytesback/vaaabl/
And also from David Epston, Dean Lobovits, and Jennifer Freeman's site - http://www.narrativeapproaches.com/anti_anorexia_index.htm

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