

## Countering that which is called anorexia

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### **Abstract**

In our dominant discourses, anorexia and bulimia are identified with those persons suffering from their effects. Thus a person is anorexic or bulimic. By contrast, narrative therapists conceive of anorexia and bulimia as separate from the person. Consequently the problem, and the person's relationship with it, rather than the person themselves, can be recognised as "the problem". Anorexia and bulimia may then be regarded as having "voices" of their own, which act as discursive parasites that draw a deal of their sustenance from the dominant discourses in society that are subscribed to by those they attack. Once the problem is divorced from the person, then those attacked by these parasites can, through therapeutic conversations, be helped to find alternative discourse resources that assist them in gaining power to resist these parasitic voices.

### **Introduction**

It is a defining characteristic of people that they attempt to make sense of their experiences and situations. They do this by drawing on the symbolic resources available in their cultures. Thus, who and what we take ourselves and our worlds to be will vary depending on that pool of resources. Consequently, we can expect to find the sense that people make of themselves, their experiences and their situation variable across time within a particular cultural tradition, and across space between different cultural traditions. Thus it is unsurprising that practices of self-starvation within western culture have been interpreted differently at different times as the resources available for social, political and ideological thinking have changed.

Hepworth (1999) provides an overview of these changes. The early interpretations of self-starvation from the twelfth century frame it as a religious act of asceticism, and women who practised it were regarded as saints who had shed their attachment to worldly pleasures and were miraculously able to sustain themselves through heavenly rather than physical nourishment. A quite opposed interpretation succeeded this as the Church began to articulate a view of women as immoral, deviant and evil. Thus self-starvation became an indication of an unnatural and sinister existence, a characteristic of a witch. The understanding of witchcraft also changed, ushering in a conception of hysteria that was widened to characterise the nature of women as having an essential irrationality. With the shift from a religious to scientific framework, self-starvation became understood as a form of hysteria and thus indicative of a “disordered mind”. Thus, “anorexia” was invented in the nineteenth century. Anorexia is still with us as a disorder of the mind, but is now decoupled from the notion of hysteria, and is regarded as an “eating disorder”.

Given this history, though, we need not draw the conclusion that advances in science and medicine have enabled us to have a better grasp of the inherent, essential quality of this “condition”, which has been carefully “discovered” through sophisticated scientific and medical practices. Nor, in addition, do we need to suppose that a better “cure” may be found through more medical research. There is, instead, another option available that has been developed following Foucault’s elucidation of “power” and its professional exercise as a disciplinary practice that “medicalizes” the body. From this perspective, it is more the case that our understanding of anorexia as an “eating disorder” is constructed as an “incontrovertible pre-given “fact” existing independently of our knowledge(s) of it” (Malson, 1998, p. 97) as a result of the historically established resources in our culture that enable it to be constructed that way. Following Foucault, it becomes possible to consider anorexia as a practice that is interpreted through a “set of interrelationships between knowledge, social practices and institutional authority” (Hepworth, 1999, p. 121). These relationships “position” women and anorexic practices in particular ways.

Anorexia nervosa and bulimia are medically defined as “eating disorders”, and included as distinct diagnostic categories within the DSM scales. Anorexia turns up in at least 1% of Western adolescent girls, and occasionally boys. It is regarded as one of the most “dangerous” of “psychiatric illnesses” because it has a course that can lead to death, with a mortality rate of between 5 and 20 percent of cases (American Psychiatric Association, 2000; Kaplan & Sadock, 1997). In general, “the prognosis is not good” (Kaplan & Sadock, 1997, p. 744), a view which has professional “helpers” concluding that the problems of anorexia and bulimia are difficult to cure. As noted, this situation might be taken to mean that medical science has not yet sufficiently delineated the true nature and causes of anorexia. We are not concerned with this line of thinking here. Our argument is that the tenacity of anorexia comes from its discursive construction, which confines and silences those inside it, so severely does it limit and usurp the ways and means they have of storying their experience.

In the case of anorexia, an alternative story is not readily available for the purpose of resisting a dominant story. Rather, our view is that in this particular arena, the dominant discourse is an immobilizing, totalitarian one that, by its very nature, virtually rules out even the possibility of countering it by a person whose life experiences have been constructed through it. This is a strong claim, and counter to the orthodox and generally insightful Foucauldian position that “there are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised” (Foucault, 1980, p. 142). Our view is, that in the case of anorexia, we are faced with a discursive “world view” that provides us with perilously few opportunities to essay that world in alternative ways. A form of resistance is possible, but only within the resources also available for the construction of the dominant view: it may be “opposed” within its own terms. In doing this, some feminist writings “have portrayed forms of patriarchal power that insinuate themselves within subjects so profoundly that it is difficult to imagine how they (we) might escape. They describe our complicity in patriarchal practices of victimization without providing suggestions about how we might resist it” (Sawicki, 1996, p. 163). Other writers re-theorise the notion of what it is to be a “subject” so as to reunite it with the body, and thus self-starvation can come to be seen as the act of resistance itself by the exercise of self discipline. We are not following this path. We are not concerned with what is just “unarticulable”. What matters to us is what is actually unthinkable because it is, so to speak, “orthogonal” to the dominant discourse. In addition, we will briefly consider some ways in which this otherwise “unthinkable” can be constructed, via conversation, so as to be available for further exploration. We will do this by looking at the ways that anorexia is approached in the emerging tradition of narrative therapy.

We need to recognise at the outset that every individual experience of anorexia will be storied differently by every individual so-called “anorexic”, though we can expect to find similar themes. We assert that it is crucial to tease out these individual stories as landscapes within which effective counter-narratives can be

constructed, counter-narratives that bring into being the possibility of sustained “acts of resistance” to anorexia, a resistance that is otherwise easily co-opted or overwhelmed. Let us also be clear, at this point, that the counter-narrative practices we will be discussing are radical ones. We are not seeking to increase the effectiveness of what Rose (1990) has termed “psy” treatments through making their terms and narratives more meaningful to those so treated (e.g., Chadwick, 2001; McCabe & Quail, 2002). We are not proposing the translation of an expert vocabulary into a lay one. We are concerned with the making of a counter-narrative, one that can contest, and finally repudiate, the dominant “anorexic” reality. Without this, the odds are that the “anorexic” reality will insidiously and irresistibly prevail, because no opposition to it can be articulated to populate what has been silenced.

### **Narrative Therapy**

Narrative Therapy has its origins in the collaborative work of David Epston, who practices in Auckland, New Zealand, and Michael White, who practices in Adelaide, Australia (e.g., White & Epston, 1990; and subsequent references in this article). Its aim is to help people resolve problems by discovering new ways of storying their situation. Thus the approach is not based on an essentialist view of either human “nature” or its’ possible defects that can be diagnosed and then “treated”. Rather, it regards problems that clients “present” as stories they have about themselves and their situations that are drawn from the mainstream of a culture’s discursive resources. These stories construct the person’s understanding of who they are and frame their interpretations of what is troubling them. The role of the therapist is to help the client find an alternative and preferable story, one that enables them to escape their problem-saturated situation.

This collaborative practice of therapy begins with settling on a mutually acceptable name for the problem. The problem then becomes the focus of the therapy, because it is the problem that is the problem; it is not the person who is the problem. The problem is often “personified”, and can be talked about as having its own intentions and a set of tactics whereby it achieves these. We might find, for example, that a person who has been having great difficulty overcoming an addiction uses a set of available cultural discourses to account for their difficulty in quitting: it is a failure of will, and, anyway, they are weak-willed. In this way, the problem and the person are somewhat compounded. But if the problem is separated from the person, it becomes possible to get a handle on how it works its influence. And the person who knows best how that happens is not the therapist, but the person (or family) who has direct experience of how the problem affects them. This focuses the investigation on how the problem has disrupted, dominated or discouraged the person and/or his or her family.

But there are always occasions on which, and ways in which, the client has not been dominated or discouraged by the problem, and when it has not disrupted

their lives. The evidence can then be gathered that bolsters a view of the client as having been competent to have stood up to, defeated or escaped from the dominance or oppression of the problem. This enables the therapist to evoke speculations from the person or family about what kind of future can be expected for the strong and competent person that has emerged from the interview so far, and to finding or creating an audience that can perceive and support the new identity and story that is being created.

As a concrete example, consider the case of Ian, a six year old who has a nasty temper. This gets him into a lot of conflict with his father, who doesn't believe that boys, especially his, should throw the tantrums that he does: that Ian is a "spoilt brat". The conflict is between Ian and his father, and Ian is seen as a problem child. Why does he do it? Ian is seen as responsible for his outbursts, and so needs to be held to account over them. He and his father are on opposite sides. If, however, we externalise the problem, and agree with Ian that the problem is "Mr. Angry", then we can start to explore with Ian what makes Mr. Angry tick: what is he up to; how does he get Ian to do these things? Ian, as the insider in all of this, can offer some explanations as to how Mr. Angry wants to spoil his relationship with his father, and he finds a way of noticing when and how Mr. Angry is able to pick the best times to do that. Ian can begin to fight back at Mr. Angry, and not let him get his way. In addition, his father can become his ally in this fight. Ian is no longer a "spoilt brat", but a brave kid trying to beat Mr. Angry with the help of his father.

In exploring the knowledge the person has of "their" problem a rich window is opened on what we might otherwise call "their thoughts". Alice Morgan (2000, pp. 26-27) provides this example, constructed from an ongoing discussion over a number of sessions with *Madeline*, who is eight, about "Dumb Bug".

- Alice:* So what does Dumb Bug tell you about yourself?  
*Madeline:* It says I can't do anything and tries to stop me trying.  
*Alice:* How does it stop you from trying?  
*Madeline:* It says, "You won't be able to do that. It's too hard. There's no point even starting, 'cos you won't be able to do it".  
*Alice:* How does it say that? Does it have a special sort of voice or way of speaking?  
*Madeline:* Oh ... it's sort of a loud voice.  
*Alice:* A load voice?  
*Madeline:* It booms at me and yells at me and says it meanly.  
*Alice:* Does it always speak meanly to you?  
*Madeline:* Always. It never says anything nice, just things like "You are dumb", "You are stupid".  
*Alice:* When does it say these things? Is it all the time or only some of the time?  
*Madeline:* Just some of the time but usually when I get my work from the teacher and also it says things to me at sport.  
*Alice:* What does it say at sport?

- Madeline:* “Your dumb, you can’t play in that team because the other kids won’t want you”.
- Alice:* So it criticises you? Is that right?
- Madeline:* Yes, it always criticises me, in everything; even when I am at home it criticises how I dry the dishes.
- Alice:* How does Dumb Bug work? Do you know it’s coming? Does it give you any warnings?
- Madeline:* Sometimes I know it’s there because it makes my stomach churn.
- Alice:* So it targets your stomach first? Is that right?
- Madeline:* No. Before that it is in my head saying things and then it goes to my stomach.
- Alice:* Then what happens?
- Madeline:* Well then it has got me because when my stomach churns, I can’t do anything and I can’t think.
- Alice:* So its tactic is to first grab your thoughts and then it works on your stomach.
- Madeline:* Yes.
- Alice:* How long would it take to do this? Does it work quickly or slowly?
- Madeline:* Once it puts its mind to it, the Dumb Bug moves fast

Now that we have a fix on Dumb Bug, we are able to go forward to figure out ways of countering or thwarting it. Without having that fix, and a separation between the problem and Madeline, a way forward is more difficult. Without Dumb Bug we cannot disentangle Madeline from her problem. In fact, we would be limited to considering her as being responsible for the problem, because she shows an oversensitivity in her thinking. To assist Madeline in overcoming the situation when it is essayed in those terms is much more difficult because of the double-bind our conceptualisation would create. Trying to turn things around might only serve to confirm her low level of self-esteem. But even when so conceived in an externalising conversation with a skilled therapist, some problems are very clever. Anorexia is one of them.

### **That which is called anorexia**

Within our culture’s dominant discourses, “psy” clinicians are able to assert that, “The patient has anorexia”, or, “The patient is anorexic”. The “patient” also has a grasp of this way of constructing their world: “I have anorexia”, and, “I am anorexic” fall off the tongue easily. It makes far less sense, and may even seem nonsensical, to say, “Anorexia has captured this person”. But, if one shifts to this non-dominant construction, a way of contesting anorexia becomes possible. The “patient” is no longer “the problem”: “the problem” is “the problem”. This shift of perspective constitutes one of the key points in the practice of “narrative therapy” as originally formulated by White & Epston (1990); Epston & White (1992); White (1989, 1995, 1997, 2000, 2003); Epston (1989, 1998); White & Denborough (1998, 1999).

The tactic of externalizing conversations, earlier known in the writings of narrative therapists as the “externalisation of the problem”, drives a wedge between the person and the problem. If I am anorexic, then there is little I can do about it. But if I am separate from anorexia, then maybe I can do something. Similarly, if I am depressed, I am instituting myself as depression, and I have little recourse but to unreflexively live out and through that depression as my way of being-in-or-against-the-world. But if either depression or anorexia are linguistically separated from the self, then perhaps an alternative identity can be constructed that can counter the narrative of depression or anorexia that the dominant construction allows me.

For example: in this short transcript, Chloe (aged 19) and David Epston (aged 57) are discussing her last hospital admission and mandatory tube-feeding the previous year.

*Chloe:* I can vividly recall how I was feeling at the time and it was not along the lines of “anorexia” wanting to end my life but rather me wanting to end it and I felt that they had no right to save my life and insist that I live when it was “my” life and all I wanted to do was die. After all, they didn't have to live with anorexia 24 hours a day. However, having said that, simply by using different language such as “forbidding anorexia to murder me” rather than “saving my life”, I'm sure that would have had an impact on our professional-patient relationship in that they are making a clear distinction between anorexia and myself as a person and that draws the battle lines differently - they are not against me but rather against anorexia.

*David:* Chloe, if a “treater” had been able to indicate to that year-ago Chloe that they suspect the above and could have compassionately said something to this effect - “A year ago Chloe, I suppose anorexia has convinced you that it is you who wants to die and given the way it has been tormenting and torturing you for 25 (sic) hours a day over the past 9 years, if I were in your shoes I would certainly be thinking the same. But I hold to this fact that you are not anorexia. How can I be so sure? Because your parents have told me stories about how as a seven year old you..... how as an eight year old, you.....That is why I refuse to listen to anorexia when it tries to have me think you are a “sick little girl” who is “out of her mind”. In fact, I believe anorexia is “in your mind” and if I had my way, I would do everything in my power, short of neurosurgery, to remove anorexia from your mind. It is your mind, your spirit and your body that I intend to save and I will do so by any means - medical or otherwise - at my disposal. I do not wish to attend your funeral but some day, I want to attend your university graduation. Chloe, look, I do not expect you to agree with me but all I am asking is that you will look into my “heart” and see if I have malice or hatred for you. Chloe, look into my eyes while I look away from you

so you cannot think I am looking at you and know I am staring at anorexia. I am thinking how immoral it is for anorexia to try to talk you out of your life, a life that it wants to terminate even before it has almost begun - to dig you up by the roots even before you have ever really flowered and blossomed".

*Chloe:* Wow...this really touched me. It is so wildly different from anything I could imagine my past "treaters" ever saying."

In this example, by linguistically separating anorexia from Chloe, an alternative narrative of Chloe is constituted through historical accounts of her personhood provided by her parents. In addition, an alternative story about anorexia is simultaneously constructed, one that casts anorexia as a would-be murderer of Chloe. As she states, "the battle lines are drawn differently". To treat Chloe as an anorexic positions any treater in opposition to "Chloe the anorexic".

One of the canons of narrative therapy is to see peoples' lives as storied experiences:

"The structuring of narrative requires recourse to a selective process in which we prune, from our experience, those events that do not fit with the dominant evolving stories that we and others have about us. Thus, over time and of necessity, much of our stock of lived experience goes unstoried and is never told or expressed. It remains amorphous, without organization and without shape" (White & Epston, 1990, p. 12).

The process by which we select "knowledge" for our stories has been described by Foucault (1978) as a power-saturated one. What is unstoried is a knowledge we might have, but without a language in which to formulate it, it remains inoperative and nugatory. This is the nature of discursive power: it is not that something is formulated and repressed (as Freeman (2002) points out), it is that there is nothing available to even formulate that void as a "something or somewhere" in the first place. It is not the case here, as Foucault has argued, that powerful dominant discourses always produce resistance against themselves. They can only do that if suitable resources are already available. Those at hand in the dominant medical discourse and the practices it creates towards those it labels "anorexic" can be resisted, certainly, but that resistance is conducted by "the anorexic" as "an anorexic". This is a pseudo-resistance. It is by the means of "externalising conversations" and the discursive move of "animating" the problem as agentive, that it becomes possible for a therapist to co-construct an effective counter-narrative with their client. Real resistance becomes possible when we view anorexia not as an illness, but as a subtle and deadly murderer whose power comes from its ability to twist and turn its rhetoric through the lines and lacunae of the only language its victims have to live in and through.

Note here that we are not using this formulation to define anorexia, to clarify its medical ontology, or to essentialise it. We are looking at a linguistic turn that gives a form to a problem that allows us to start exploring how it does its work, and how it can be resisted. We can view “that which is called anorexia” as an agentive force that co-opts the logic of a culture’s dominant narratives and linguistic formulations for its own ends. It is, thus formulated, a parasite that acts invisibly and silently within a person’s construal of their experience, so as to speak through them. We take it that personhood is a symbolic construction, founded upon the discursive resources available in a culture. Personhood draws its sustenance and maintains itself via the system of symbols from which it is constituted. Anorexia subverts this system to its own, rather than the person’s, ends. It is in this sense that we are able to talk about it as a parasite that uses for its sustenance the constitutive discursive symbols that persons are “made from”. We will show that it can be therapeutically useful to talk about, and with, the “voice” of anorexia in this way. It may, however, be useful to talk about it in other ways in other contexts.

### **Anorexia as a discursive parasite**

The writings of Foucault (e.g. 1978, 1988) and others (e.g., Bordo, 1993; Eckerman, 1997; Gremillion, 2002, 2003; Hepworth, 1999; Malson & Ussher, 1996; McNay, 1992; Probyn, 1988; Sesan, 1994) have brought to the fore glimpses of the ways in which Western societies have discursively instituted practices of disciplining the self and the body. At the same time, these discursive formulations act to constitute for us what it is to be a self, and thereby create the lens through which we experience the world and the demands our society imposes upon how we are to experience these worlds we live in and through. Our “selves” become “factual objects”, and power operates as a “natural discourse” through “the pretension of transcending [words] into a factual system” (Barthes, 1972, pp. 131-134). Our selves have a “performativity as citationality” – an existence brought into being in the act of ‘being ourselves’ - that comes from the establishment of ‘normative conditions under which the materiality of the body is framed and formed’ (Butler, 1993, pp. 12 & 17).

Accordingly, people “work” deliberately to discipline their bodies (as well as their minds and relationships) to meet the normative demands of being “a person of good standing”. The external gaze and established public penalties that may have ordered our conduct in times past have become instituted internally as a system to police us to conform to ideals of health, beauty, wisdom and success. We punish ourselves for our own transgressions as a taken-for-granted part of being a good person. It is habits such as these that anorexia preys on, and given the slightest opportunity, will co-opt to its own purposes. Anorexia seduces a person by promising itself as the very means to realise the person’s desire to perfectly realise these internalised ideals. And once the person has been taken in, anorexia incites the person, largely by subsuming and then ventriloquizing her voice, whereby her demise is the almost inevitable solution to ever-increasing

demands for Perfection. This tactic then insulates anorexia from attempts at “treatment”, because the medical narrative fails to cast the person and anorexia as separate, but conflates them as one voice. The “patient” can then only respond to the “treatment” by excelling at anorexia, which continues to define her. For example, here is David Epston in conversation with Kris, aged 17, at their second meeting:

David: We were just reviewing the first meeting and I asked you what your response to that meeting was and you said that it made you feel more confident because we talked about quite positive things. And you said that you had been to some other people and they did something different. What was the difference?

Kris: The difference was that they talk about how long have you had anorexia, how bad it has been and what things you do . . . how many times you make yourself sick a day ... you end up believing that you are anorexic. Because I believed I was anorexic, I felt I actually had to compete, that I had to be a better anorexic than others.

If the person is identified as anorexic, “treatment” naturally focuses on the person. How could this person, one might wonder, possess such an adamant and unwavering conviction about their own “badness” and “fatness” and, furthermore, continue to cling to this truth even to the point where her body’s only hold on life is at the end of a feeding tube? Even if professionals were to seek the knowledge of people trapped in anorexia/bulimia about anorexia/bulimia, as long as they view the problem as entwined with the “self”, they will be more likely to ask questions about the person’s feelings, thoughts, relationships, and history than to ask questions about anorexia/bulimia and its relationship to the person. The results of such an enquiry often leave the person feeling even more identified with anorexia/bulimia. In addition, this linguistic trick of identifying the person and the problem as one and the same bemuses and paralyses those who are outsiders to anorexia, because they can only see the inexplicable outcome of anorexia’s influence upon the person, *rather than the means by which this influence has been exerted*. And to compound the problem further, by maintaining this identification, any account offered by the person is rendered untrustworthy, since it can be taken to be tainted by the problem itself. That is, the distinction between the person and the problem is blurred or altogether lost, and, thus, any account of the problem by the “problematic person” could itself be viewed as problematic (Epston, Morris & Maisel, 1998; Maisel, Epston & Borden, 2004).

We suggest that here, then, any counter-narrative that can be engendered can only be effective if it steps outside the premises of the dominant narrative. A counter-narrative cannot just be an act of resistance founded on the same footing, but must radically challenge many of the foundational presuppositions on which the dominant narrative is built. Once this is done, other resources of the dominant narrative can be co-opted back to the purpose of resistance. That is, resistance can be retargeted, and the person’s abilities to use the rhetorical and

other discursive resources of their language can be brought to bear on the newly-visible enemy, instead of against themselves. Otherwise, anorexia remains a modern “regime of power” (Foucault, 1977) that operates in a characteristically invisible way. It does this by adopting the dominant cultural narrative as its own, and sharpening it to such a keen edge that it cuts deeply into the flesh of anyone who holds onto it.

By separating anorexia from the person, it becomes possible to ask about anorexia’s tactics of voice, about its rhetorical strategies, the moves it makes, its attempts to cover its tracks in order to deny its effects. The reality of the effects of anorexia on the experience of those caught up in it is such that, within the constraining pool of the dominant narrative, young women are effectively blinded to the horrifying physical effects on their bodies that are so obvious to witnesses. Its concealment and disappearance is achieved by its ability to co-opt the sense-making abilities of the person, so as to thoroughly take over and obliterate their own voice with it’s own, to create an imposition of meaning which is accomplished through a sophisticated use of language. Anorexia speaks in many guises, including that of a friend, confidant, lover, coach, logician, belittler, bully, inquisitor, and judge. Many of these representations have in common the effect of conveying meanings that convince the person that they possess moral flaws or deficits that reside inside themselves and their bodies – what Sandra Lee Bartky (1990, 1998) refers to as the “inferiorization of the body”. These flaws and defects can only be remedied by operating on their bodies and their “self” in cruel and exacting ways. Anorexia provides the grounds for practices that insidiously consolidate the problem while masquerading as solutions. Anorexia is advantaged by the contemporary psychological discourse that conflates persons with problems that consequently makes it easy for it, like a skilled puppeteer, to continue to pull the strings of their lives.

By separating the problem from the person, narrative therapists have provided themselves with an opening through which to gain some comprehension of the relationship anorexia can have with a person. It becomes possible to ask what practices anorexia/bulimia can adopt to transform highly intelligent and, in many respects, “model” girls and women (and sometimes boys and men) into accomplices in their own torture and execution. How does anorexia seduce or terrorize its victims so successfully that they seek refuge in its deadly embrace? And how does anorexia inflict painful torture, deprivation and even death, while convincing its victims that they are being saved, improved, and perfected? As answers are formulated to these questions, it becomes possible to strive towards counter-practices that first expose, and then resist and repudiate such a would-be murderer.

There is insufficient space here to discuss fully the repertoire of counter-practices that have been found (see Madigan & Epston, 1998; Madigan & Goldner, 1998; Maisel, Epston & Borden, 2004, for this). Rather, we give here as an example an unashamedly long extract from a session involving David Epston, Caroline and

Paula Parsonage (Epston, 2001) in which a few of those tactics are implicitly demonstrated. This consultation meeting with Caroline and her therapist, Paula Parsonage, follows the Mental Health Service's decision, made known to all the concerned parties, that no further extraordinary efforts to save her life will be made following her discharge from her fifty-third hospital admission over a twenty-three year period. Paula Parsonage, who worked for another agency, decided to retain contact with her in spite of this.

In the same way in which we have been developing a contextualisation of anorexia up to this point, this extract also needs to be contextualised within narrative practice as specific to this particular session. David's tactic of speaking as the voice of anorexia is not one that would be routinely adopted by a narrative therapist. It is fitted to the person, the history of the therapeutic relation, and, in this instance, the dire circumstances. More usually, the approach would be along the lines implicit in Alice Morgan's talking with Madeline (2000, above), of exploring the nature and tactics of the problem; moving on to discover when the person has shown strength in resisting the problem; elaborating on that strength so that the person realises they are not without resources in the face of adversity, and so on. Anorexia, however, has the character of a double-bind with respect to its victims "strength", for to actively resist the very real feelings of hunger and so on that come from a regime of starvation requires the possession of a massive disciplinary strength, and maintaining this discipline over twenty-three years and fifty-three hospitalisations is, paradoxically, a quite remarkable achievement. Caroline's strength has led her to a dire situation through a great deal of practice, and the situation demands some desperate measures if, as she has indicated, she wants to come out of it alive.

The following is extracted from near the beginning of their third meeting.

DE: Do you want anorexia to speak for you and demand your death or do you want to speak for yourself?

C: I want to speak for myself....

DE: Okay, you have been taking some steps in an anti-anorexic direction?

C: I have been trying to...I have been trying to get involved with various groups and people.

DE: "Groups and people". And what does anorexia say when you think it is a pretty good idea to get involved with groups and people?

C: I don't know.

DE: Do you want me to be anorexia and you be you?

C: Okay.

DE: You have been thinking some thoughts of your own and I don't like it!

C: Oh, too bad! (laughing)

DE: Oh, it's all very well for you to get smart but you need to depend on me. After all, I have looked after you for the past 23 years. I have been looking after you.

Caroline initially identifies some anti-anorexic steps she has recently taken. Because she is still largely dominated by anorexia, undoubtedly these steps represented moments in which she succeeded in overcoming the “voice of anorexia”. David reasonably assumes that anorexia would continue to construct meanings so as to undermine these steps. The fact that Caroline is unable to identify this voice suggested to David that she was unable, at that moment, to disentangle “her” voice from “the voice of anorexia.” David offers to “be anorexia” so that “you can be you”, which is in keeping with her previously expressed desire to speak for herself, rather than to allow anorexia to speak for her.

By embodying the “voice of anorexia”, David articulates what he imagines anorexia might be saying to her, based on his previous conversations with Caroline, as well as on the sum total of his familiarity with that “voice” from his years of conversing with other women who have been subject to anorexia. By giving voice to anorexia in an attempt to make its presence more tangible and therefore more contestable, David is not merely speaking the very words he thinks anorexia might speak to Caroline. Instead, in some instances, he voices what he believes anorexia is, *in effect*, saying. In the above exchange, for example, Caroline would probably not hear anorexia speaking to her about some thoughts of her own, but instead would just denigrate these thoughts. David, by using this expression “thoughts of your own”, helps Caroline see what anorexia is, in effect, doing; belittling any attempt to steer her own life in a preferred direction. Because Caroline values “thinking her own thoughts”, David voices anorexia as an assault on this value and thus invites Caroline to perform an anti-anorexic counter-narrative in response to this assault.

- DE: Oh, it's all very well for you to get smart but you need to depend on me. After all, I have looked after you for the past 23 years. I have been looking after you.]
- C: That's what you do (becoming distressed).
- DE: Look, if only you were perfect.
- C: (increasingly distressed) I can't. I just want you to go away (crying).
- DE: I like you a lot.
- C: I don't like you.
- DE: I am a very good friend of yours.
- C: Look how I look (crying).
- DE: You look beautiful. You look beautiful.
- C: I am wrecked.
- DE: They don't know anything. Just listen to me.
- C: You nearly got me there the last time I was hospitalized and killed me.
- DE: No, no. All those people, just leave them alone and come with me. I will take you away to heaven.
- C: No you won't. You have put me in a nice lot of hell. That's what you've done.
- DE: Are you trying to suggest that you don't like me anymore?

- C: Those people are all involved with the church. And I am different than I am with you... drinking and all that crazy-type stuff...
- DE: Just come with me...
- C: No, you are not going to get me...
- DE: Caroline, just come with me and do what I say.
- C: Go away...
- DE: I will give you peace.... eternal peace...
- C: You will give me hell.... you've put me through enough of it already...
- DE: Can I get back to being David?
- C: Yes....

At this point David wants to resume his therapist persona so as to be able to emphasise the points that have emerged thus far in this dialogue, to adopt a reflective position on the conversation.

- DE: You are pretty feisty....strong. If I was anorexia, I would have felt that you really [didn't] want me around. I would have felt the weight of your dissatisfaction with me. Did you feel that way?
- PP: Yah..."Go to hell" was pretty strong. It felt good being on this side of the room.

In the next portion of this meeting, David elects to speak to Paula as if he were anorexia. This allows Caroline to assume a witness position, affording her a little more distance from the anorexic duelling. It is David's hope that this increased distance might provide a platform from which Caroline might more easily reflect upon these two duelling versions of morality and identify her own moral position. In addition, Paula now becomes the spokesperson for anti-anorexia and contributes to a thickening of the counter-narrative about anorexia and Caroline.

- DE: Paula, can I just talk to you as anorexia, do you mind? "I understand you have been putting some ideas into my friend's head that she shouldn't go out with me and live her life according to how I want her to live her life. Why do you think you know so much? Give her to me. She's my friend, not yours."
- PP: I guess the difference between you and me, anorexia, is that I want to stand beside her and share some of the joys and sorrows of her life and I don't like that you want to control her. It's wrong; it's not what a friend does.
- DE: Look, you weren't around for the last twenty-three years. Without me, where would she be?
- PP: I think she might be a lot happier, doing a whole lot more things with her life than spending it with you.
- DE: That's all very well for you to say but if she would just try a little bit harder, she could make it. If she would just try a little bit harder. She doesn't try hard enough. She doesn't please enough people.
- PP: I hate when you talk like that, because "Perfection" is not something anyone should seek to achieve. It's a game.... a pathway to destruction. I

don't feel comfortable talking to you like this. You are just playing a game and you are a liar. I have to say that.

DE: Well, who is Caroline going to believe, me or you? I have got a lot going for me. If she would only be Perfect, I would give her everything.

PP: What would you give her?

DE: Perfect happiness...and every dream she had would come true. Every dream she has ever had in her life, I would make it come true.

PP: That's a lot to believe.

DE: Look at all the other people I've helped.

PP: Like whom?

C: Can Karen Carpenter be No.1?

DE: Yes, Karen Carpenter! Without me, she wouldn't have been such a great singer.

PP: Without you, we would still be listening to Karen Carpenter. She was a great singer.... a wonderful singer..

DE: Oh well, she just didn't get down to the right weight.

PP: I think your promises are based on nothing that I've seen anywhere. Nothing good and lots of bad things. It's up to Caroline to decide who she believes.

DE: So it is between you and me?

PP: Well, it seems to be. Certainly when David was reading the letter, it really hit me that in some ways it is between what you believe in and what I believe in. It also struck me that Caroline had listened to you and that made me feel very fearful that you may win this battle for her life.

DE: I am glad that you recognize that Caroline really prefers me to you.

PP: I didn't say that. I said that you are still speaking to her and she was still listening. I don't think Caroline has decided whom she prefers. I think she is still deciding.

DE: Caroline doesn't know anything. Caroline knows what I tell her.

PP: That's not true.

DE: Well, what does Caroline know?

PP: Caroline knows lots of things about what she wants, what she likes, and what she can do.

DE: Yah, but she is guilty. She has no rights.

PP: I don't believe that. You know I don't believe that.

DE: Well, I know this will have to go to Court but you know she has believed this for twenty-three years so why shouldn't she just go along with me for the rest of her days?

PP: I don't think it is right to say that she has believed it. She has listened to anorexia and tried it out. And she keeps trying it out. But if she totally believed it, you would have had her by now.

DE: Well, I almost got her late last year. I thought I had her. She really believed in me then. I think it was you that really wrecked it for me. If you didn't show up at that hospital, she would be with me. You stole her from me, because you wouldn't go along with what the hospital said. Why did you not go along with your colleagues?

- C: (interrupting) I nearly died on those drips...I blew up like a balloon....
- PP: I hadn't met you...or been seduced by you. And I don't like what you stand for. So I didn't choose to go along with you and I won't.
- DE: I can see that I am not going to get very far with you. So I guess this is it between you and me. I don't think I'll spend much time talking with you any longer. But I'll prove you wrong. I'll take her.
- PP: I don't think so.
- C: (interrupting again) Don't talk to me anymore either, you anorexic wretch. You can go away. I have had enough of it.
- DE: You are just listening to Paula. And she is just johnny-come-lately and I have been with you for so long that you might as well just stick with me.
- C: I have been dead for the past twenty-three years with you hovering around me. The last couple of years have been hell.
- DE: You are hurting my feelings.
- C: Just go away. I don't care what you think. Paula is on my side. So just go away.
- DE: I might just try to come back but I've got the message.
- C: Don't try and come back. Just go away.
- DE: What about if I could just come on weekends? What about if we could become apartment mates?
- C: That's the trouble. Go away. It's nice to have a little bit of company in the place. And you're still hovering around. You're not there when I have a bit of company.
- DE: Tell me some of the people who you think are preferable to my company?
- C: BIG FAT FRIENDS.
- DE: Are you hanging out with fat people? (shock) Oh God no!
- C: You don't look very thin to me (laughing).
- DE: Hey, do you mind me being David again? I noticed you had a bit of fierceness there. You remember you saying you were "helpless" - you're not so helpless. Would you agree, Paula?
- PP: Yah, I would.

This conversation represents an extreme instance of “externalizing conversations” (Freedman & Combs, 1996; Payne, 2000; White, 1989; White & Epston, 1990), a key practice within narrative therapy, in which the presence and operations of anorexia can be flushed into the open. It is extreme in that there are a number of points where David might well have stopped “being” anorexia because it is not normal practice for a therapist to push on with a conversation to a point of almost jeering at and mocking his or her client. Having assumed the persona of anorexia does not give him carte blanche to jettison ethical practice.

But in this case his client, Caroline, has an extensive experience of identifying herself as anorexic, and thus is well aware of “her” habits of thought. She knows the moves “she” makes, though in not previously having entertained that these might not be “her” thoughts, but a parasitism of her skills for another’s – anorexia’s -purposes, she has not been able to stand outside of them. She

“knows” the circles and knots she goes around in. She knows the strange loops of logic whereby her attempts to “prove” to herself that she is not weak turn out to be demonstrative of her very weakness. She knows that if she resists one set of doubts and overcomes them, even if only momentarily, that her doubts will shift their ground, just as an alcoholic knows that when having resisted one reason to have a drink, another will pop up, with another set of procedures for justifying it as OK. We all recognise, on occasions, this “Precious/Gollum-complex” in our own lives. Thus, David “pushes it”. In Caroline’s situation, it is not enough to show a single resistance to a single challenge. She needs to be pushed into a defiance of a string of wheedling, to find her strength in this reconceptualization of who she is and who she isn’t, by being pushed through exasperation to the point of exhaustion. It is a therapeutic situation of “your ethics, or her life”, and David takes the risk.

In the end, Caroline’s strength comes through. “Don’t try and come back. Just go away” makes her point, but it doesn’t work, for it puts the onus on anorexia to “do the right thing”. This is the last thing anorexia will do: “What about if I could just come on weekends?”. That is the trouble with anorexia: “Go away. It’s nice to have a little bit of company in the place. ... You’re not there when I have a bit of company”. So, “Tell me some of the people who you think are preferable to my company?”. And here, Caroline “finds herself” and re-establishes her agency in her own affairs with a calculated insult: “BIG FAT FRIENDS”, and reinforces this by re-crossing the boundaries of charade and reality with another skilfully crafted insult which gives David his opportunity for closure.

### **Radical counter-narratives**

Prior to the conceptual and linguistic twists that are being constructed in these extracts, there are few linguistic resources with which the subjugated person can represent anorexia. There only exists the repertoire of self-blame, self-reproach, and self-hatred, premised on the grounds that it is the self that is “doing the anorexia”. The identification of self with anorexia inexorably leads to guilt. The lack of alternative linguistic, conceptual and narrative resources leads, logically and rhetorically, to a voicing of the person as the problem. Externalising conversations reverse this process, linguistically and conceptually constructing anorexia as a force or influence separate from the person, and inviting the identification, objectification, and critique of anorexia and its voice; the construction of an “enemy” that could not otherwise be identified; and a moral crusade to repudiate it.

Thus, the practice of countering anorexia with externalising conversations that has been constructed by narrative therapists provides a separating of “the person from the problem”. Externalising conversations can provide a release, and a clearing for an objectification of that which was otherwise integral to the self. They can also counter the guilt that is constructed through the resources of the dominant narrative in which that self has come to have its very existence. The

study and encouragement of counter narratives must, we suggest, be taken much further than the investigation of those of “gentle defiance and resistance”, reported by Andrews (2002) and Throsby (2002), and into far more radical territory.

Coming out from the shadows of the dominant discourse, an anti-anorexic counter-narrative fiercely contests it, by way of a “duel” for the very life or death of the contestant. Here is a succinct concluding example:

D: Chloe, you mention that "I have managed to resist anorexia's commands that I lose weight". Can you write that up in some detail?

Chloe: I guess I really “dug deep” and asked myself some questions. Why do I feel I need to be the “thinnest”? Is that something that I want to be “known/admired” for? If I were to be hit by a car and die tomorrow, would I want to be remembered for my “success” at being thin or would I prefer to be remembered for giving all I could to my family, friends, community and living life to the fullest?

This is what I concluded: "I don't wish to be “known” for or “admired” for being the “thinnest”. If I were to die, I would much rather be known for being a good friend, family member and person to those around me and be remembered for the things I value and “stand for”, rather than being remembered as the girl who was “oh so thin” or “very sick”. I despise the way that our society puts so much emphasis on shape/weight and do not wish to buy into those values, and by acting on my feelings of “wanting to be the thinnest”, I would be giving the message, although unintentionally, that I too place meaning and value on weight/shape.

This is what anorexia had to say: "So you want to be remembered for being something other than just “thin”? Well, that's all very well for anyone else but as you know, you are a bad person and are completely worthless and therefore if you are not thin, you are nothing .... absolutely nothing. So... here's your choice - you can either be a fat nothing or a thin nothing... which would you prefer? You know that there's nothing worse than knowing you are a fat nothing and therefore, your only choice is to be a thin nothing. Yeah, I know it would be better to be remembered for what a great person you are and what you contribute to the lives of those around you but unfortunately you don't have the option because you are a hopeless failure. Bad luck, but hey, it's okay because by starving yourself, you can punish yourself for being the worthless nobody you are and that feels good".

Asking these questions and thinking about what losing weight would really mean for me helped me stop and “gather” myself before I launched down the weight loss “path”. Although anorexia didn't let my responses to the questions go

untampered with, my “anti-anorexic answers” were able to hold sway, only just, over the “anorexic” ones.

We see, then, that it is only through reformulating the “ground rules” of the discursive topic that resistance becomes possible. Without this reformulation, Chloe faces a situation given to all of us by the ways in which we constitute ourselves through our culture’s resources: the identification of “our” thoughts as “our” thoughts. This reflexive identification of “self-as-knower” and “self-as-known” provides an almost irresistible logic of rational despair: “I want to do this, but I have many doubts about my ability to accomplish this, so I hate myself.” This is a reasonable tactic within the discourses that construct the individualised self of occidental cultures. We can even construct the tactic of dissociating ourselves from our achievements so as to maintain such self-loathing. A talent or a gift can enable us to do something well, but we do not necessarily identify ourselves with that talent or gift, and so can feel unfulfilled because our achievements are not are own. Alternatively, we can identify with our talent or gift, but resist, as “perfectionists”, accepting what we have produced as valued. Selves are thought to have essential characteristics, rather than to be constructions that, as Vygotsky (1962) essays the process, first exist in the relationships between people, and which are subsequently taken “inside” us as we adopt, for our own purposes, the words of others. Our autonomy is constructed rather precariously, and while we have ways of offloading our self-investment in certain of our activities, we do not possess legitimate ways of doing that for our own thoughts: to claim that the “voices in one’s head” are not one’s own is not a viable tactic in our current situation. Perforce, we must identify ourselves with our thoughts. But the therapist can, in this situation, provide the resources that resonate through the fog of the previous resources the client has had to work with. Revealed in this way, the insidious logic of the dominant discourse can be deflected by counter-narratives such as these anti-anorexic ones from their otherwise inevitable “dead end”.

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