

Resisting anorexia/bulimia: Foucauldian perspectives in narrative therapy

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ABSTRACT

Foucault's analysis of 'unseen power' as it operates in discourses that construct 'practices of discipline' and 'technologies of the self' has been a central conceptual resource in the development of Narrative Therapy. Narrative therapists take the view that unseen aspects of power work to construct both how a person understands their situation, and how their relation to 'the situation' they find themselves in has been constructed through the discursive resources available to them. If the consequences of the operation of these discursive resources can be brought into view, then alternative resources may be mobilized to resist the problems that have been created by the 'power' of the discursive resources that are available in the *status quo* of people's cultural milieu. Narrative therapists work to disentangle the person from the problem, against the grain of the common constructions available in the resources of Occidental cultures that work to identify the person as 'the problem'. This is demonstrated in the assistance they offer to people in finding ways to resist anorexia, by identifying anorexia as the problem, and not the person as anorexic. In this perspective, other apparent tactics of resistance – such as the tactic termed 'pro-ana' – are revealed as counterfeit, and ultimately supportive of the problem situation.

INTRODUCTION

Foucault's writings provided a prominent impetus to the beginnings and subsequent elaboration of Narrative Therapy by White (1989; 1995; 1997; 2000; 2003; 2004) and Epston (1989; 1998; see also Epston and White, 1992). This influence of Foucault, however, needs to be seen in two contexts. First, it needs to be seen in respect to the times in which narrative therapy had its stirrings. The Australasian book by White and Epston (1990) entitled '*Literate Means to Therapeutic Ends*' was published in Australia in 1989, with the retitled edition '*Narrative Means to Therapeutic Ends*' released internationally in 1990. Preparation of the manuscript took place between 1987-1989. Second, it needs to be placed in relation to other writers whose work feeds into White and Epston's approach: Bateson (1972, 1979), Bourdieu (1988), Bruner (1990), Derrida (1978, 1981) Erickson (Erickson, 1954, 1979) (an influence on Epston but not White), and Turner (1969), for example. We make no pretence of being exhaustive here. Neither are we aiming at providing an academic scrutiny of minutiae or nuance as a definitive account of the intellectual history of the elaboration and practice of narrative therapy. Rather, we are painting with a broad brush to set a scene. The scene we refer to here is the practice of anti-anorexia/anti-bulimia (e.g.,

Lobovits, Epston and Freeman, 2004; Maisel, Epston and Borden, 2004).

'FINGS AIN'T WHAT THEY USED TO BE'

(Book by Frank Norman, Music and Lyrics by Lionel Bart; Produced under the direction of Joan Littlewood at the Theatre Royal, Stratford, London 1959 and subsequently at the Garrick Theatre, London)

The 1960s certainly changed occidental cultures. While the then British Prime Minister Harold Macmillan, almost the last member of the British Ruling Class to hold that position, might have been able to observe that 'the winds of change' were blowing through Africa, he was ill equipped to reflect on the turmoil that was about to engulf the Establishment in the trans-Atlantic nexus of white interests that had been produced by technological revolutions over the previous two centuries. That turmoil had many roots (see, e.g., Cate, 1988; Marwick, 1998). The events of the 1960s did for secular life what the rise in secular life had previously done to the power and authority of an established order presided over by the institutions of Christianity. It brought what had previously been invisible and taken-for-granted into question, and by doing so rendered it contestable. That questioning was galvanised in the 1970s by the translation of a number of Foucault's works into English that have come to be known as the 'early Foucault' (e.g., 1970, 1972, 1973, 1979). Prior to Foucault, it was enough to question why things were as they were to spark a revolution, as Lenin had achieved through his reading (and implementation) of Marx. What Foucault made available for consideration was how the objects of the human world came into being. Where early feminists at the end of the 1960s might protest at their moral disadvantages in the face of the inherent sexual discrimination entrenched in the traditional structure of society, the Establishment could, with the aid of pop-biologists and later the 'respectable' science of sociobiology, justify the situation as a reflection of 'the natural order of things'. What Foucault's analyses produced was a dawning grasp that things might not be quite like that: that much of the human world was not naturally given; that language was not neutral in describing a world of pre-given facts about the 'nature' of people. Rather, much of what people thought to be 'of nature' had as its provenance the very symbolic resources they grew up with, resources that enabled them to talk about objects and events as they were constructed by these selfsame symbolic resources. This was in clear opposition to the more naïve presumption that such objects and events were actually given in nature as real, but hidden, phenomena that science and technology worked diligently to uncover in order to discover them.

This alternative view would have been familiar to the Anglo-Saxon intelligentsia from Wittgenstein's later philosophy (e.g., 1953) where he indicated that words were used in 'language games' that constructed 'forms of life' rather than directly mapping onto a pre-given reality so as to accurately picture it. But Foucault's additional twist on this point let more than Wittgenstein's metaphorical 'fly-out-of-the-bottle'. Where previously Marx had taken society to be grounded in power relations between given sectors of society, Foucault reconceptualized 'power' in a radical way: power not only positioned people, it also 'created' them: there was positive constitutive power as well as negative repressive power. Thus, according to Foucault, sectors – or classes – of society did not just pre-exist as entities destined to get into power-struggles - impositions and resistances - amongst themselves. Rather, the exercise of power, by humans, created – almost out of nothing – the sectors and classes themselves. And, most importantly, this exercise of power, in the way that Foucault was essaying it, created selves, and technologies whereby the so-constituted self eventually – in our recent times - disciplined itself. Let us take some examples directly from Foucault here for the purpose of clarification. These will help us grasp why Foucault's writings had their particular effect in the elaboration of narrative therapy and particularly its anti-anorexia/anti-bulimia stance.

SELVES, BODIES, AND DISCIPLINE

Foucault's appeal (e.g., 1988) to Jeremy Bentham's design for an 'ideal' prison – the Panopticon – needs little elaboration as a guiding metaphor. What we need note, however, is Foucault's slant on the relation between technology and personhood through the construction of new ways of exercising power over selves, and thus, through this exercise, the making of new selves, and the conditions for these new selves to reproduce themselves. The Panopticon design might be thought of as a time-machine for tinkering with the temporal relation between action and, in this case, its negative consequences. For millennia of human existence, retribution for stepping out of line was immediate, because our existence was played out over the short distances of interpersonal action. What Bentham's Panopticon design did was to extend the gaze of the public into the realm of the private, increasing the odds that one would not transgress, because this gaze had become 'psychologised' as part of the apparatus of individual self-control. This, Foucault argues, acts to increase the time-span over which a person needs to exercise a psychologically-enforced self-constraint upon their own actions. A new kind of self is elaborated: 'persons are incited to perpetually evaluate themselves, to police themselves and to operate on *their* bodies and souls to forge them as

docile' (White, 1993: 51, emphasis added). Previously, people tended to operate on other people's bodies:

If one were to do a history of the social control of the body, one could show that, up through the eighteenth century, the individual body was essentially the inscription surface for tortures and punishments; the body was made to be tortured and punished.... From the nineteenth century onwards, the body acquired a completely different signification; it was no longer something to be tortured but something to be moulded, reformed, corrected, something that must acquire aptitudes, receive a certain number of qualities, become qualified as a body capable of working' Foucault, in Faubion, 1984: 82; originally 1973).

Foucault's illustrative analysis of the Panopticon outlines how the structural characteristics of such an operation of power over people's actions recruits people into complicity in the subjugation of their lives and their bodies. There arise what he terms 'technologies of the self',

'which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (1988: 18).

The insidious part of this collaboration is that it occurs unawares, because the norms for behaviour through which a person lives their life are just that: they are unseen 'constitutive truths' as to 'what life is about' that become 'rationally invisible'.

FOUCAULT AND NARRATIVE THERAPY

The above Foucauldian analysis has been central to the development of Narrative Therapy, particularly as essayed by White and Epston (1990) and their colleagues (e.g., Epston, Morris and Maisel, 1998; Freedman and Combs, 1996; Freeman, Epston and Lobovits, 1997; Monk, Winslade, Crocket and Epston, 1997). Selves, identities, and our relations with each other, for example, are, in this view, at least in part an outcome of how these 'things' we 'possess' have been constructed. If, for example, we take Mead's (1934) view that the development of a self involves 'taking on the attitude of the other', and if that other's attitude to us tells us we are 'bad', then we come to regard ourselves as 'bad'. The twist that Foucault (above) adds to the Meadean view is that the other's perceptions of what constitutes 'being bad' is, in large part, the result of the sedimentation of regimes of

power into the construction of somewhat historically-arbitrary standards of judgement, so as to make them appear as somehow essential truths and timeless, universal moral standards. Hence, the reformulation of some problems that people might experience as a result of operating according to this rationally-invisible way of making sense of their situation makes them potentially soluble – or at least open to resistance – when what warrants these problems as ‘real’, as ‘how things must be’, is made visible and thereby contestable.

Before we make any of this concrete with examples of how a narrative perspective is employed in therapeutic situations, it is important to state some caveats around the notion of ‘historically-arbitrary standards of judgement’ that was just introduced. Narrative Therapy draws on post-modern and post-structural ideas, and these can often, simplistically, be taken as stating that ‘everything is arbitrary’. This simplification can lead, via the metaphoric co-option of catch-phrases such as ‘The Myth of Mental Illness’ (Szasz, 1972), to the view that Narrative Therapists do not believe that, for example, mental illness exists: or that they do believe that medication is inappropriate; etc. This, however, is not the case. Michael White makes this clear in this interchange with Ken Stewart:

- Ken: So, you don't have a position on aetiology?
- Michael: To answer your question, I have always resisted taking a position on the aetiology of the so-called psychiatric disorders. In fact, I have consistently refused the incitement that I have experienced to step into a position on this, and to enter into debates and other activities that depend upon such positions. I am willing to consider most notions of aetiology, but, quite frankly, these considerations are as irrelevant to what I do in this work as they are for others.
- Ken: Does this mean that you are even willing to entertain some of the current biological notions of aetiology for what is referred to as schizophrenia?
- Michael: Of course! Of course! But this is not relevant to what I do. ... I am simply talking about standing outside of the territory as it is defined by psychiatric knowledge, and as it is structured by pathologising discourses. I am not talking about standing apart from people and their experiences, including those experiences that are so often taken up into pathologising discourses.
- Ken: Okay, what are our options?
- Michael: I think that we can assist people to challenge the hegemony of the psychiatric knowledges. We can work with them to identify the extent that their own lives are "knowledged". We can engage people in conversations that are honouring of their knowledges of life, and that

trace the history of their knowledgeable. We can join people in conversations that provide the opportunity for them to build on these knowledges, and that assist people to develop plans for applying this knowledgeable to those experiences that they find troubling. We can make it our business to work collaboratively with people in identifying those ways of speaking about their lives that contribute to a sense of personal agency, and that contribute to the experience of being an authority on one's life. And we can assist people to draw distinctions around these ways of speaking and those other ways of speaking that contribute to experiences of marginalisation, that subtract from a sense of personal agency, and that undermine an appreciation of one's authoritativeness.

Rather than referencing what we do to the sort of formal systems of analysis that we have already discussed, we can strive to build on those developments in our work that are more referenced to people's experiences of life, including of psychotic phenomena. We can find ways of attending more directly to people's experiences of life. And we can join with people in challenging those relations of power that inform the subject/object dualism that I referred to earlier in this conversation (White, 1995: 121-2).

The issue is not 'What is mental illness *really*', but how does a person make sense of their situation. The issue is not 'Is there *really* a problem'. The issue is 'What sense does a person make of 'their problem''; 'what relation do they have to this problem'; and thus 'how might their relation with the problem be changed so as to make it less troublesome'. We might, for example, consider an eating disorder as 'a problem'. What is at issue is not whether people have problematic relations with eating, which, of course, some do. More at stake is how someone might make sense of this problem. Hepworth (1999), for example, has pointed out how Western ways of making sense of self-starvation have changed quite markedly over historical time: medieval women who adopted this practice were regarded as Saints who were shedding their attachment to worldly pleasures and sustaining themselves on heavenly rather than physical nourishment. These women did not relate to their experience through the modern discourse of 'anorexia'. Similarly, the Delphic Oracle was revered for hearing the voices of Gods, rather than positioned as 'schizophrenic'. Such Oracles were revered as 'blessed' rather than marginalized as 'ill'. The different discourses in which their experiences were available to be constituted and made sense of place both of these historical examples in very different relations to very different 'problems' than their modern counterparts. We will focus here on eating disorders, and how they may be approached differently.

THE DOMINANT MODERN DISCOURSE ON ANOREXIA NERVOSA

The National Centre for Clinical Excellence (NICE) in the UK has recently published (2004a, b) guidelines for the treatment and management of eating disorders. As a 'Centre for Clinical Excellence' jointly representing the British Psychological Society and the Royal College of Psychiatrists the views stated in these guidelines may, with some confidence, be taken as representative of the most expertly-informed 'state-of-the art': the scientific last word. Two quotations from these guidelines are illustrative of the medical view of anorexia:

Anorexia nervosa is an illness in which people keep their body weight low by dieting, vomiting, or excessively exercising. The illness is caused by an anxiety about body shape and weight that originates from a fear of being fat or from wanting to be thin. How people with anorexia nervosa see themselves is often at odds with how they are seen by others, and they will usually challenge the idea that they should gain weight. People with anorexia nervosa can see their weight loss as a positive achievement that can help increase their confidence and self esteem. It can also contribute to a feeling of gaining control over body weight and shape. (NICE, 2004a:11).

1.1.6.2 When screening for eating disorders one or two simple questions should be considered for use with specific target groups (for example, "Do you think you have an eating problem?" and "Do you worry excessively about your weight?") (NICE, 2004b: 9).

The medical view is that anorexia is an illness, and one that is identified with the person who has it – as revealed both by its cause, how those people who have this illness are the loci of their fears and anxieties, and by the identification of them as being the 'owners' of the problem. It is a small step from positing anxiety as the cause of anorexia to viewing the person who has this illness as anxious and essentially flawed, and in need of expert help. Another example from these Guidelines adds to this picture:

1.2.2.1 Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions focused explicitly on eating disorders. (NICE, 2004b: 10)

All these approaches implicitly adopt the approach that there is something wrong with the person and/or their family: something that

requires an expert to correct it, and then the person can be considered as 'recovered'. Narrative Therapy takes a different approach.

THE NARRATIVE APPROACH TO ANOREXIA: RESISTANCE/ANTI-ANOREXIA

As we noted above when citing White's view of aetiology, Narrative Therapists are not concerned with characterizing what anorexia *really is*. They are concerned with the sense that someone who lives with an eating problem makes of their situation: that is, with how they construct it. The intention is to assist in how that experience might be constructed otherwise. Their interest in Foucault is, first, in how his notions suggest that some of the circumstances people find themselves in arise through the invisible effects by which power-in-discourse operates so as to frame the sense people make of their experience; and, second, his elucidation of the historical twists that have enabled the body to be used as the subject of power. One central notion in their approach is summed up in the epigram 'the person is not the problem, the problem is the problem', which can be made more sophisticated by subsequently noting that, once the problem and the person can be conceived of as separable, the problem is neither the person nor the problem, but the person's relationship with the problem. A second central notion is that of 'externalising conversations'. A third is the realization that if there are any experts in what it is like to 'experience a relationship with a problem', the expert is the person who is experiencing it. We will briefly expand these three points here.

A: 'The person is not the problem, the problem is the problem'

Being a person identified with a problem is a very tight spot to be in, in that there doesn't seem that there is much one can do about one's situation. This is, discursively, the position a person struggling with anorexia is in when they are talked about as 'being anorexic', and construe themselves as 'having anorexia'. If, by contrast, as Narrative Therapists would do, the person is not regarded as the locus of the problem – 'they' do not have anorexia, but rather anorexia has 'them' – they, as people, can linguistically start to be disentangled from the problem, and can discover that they, actually, might be otherwise than how 'anorexia would have them believe themselves to be' (for example, 'worthless'); and perhaps other versions of themselves could be foundational to efforts of resistance to, and refutation of, the newly-defined problem – anorexia itself.

We have previously turned the theoretical stance of the dominant medical discourse on anorexia about face (Lock, Epston and Maisel, 2004). People may, for example, 'have malaria' and suffer its consequences because their bodily systems have been taken over by a parasite, an organism that is quite separate from them. We advanced the view that, for certain purposes, it can be useful to apply this metaphor to anorexia, and view it as a 'discursive parasite', one that takes over a person's voice to use it for its own purpose, its own hegemony over that of its host. Conceived as a discursive parasite, one of anorexia's tactics is to cover its tracks so as to become invisible to its host. It can do this by co-opting those discourses that have already constructed the person to think about and articulate themselves in the ways they do, and promising them all the things they have come to believe they cannot do for and out of themselves: 'Yes, you are bad, but if you come with me, and truly make an effort to discipline your body by being the site for the exercise of this implicit regime of Occidental power that made you, then I (not you, you wretch) will deliver true happiness to you'. A 'discursive parasite' may seem more the product of science fiction rather than fact. But it enables a new relationship with the problem to be inquired into.

B: Externalising conversations

This new inquiry is conducted in Narrative Therapy through what are called 'externalizing conversations' (what Halliday (1976) also refers to as an anti-language, i.e., a language-within-a-language intended to subvert its over-language). Objectifying the problem, rather than conflating it with the person, allows the rationally-invisible practices of Foucauldian-conceived power to be flushed out into the open. Once these can be 'viewed', then the person is able to take a stance with respect to them, and to seek ways to counter the problem as it has now been construed. Through such conversations, people can be enabled to consider their previous experience of the problem as not necessarily 'nothing but the truth', and in its place offers them a glimpse that, now, 'fings ain't what they used to be'. Through participating with the therapist in externalizing conversations, people are enabled to:

- (a) appreciate the degree to which these practices are constituting of their own lives as well as the lives of others,
- (b) identify those practices of self and of relationship that might be judged as impoverishing of their lives, as well as the lives of others,

- (c) acknowledge the extent to which they have been recruited into the policing of their own lives and, as well, the nature of their participation in the policing of the lives of others, and
- (d) explore the nature of local, relational politics (White, 1993: 53).

C: Expertise

Scientific practice is founded in the taking of an objective view. This is a very powerful technique when applied to the material world. However, it can be problematic if applied as an exclusive approach to the human world. The problem is that the taking of an objective view ignores the fact that human beings have an embodied subjectivity, and, by being seen as a powerful technique whereby the 'truth' of a situation is established, the objective stance becomes a standard that acts as a denigrating technology of the self: 'we (professionals) know the truth about your condition; you, as an untrained person, do not.'

What this means is that certain speakers, those with training in certain special techniques – supposedly to do with the powers of the mind to make contact with reality – are privileged to speak with authority beyond the range of personal experience (Parker and Shotter, 1990: 7).

A further consequence of the privileging of the objective position is that it disenfranchises the voice of the person subjected to it, by making how they express their situation a potential symptom of their diagnosed condition.

Narrative therapy takes a different stance, almost reversing this view, adopting the position that people themselves have a more 'experience near' (Geertz, 1983) grasp of their situation than is available to anyone else:

I know no 'problem' as lethal as anorexia/bulimia, given what I have seen with my own eyes and heard tell that is so misrepresented. And those who suffer are equally misrepresented. Once provided with the means to speak against anorexia/bulimia, almost to a person everyone has railed against most of the psychological/psychiatric constructions of them as 'anorexics' or 'bulimics'. The stories - from the insiders - are incomparable to the stories written about them by outsiders. (Epston, 2000).

Consequently, Narrative Therapists (e.g., White and Epston, 1990) have rejected the idea that therapists can usefully access 'objective' knowledge about the problems, or preferred identities, of persons who

seek their help. A therapist is not able to see outside of the narratives and practices that constitute persons' lives and relationships. In addition, while such a claim to expert knowledge is often couched as culturally and politically neutral, it can have the effect of reinforcing dominant cultural assumptions defining illness and health as qualities that are internal to persons, thus recreating the experiences of self-objectification and self-criticism that resource anorexia (see Gremillion, 2003).

By contrast, Narrative Therapists consider the client as having privileged knowledge in relation to the problem, and seek to help the client articulate their relation to the problem by driving a wedge between the person and the problem; and thereby articulating how their situation has been constructed through unseen technologies of the self that have become an integral part of the ordering of everyday life. To be resisted, such cultural practices need to be brought into full view; the client's knowledge recognised as legitimate and expert in their own right; and the objective knowledge system of dominant medical practice revealed as no longer having a monopoly on the definition of the situation. When this takes place, then 'at times, the differences are so vast as to be incomprehensible and then chilling when you consider the consequences for those tormented and tortured by anorexia' (Epston, 2000).

For example, in separating the person and their problem, e.g, anorexia, rather than identifying the person with anorexia as 'an anorexic', the person's understanding and grasp of anorexia can be brought out into the open as something that then can be inspected and challenged. And in doing this, a knowledge can be elucidated of how anorexia insinuates itself by otherwise taking over the person's voice as one they believe to be their own, at the same time as deceiving her that anorexia is the very limit of her expressions. Note that this is a three-part process: separate, inspect, contest. Elizabeth, aged 17, writes (in Maisel, Epston and Borden, 2004: 19-22) about the beginnings of such a separation below:

I made a new friend this year. Confident, strong, in control, my friend understands me as no one else does. His black eyes watch over me as He breathes softly in my ear, whispering secrets about myself. He tells me who I am. He tells me who I should be. Silently and without fear, He gently takes my hand and leads me to the places where He knows I should be going.

Together, We are like two mountain climbers, scaling the face of a dangerous cliff. My friend is always in the lead, comforting, encouraging, coaxing me to keep on climbing. Though the wall is steep and hard to grab on to, though my body is scratched and bruised and broken, and though I keep falling again and again, I continue to follow and obey His orders, intrigued by his promises of the beautiful things We will see from the top. Though I cannot see it, I know it is there, somewhere above, somewhere close, a little higher than I am right now. The top is always just out of reach. I know it is there because He told me so.

My friends and my family, even my doctor - they are jealous of my new friend. They say He has a name, but they must have him confused with someone else. They call him a bad influence and try to push him away. But with each push, my friend pulls back harder. He clings tighter to my fingers, explaining that they do not understand.....

He is not just a friend, but something more. A guide, a counsellor, a teacher, a coach. Each morning He wakes me up early, dictates Our plans for the day. If I do what He says, then I am rewarded. I get to sit down or drink a glass of water. I cannot eat. Only He can.

If these thoughts were to remain available only in and to a discourse that identifies them with Elizabeth as 'her' thoughts; and if they are left there so that the origins of such an identifying discourse are not brought out into the open, there is little chance of a genuine resistance to them becoming a possibility. This, tragically, can happen, and engender an ultimately ersatz resistance (see below). But with the opening of such a separation, Elizabeth is positioned with respect to her situation so as she can begin to inspect and query it. Is 'He' my friend? She continues:

.... He eats at my body, my heart, my mind. He eats at my strength, my energy, my soul. He eats at the bonds that connect me to my family and friends. And even then, he is not full. My friend is always hungry. Licking his lips in satisfaction, he eats my smile for dessert. Are these the actions of 'a friend'? And such an inspection can lead on towards the stirring of a resistance:

Sometimes I get angry with my friend. He tricks me, deceives me, lies to me, leads me on. He makes promises he can't keep, sets up goals that I can't meet. He fills my head with his voice, invading my thoughts so that his words become mine. As I climb the side of the cliff, he offers his hand then snatches it away, laughing as I fall to the ground. He looks down upon me with disgust, calls me weak, then

scolds me for betraying him. It is hard to climb a cliff with his hands over my eyes.

There are many things I like to do, but my friend does not like for me to do them. I like to walk with my dog. I like to read and relax. I like to go out dancing and come home late. I like to sit in coffee shops with my friends, talking for hours and laughing out loud, not caring that all the other customers are staring at us and rolling their eyes. I like to sit on my mom's bed and tell her how my day went. I like to watch Saturday Night Live with my dad. I like to lie on my back on a sunny day, staring at the clouds and imagining what animals they would be. I like to just sit and let my thoughts wander, leading me on a journey with an unknown destination.

My friend does not like when I do these things. He tells me they are bad and I do not question because I know He is right. He is always right. Sometimes He comes along to torment me. Others, He lets me go alone and I wonder if He will be there waiting when I return. Yet I keep on struggling. I keep on climbing (the mountain) in hopes of one day reaching the top, standing proud on that cliff high above the world. And my friend will be there waiting, watching as He always does. I will close my eyes as He swings and joins me around, dancing to the music only We hear. And as We waltz about the cliff so far from the ground, sometimes I worry and I wonder: how will I know when We reach the edge? 'Just keep your eyes closed', my friend assures me. 'I will catch you before your fall'.

Elizabeth provides here a frame for the 'instigation of her dissidence', one she can be assisted in pursuing with the assistance of a therapist and with the support of other 'experts', such as Megan (aged 17) who is a member of the Anti-anorexia/bulimina League (see, for details, Epston, Maisel and Borden, 2004; Lobovits, Epston, and Freeman 2004; Freeman, Epston and Lobovits, 1997), and an expert whose expertise is based in her own intimate knowledge of the ways of Anorexia:

All my life, I have been told that to hate is wrong. Forgive others. Change yourself, not them. No one is evil, just misunderstood.

WRONG

It is O.K. to hate. And that's what you have to start doing. I know that is scary to begin to hate what you feel is your only friend, but when you can finally convince yourself that Anorexia is wrong and evil, the world becomes so much better (Personal correspondence to David Epston, 2003).

Ersatz Resistance: Pro-Ana/Anorexia

Seen in this light, Elizabeth's account provides a new perspective into the NICE statement (2004b: 8) that:

1.1.2.3 Healthcare professionals should acknowledge that many people with eating disorders are ambivalent about treatment. Healthcare professionals should also recognize the consequent demands and challenges this presents.

Through the local 'insider' knowledges that are revealed by Foucauldian-informed narrative therapy it becomes possible for healthcare professionals to further understand this 'being in two discourses'. Elizabeth's account of what anorexia is telling her makes comprehensible that what threatens her is also masked as a friend, and perhaps saviour; and where her Doctor might be jealous of this friend, other Doctors may be even more hostile; and friends require loyalty. In addition, if not externalized, then Elizabeth's account remains what both her treaters and Elizabeth think **she** is 'telling herself': that **she** is bad. Without the Foucauldian analysis of power that informs the narrative approach, health professionals, however much they 'help', may very well reproduce the conditions of the situation that anorexia is exploiting, and thus, not surprisingly, encounter such ambivalence.

In this situation, almost the only options available to the person are to (a) unwillingly go along with the treatment until discharged, so as to 'get out of there' and get on with their 'real life of being anorexic', or (b) resist the situation by resisting help, and thus producing an ersatz-resistance through an increasing identification of themselves with anorexia, and enshrining anorexic actions as the only means of resisting the dominant discourses in which it is embedded. That is, resistance is aimed at the wrong target, and thereby acts to support anorexia's intentions. The paradox here is that without revealing the influences of power in constructing their situation and co-opting them to it, the twisted logic revealed in Elizabeth's account is allowed murderous free-play. And anorexia is unparalleled in twisting logic to its own ends. Witness some of what it says to Kristen, aged 17, a young woman in the grips of anorexia:

Kristen deserves to die if she doesn't listen to me. She might as well just kill herself if she disobeys me because she'll never find happiness. I have the answer to her happiness. I care about Kristen very much – I only want the best for her and I'm striving for here happiness. Nothing can go wrong by listening to me. I'm the only one who tells her the truth and knows all the secrets to how she can gain happiness and respect. I dedicate myself to her. This is my unselfish mission – to save Kristen's life (Maisel, Epston and Borden, 2004: 71; see there, pp. 66- 72, for more on what Anorexia tells Kristen, and

<http://www.narrativeapproaches.com> for David Epston's response to Kristen).

Unsettling as this travesty of deceptions is, the distinction that is occurring between Kristen and Anorexia does portend the possibility of an escape from this prison that would not be available were such a voice to remain identified with Kristen *by Kristen*, in the essentialising discursive resources of the culture at large: 'I deserve to die because I will never find true happiness unless I starve myself...'

This twisted logic further reveals itself in the 'movement' that has come to be termed 'pro-ana/anorexia', where the possibilities for resistance are themselves co-opted by Anorexia for its own ends and to sustain it, rather than mobilized against it. This movement has come into existence through the decentralized, mass-publishing phenomena made possible by the Internet. The Internet allows the telling of uncensored stories, and search engines provide the means for finding these accounts, and of linking them up, of collating them, and the building of resource sites for all manner of human activities. 'Pro-ana' has become the term to describe a position on anorexia adopted by many women who have coalesced in an Internet community, using a range of message boards, bulletin boards, journals, chat rooms and web sites to mobilize their activities. Through these media they talk openly and seemingly honestly about topics such as weight loss (including practical advice and tips as to how to achieve and sustain it), the pride they feel about their 'eating disorders', and many of the day-to-day issues involved in living with an 'eating disorder'.

Underlying themes have made this movement taboo, especially in relation to dominant constructions of anorexia as a disorder requiring treatment and of anorexics as in need of recovery. The media have variously constructed pro-ana as 'disturbing', 'shocking', 'dangerous', and as 'preying' on young women and girls through 'glamourising' anorexia, and promoting it as a 'lifestyle'. Many communities have been shut down by their hosts; many lapse because the web-site owner actually dies (of weight-loss complications); thus we provide no web addresses here but suggest the term 'pro-ana' as the keyword for a search by anyone who wants to see an example of this 'movement' (though we urge caution in undertaking such a search by anyone who might be vulnerable). Despite this opposition, pro-ana women defend their right to communicate their views by invoking the right of free speech. Their views can be captured under a number of themes. In the sections below words in inverted commas are taken from the voices behind pro-ana websites.

1. What it means 'to be' ill/disordered – is anorexia an illness or lifestyle choice?

Those women who construct themselves to be ill/disordered have taken on the dominant position of what it means to be anorexic, and for them 'pro-ana' and its community becomes a means of 'support'. However, while 'ill' these women are 'not looking for treatment' or 'recovery', but need and offer support to 'battle' or 'fight' their illness. While they maintain they are 'sick', that 'this is not OK', they maintain that they would be worse off without their 'disorder', thereby adopting the dominant discourse of the chronically, terminally ill and disordered, that of 'acceptance'.

Those women who adopt the opposite stance of not being ill/disordered resist the above, and advocate the notion of anorexia as a life style choice, as a product of their 'will'. Thus pro-ana is here portrayed as 'resistance', as a 'counter-culture', and anorexia is a deliberate choice - it 'not only involves choice but downright requires it' in the hourly decisions not to eat in the face of hunger. They say that overriding this biological urge earns them a feeling of 'self-control'. This coalesces into a number of discourses of self-determination/government, choice, self-discipline/control which are acts of resistance in defining themselves against the dominant professional anorexic discourses, while simultaneously asserting they are rational, against the dominant discourse of women as irrational. What is tragic here is that while a self is maintaining its voice against a complete takeover by anorexia's voice, that self has been co-opted by anorexia to further its own ends

2. Body/Mind and control

Anorexia is often constructed as to be 'thin', because this is to be 'beautiful'. To achieve thinness is a 'sign of true will, power and success'. But, in a somewhat contradictory set of appeals, thinness is 'doing it for yourself', not for anyone else 'especially some guy'. Weight loss is a form of 'self-care' aimed at achieving personal happiness, satisfaction and health (cf. Malson, 1998). Less bodily-focused, anorexia is a 'state of mind', a means of 'keeping in control', where control 'breeds confidence', 'nurtures self worth' and 'brings order to chaos'. Where the bodily discourse is concerned with showing restraint in the face of desires, here it is about getting hold of one's emotions and rationality.

We suggest that, while these two strategies just described do contain within them acts of resistance, these acts are not genuine but ersatz resistances. We suggest this in the context of Bourdieu's observation that

A description which contains no critical reflection on the position from which it is articulated can have no other principle than the interests associated with the unanalysed relation that the researcher has with this object (1988: 15).

In the sense that pro-ana women are conducting research into their selves, this is an apt description. The resistance to their situation is without reference to, or articulation of, the way that situation has been constructed for them. Resistance here is by side-step only. That this is the case is supported by the third theme in pro-ana sites.

3. Disorders of 'the self' or 'personality'

This is not an act of resistance per se, but an aspect of the ill/disordered position in 1. above. Pro-ana women draw on the dominant cultural discourse and psychological ideas that certain personality types (e.g. 'obsessive personalities' or those who are 'perfectionists') are susceptible to 'eating disorders', because they are 'that type of person', and they are women who have 'always had issues' and are 'not normal'. If they did not have ana/anorexia they would likely 'have something else' or 'focus on some other unhealthy area. Ana/anorexia is about being an 'essentially disordered personality', an essentially disordered person.

Our suspicion is that this notion underlies the other ersatz resistances we have just mentioned. In it and them we hear the tactics of the unmasked voice of anorexia, where the 'invisibility' of discourses have constructed the means whereby something that can profitably be disentangled from the person ends up confining them in a maze from which there is no way out, except death: 'they' *essentially* 'are the problem.' We have argued here that when a therapeutic stance, such as that taken in Narrative Therapy, avails itself of a Foucauldian analysis of the constitutive nature of power, *genuine* resistance can be mobilized. Without these Foucauldian resources, then, even with the best of intentions, treaters can unwittingly reproduce the voice of Anorexia, with unintended consequences for the person whom they are treating: they reproduce the status quo rather than provide the discursive means to critique, contest, and finally repudiate it.

Voices at large

While we have focused on anorexia here, narrative therapists engage with a wider array of problem voices in their practice. Externalising conversations work in the Foucauldian sense of deconstructing dominant discursive resources to reveal other senses in which problems can gain a 'life' of their own, and work to sustain that 'life', through a parasitizing of thinking. The general parameters of such a situation will be clear to anyone reading this article, as everyone has had the experience of, say, getting a tune stuck in their head. The tune seems to have a 'life' of its own, as though we cannot stop it: the tune, in a manner of speaking, is singing us. The same occurs with what have been constructed as obsessional thoughts, as Frankfurt (1979: 240-1) points out:

The thoughts that beset us in these ways do not occur through our own active doing. It is tempting, indeed, to suggest that they are not thoughts that we *think* at all, but rather thoughts that we *find* occurring within us.

In such instances, the separation between us and the tune or the thought is quite apparent. But within the dominant discursive structures of occidental cultures, the resources readily available for discussing problems as separate from us are few and far between, and those that we do have at our disposal seem rather quaint. The conventional ways of talking about problems – ways that define and set the limits for our thinking about and relating to them – is more to identify them as an inherent aspect of the individual than as separable from the individual: 'I am an alcoholic', for example, or 'I have an addictive personality'.

By contrast, the narrative approach to externalizing conversations works in many arenas (see, for example, Monk, Winslade, Crocket and Epston, 1997) in similar ways to those we have outlined with respect to anorexia. Both alcohol and nicotine 'talk to us' whenever we attempt to give them up: 'I'll just have one, I deserve it'. Without externalising the craving and understanding it as the voice of a discursive parasite using its tactics to maintain its 'life' through usurping our thoughts and convincing us that its thoughts are ours, the hold that the problem has is maintained. At the same time we compound our predicament by then assuming our lapse as our fault, and essaying more guilt at our weakness and maladjusted personality, a self-fulfilling and perpetuating misconstrual. Resistance is not directed against the problem, but against ourselves. Alternatively, We could personify the alcoholic lifestyle and call him Al. ... We can all ask ourselves, if we care to, how Al has sought to befriend us over our

lifetime ... we have all met AI. We can't avoid him. And he offers us no choice but to relate to him. We are offered several different kinds of relationship according to how we respond to his recruitment drives. ... [But] what he needs from us are ways of thinking about alcohol problems that blame the person in the middle of the problem rather than AI himself ... As long as a deficit can be found in the person, AI is happy, because attention can be diverted from his influence (Winslade and Smith, 1997: 171-4).

Resistance can thus be directed against the problem. It is in these ways that a Foucauldian-inspired exploration of the ways in which power and the very representations of problems are sedimented into everyday language lies at the heart of narrative therapy practice.

References

- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballentine
- Bateson, G. (1979). *Mind and nature: A necessary unity*. New York: Dutton
- Bourdieu, P. (1988). *Homo academicus*. Stanford, CA: Stanford University Press
- Bruner, J. S. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.
- Caute, D. (1988). *Sixty-eight: The year of the barricades*. London: Hamilton.
- Derrida (1978). *Writing and difference*. London : Routledge & Kegan Paul, 1978
- Derrida, J. (1981). *Positions*. Chicago: Chicago University Press.
- Erickson M. H. (1954). Special techniques of brief hypnotherapy. In Rossi, E. L. (Ed.). (1980). The collected papers of Milton H. Erickson on hypnosis: Vol. 4. Innovative hypnotherapy. New York: Irvington. pp. 149-173.
- Erickson, M. H. (1979). *Hypnotherapy: An exploratory casebook*. London: Wiley
- Epston, D. (1989). *Collected papers*. Adelaide: Dulwich Centre Publications.
- Epston, D. (1998). *Catching up with David Epston; A collection of narrative practice-based papers published between 1991-1996*. Adelaide: Dulwich Centre Publications.
- Epston, D. (2000) *The History of the Archive of Resistance - Anti-anorexia/Anti-bulimia*. **Retrieved 27 May, 2004 from** <http://www.narrativeapproaches.com/antianorexia%20folder/history.htm>]
- Epston, D., Morris, F., & Maisel, R. (1998). A narrative approach to so-called anorexia/bulimia. In D. Epston (1998), *Catching up with David Epston; A collection of narrative practice-based papers published*

- between 1991-1996 (pp. 149-74). Adelaide: Dulwich Centre Publications. (Previously published in K. Weingarten (Ed.) (1995). *Cultural resistance: Challenging beliefs about men, women and therapy* (pp. 69-96). Binghampton: Haworth Press).
- Epston, D., & White, M. (1992). *Experience, contradiction, narrative and imagination*. Adelaide: Dulwich Centre Publications.
- Faubion, J. D. (1994). *Michel Foucault: Power, the essential works, Volume 3*. London: Allen Lane.
- Foucault, M. (1970). *The order of things*. New York: Random House
- Foucault, M. (1972). *The archaeology of knowledge*. London: Harper.
- Foucault, M. (1973). *The birth of the clinic*. London: Tavistock Publications
- Foucault, M. (1979). *Discipline and punish: The birth of the prison*. London: Peregrine Books.
- Foucault, M. (1988). *Technologies of the Self: A Seminar with Michel Foucault*. In L. H. Martin, H. Gutman, & P. H. Hutton, (Eds.), Amherst, MA: University of Massachusetts.
- Frankfurt, H. (1976). Identification and externality. In A. O. Rorty (Ed.) *The identity of persons*. Berkeley: University of California Press. Pp. 239-251.
- Freedman, J. and Combs, G. (1996) *Narrative therapy: The social construction of preferred realities*. New York: Norton.
- Freeman, J., Epston, D. and Lobovits, D. (1997) *Playful approaches to serious problems: Narrative therapy with children and their families*. New York: Norton.
- Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology*. New York: Basic Books
- Gremillion, H. (2003). *In fitness and in health: A cultural analysis of psychiatric treatments in anorexia nervosa*. Durham: University of North Carolina Press.
- Halliday, M. A. K . (1976). Anti-Languages. *American Anthropologist* **78**: 570-584
- Hepworth, J. (1999). *The social construction of anorexia nervosa*. London: Sage.
- Lobovits, D., Epston, D. & Freeman, J (2004) *Archive of resistance: Anti-anorexia/anti-bulimia*. Retrieved 27 May 2004 from http://www.narrativeapproaches.com/antianorexia%20folder/entry_conditions.htm
- Lock, A., Epston, D. and Maisel, R. (2004). Countering that which is called anorexia. *Narrative Inquiry* **14**: 275-301 .
- Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. London: Routledge.

- Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: W. W. Norton.
- Marwick, A. (1998). *The sixties: Cultural revolution in Britain, France, Italy, and the United States, c. 1958-c. 1974*. Oxford: Oxford University Press.
- Mead, G. H. (1934). *Mind, self and society*. Chicago: Chicago University Press.
- Monk, G., Winslade, J., Crocket, K. and Epston, D. (1997) *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass.
- National Centre for Clinical Excellence (NICE) (2004a). *Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. London: NICE (available from <http://tinyurl.com/38qb4>)
- National Centre for Clinical Excellence (NICE) (2004b). *Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders - understanding NICE guidance: a guide for people with eating disorders, their advocates and carers, and the public* London: NICE (available from <http://tinyurl.com/38qb4>)
- Parker, I. and Shotter, J. (Eds.) (1990). *Deconstructing social psychology*. London: Routledge
- Szasz, T. (1972). *The myth of mental illness: Foundations of a theory of personal conduct*. London: Paladin
- Turner, V. W. (1969). *The ritual process: Structure and anti-structure*. London: Routledge and Kegan Paul
- White, M. (1989). *Selected papers*. Adelaide: Dulwich Centre Publications.
- White, M. (1993). Deconstruction and therapy. In S. Gilligan & R. Price (Eds) *Therapeutic conversations*. New York: W. W. Norton
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.
- White, M. (1997). *Narratives of therapists' lives*. Adelaide: Dulwich Centre Publications.
- White, M. (2000). *Reflections on narrative practice*. Adelaide: Dulwich Centre Publications.
- White, M. (2003). Addressing personal failure. *International Journal of Narrative Therapy and Community Work*, 3, 33-76.
- White, M. (2004). *Narrative Practice and Exotic Lives: Resurrecting Diversity in everyday life*, Dulwich Centre Publications, Adelaide, South Australia
- White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. San Francisco: W.W. Norton.

Winslade, J. and Smith, L. (1997). Countering alcoholic narratives. In Monk, G., Winslade, J., Crocket, K. and Epston, D. (Eds.) *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass. Pp. 158-92.

Wittgenstein, L (1953). *Philosophical investigations*. Oxford: Basil Blackwell