



The International
Journal of
Narrative Therapy
and
Community Work

2019 No. 3



Contents

Editorial <i>by Kristina Lainson</i>	3
Refusing to separate critique from respect <i>by Kelsi Semeschuk</i>	9
Travelling down the neuro-pathway: Narrative practice, neuroscience, bodies, emotions and the affective turn <i>by David Denborough</i>	13
Reflections on narrative, neuroscience and social engagement <i>by Karen Young</i>	54
Reflections on narrative, neuroscience and social engagement <i>by Gene Combs</i>	58
Feelings, thinking and action as a coherent whole : A reflection on ‘Travelling down the neuro-pathway’ <i>by Jill Freedman</i>	61
Narrative therapy, neuroscience and socio-emotional discourses: Comments <i>by Tom Strong</i>	64
A reflection on self-regulation and neuro-conceal <i>by Emma Van der Klift</i>	68
Responding to David Denborough’s paper: A short interview with Marie-Nathalie Beaudoin	74



Contents continued

Narrative therapy, neuroscience and anorexia: A reflection on practices, problems and possibilities <i>by Kristina Lainson</i>	80
Intensifying the preferred self: Neurobiology, mindfulness and embodiment practices that make a difference <i>by Marie-Nathalie Beaudoin</i>	96
Michael White's particularist ethics in a biological age <i>by Philippa Byers</i>	106
Narrative responses to physical pains An interview with Sister Seraphine Kaitesirwa	117



Editorial

by Guest Editor Kristina Lainson



Kristina Lainson is a narrative practitioner from Aotearoa New Zealand and is currently a PhD candidate at The University of Melbourne. She is a member of the faculty at Dulwich Centre, where she is involved in a variety of projects and tutors on the Master of Narrative Therapy and Community Work. She can be contacted at: kristina.lainson@icloud.com

Welcome to this special issue of the International Journal of Narrative Therapy and Community Work. Since first being invited to act as guest editor I have been captivated by watching this issue unfold, each contribution adding a new facet to a rich and rigorous discussion. The term editor has many meanings to suit different contexts, whether it's initiating the design of a publication and having authority over what content is included, responsibility for fact-checking submitted articles, or making amendments to manuscripts. Of all the possible interpretations of the term editor the best fit for my role is largely that of commentator and contributor. This innovative issue's conceptualisation and orchestration would have been well beyond my scope, and it has been a great privilege to play even a small part in the evolving process of invitations, dialogues and gaining greater appreciation for complexity and nuance in the fields and debates this issue seeks to illuminate and explore. Complexity is an unofficial but very present theme in this issue, and readers will discover apparent contradictions between some articles that offer differing perspectives, as content has been selected to reflect diverse knowledge bases, interests, and stances. No attempt has been made to settle these incongruences, or to come to agreement or create a unified position. This is a multi-storied special issue that has intentionally created space to highlight complexity, allow incongruence, invite critique and celebrate debate.

Let me introduce the two topics of focus in this issue. The first topic under discussion is narrative therapy in relation to neuroscience, emotions and embodiment. The second is attended to more briefly but is no less significant. It is the broader subject of how we in this field can create contexts for professional differences, debates and critique.

I'll begin by introducing the focus on neuroscience and related matters.

Narrative therapy, neuroscience, emotions and embodiment

Neuroscience is a field that we increasingly hear of in our day to day lives, as its ongoing developments contribute to many realms. Curiosity about whether recent advances in neuroscience can contribute to the field of narrative therapy is already attracting the attention of many practitioners, and others with an interest in narrative ideas. This attention is frequently

closely related to questions about how narrative therapy responds to emotions and embodied experience. These are important curiosities, to which there have been diverse responses. Some narrative practitioners have readily found a space for neuroscientific developments in their practice, whilst others suggest neuroscience is a poor fit for narratively informed conversations. Some practitioners have tentatively explored the possibilities but found themselves with unanswered questions, others remain unconvinced that neuroscience has relevance for their practice or the lives of the people with whom they meet. In this context, both highly experienced practitioners and beginning students of narrative therapy may find themselves grappling with big questions and plenty of uncertainty. This special issue aims to address some of these questions and create an opportunity for readers to engage rigorously with neuroscientific claims in relation to narrative therapy and highlight some consequent implications for practice. Articles included vary greatly in how they engage with ideas drawn from neuroscience, considering the theoretical, the practical and the philosophical. This issue is intended to be useful, accessible and interesting to readers with an interest in narrative practice, whatever the extent of their current knowledge about neuroscience.

Narrative therapy as evolving practice

Narrative therapy was developed out of a willingness to explore, innovate and embrace new philosophies and concepts into therapeutic endeavour. There has never been an intention that the practices of narrative therapy should remain static, or that the ideas should become fixed in a particular era or location. Far from it. Flexibility and openness to adaptation as circumstances require, or development as new ideas and understandings emerge, is a particular strength of narrative therapy, one that has enabled it to become useful in multiple contexts, shaped by local and cultural considerations. This is cause for celebration but also leads to significant questions, such as: When does openness to adaptation reinforce practice through flexibility, and is there a point at which openness contributes to a 'fraying around the edges' that begins to diminish practice? Can flexibility and openness ever lead to an unravelling? It is also pertinent to ask ourselves whether there is a difference between adaptation and alteration, to reflect on how wary or enthusiastic we should be about integrating ideas developed in different paradigms. Narrative therapy has always sought to centre the lives of the people who consult us. Is there a chance that undue caution

in the face of change simply closes off new avenues for alternative possibilities? These are all legitimate lines of enquiry.

Michael White described narrative ideas in the following terms:

Is this work better defined as a world-view? Perhaps, but even this is not enough. Perhaps it's an epistemology, a philosophy, a personal commitment a politics, an ethics, a practice, a life, and so on. And, because whatever it is happens to be on intimate terms with recent developments in social theory that are generally referred to as "non-foundationalist" or perhaps "postmodern", then whatever it is also happens to be a theory. (White, 1995, p. 37).

What is evident from this statement is that narrative ideas are far from being a set of atheoretical practices or principles, free for adaptation according to a broad range of philosophies, epistemologies or politics in order to be useful. The above statement is very clear that narrative ideas are grounded in something. That something may not be entirely tangible and may at times be fluid or flexible, but if the work can be described as more even than a world-view or as a theory, then there is inevitably some essence that connects the practices and ideas. There is some meaning, commitment or intention that exists beyond the immediate application. It is surely this essence, this commitment, this theory, that should inform what ideas and practices can appropriately be accommodated as part of narrative therapy. Equally, the desirability of any endeavour to define this essence is of pivotal concern. Narrative ideas are more than just a theory or the inevitable consequence of an essence. They are the basis of practices that have real effects for people's lives. These effects are themselves key in practitioners deciding which practices they choose to embrace.

A tessellation of perspectives

This special issue grapples with dilemmas of theoretical congruence and their potential for effects through considered discussion of principles and practice from a variety of vantage points. The result of bringing together a diverse array of articles and reflections around a single but complex topic is in an intricate and intriguing mosaic. Let me introduce you to what lies ahead.

A good place to begin, particularly if this realm is one you have yet to explore in depth, is David Denborough's article which provides a critical engagement with concepts of neuroscience and narrative practice. Attending to ontological and political considerations and bringing together the theoretical with the practical whilst drawing extensively on Michael White's writings and practice, David extends his discussion to address questions about whether narrative therapy adequately attends to emotions and embodied experience. This article is a long one. You may wish to set aside some space in your week to read it in one sitting or choose to read it in segments. But once you begin you will need no encouragement to continue. This rigorously researched article illuminates the importance of these discussions. It represents an exquisite level of intellectual and critical engagement with complex considerations, presented in accessible and engaging ways typical of David's writing.

Marie-Nathalie Beaudoin contributes to the discussion through an article and separate interview, in which she describes how ideas from neurobiology captured her own imagination as she saw possibilities for bringing neuroscience and mindfulness into her regular narrative practice. Marie-Nathalie describes how neuro-scientific concepts became meaningful for her in relation to her therapeutic practice, detailing what it is that she has found they offer to the people she works with. Through thoughtfully told stories of practice, Marie-Nathalie presents a potential for transformative effects in people's lives, arguing for holistic approaches that recognise biology as a significant component of individual experience and personal meaning-making.

Philippa Byers joins the conversation from her perspective as both philosopher and social worker. Her elegantly written article draws readers' attention to ethical principles that she has identified from her careful reading of Michael White's writings, linking her insights to concepts within moral philosophy, and meticulously relating these explorations to neuroscientific considerations. Philippa courteously takes time to invite in those of us who are new to these philosophical concepts, ensuring they are made readily available as she interweaves philosophy with practice principles, placing philosophical observations cogently within the realms of personal experience of her training as a social worker and a touching personal narrative about implications for people's lives.

An interview with Sr. Seraphine Kaitesirwa provides readers with insights into the careful and generative work she undertakes with young people experiencing difficulties that have become named somatoform

disorder. Sr. Seraphine describes how she uses thoughtfully constructed, narratively informed, questions and practices to invite young people and their families into new understandings about physical experiences. She goes on to illustrate how these practices often result in generative conversations between young people and their loved ones about distress, opening doors to new possibilities.

My own contribution to this issue has the very specific focus of recent developments in relation to anorexia, a realm where neuroscience is gaining acclaim with respect to aetiology and therapeutic approach. Writing from an insider-practitioner-researcher perspective I juxtapose treatment recommendations proposed by some neuroscientists with my own experiences and understandings of narrative practice as both insider and practitioner. I reflect on how our understandings can both inform and impinge upon the way people become positioned by theories of suffering and by models of therapeutic intervention, as well as illuminating a range of potential effects. Some of which are more welcome than others.

In addition to the articles and interviews there are a number of smaller pieces that reflect on the ideas shared in David Denborough's article. Each of these authors – Karen Young, Jill Freedman, Gene Combs, Emma van de Klift and Tom Strong – was invited to read the article and offer a response. Collectively they represent some of the diversity of voices and interests involved in the field of narrative practice, and further inform our thinking on these matters.

The focus on critique

This brings us to the second focus of this special issue, that of critique. There is an inevitability to critique when considering evolving concepts and practices, especially where there are many different perspectives available. It is critique that often invites and enables this evolution of ideas in the first place. As Mary Heath (2012) points out, it is the capacity to engage in a critique that can be differentiated from criticism that is a key component of the sort of critical thinking that enables us to analyse and evaluate concepts, develop the sort of awareness that can interrogate 'flows of power' (p. 16), and to challenge established assumptions and regimes. As such, it is highly desirable that we create contexts where open discussion, reflection and even disagreement can prevail. Critique is crucial to the development of robust and useful ideas but offering and receiving it is not

always easy or comfortable. Especially if the recipient has a good deal invested in what is being critiqued. There is responsibility when offering critique to consider the feelings and reputation of others. There is also responsibility to offer even the most uncomfortable critique when the matter is significant, compelling and has effects for people's lives.

Critique has always been important to narrative therapy, which emerged out of a critique of some dominant ideas at the time. It was through self-critique, openness and rigorous discussion that Michael White and David Epston, along with colleagues and friends, were able to reflect on their own practices and ideas, as well as those of others, to develop narrative therapy.

Reflections on receiving critique

There are good and less good ways of offering critique! As I write I find myself returning to one of my first attempts at submitting an article to a non-narratively informed journal, and my writing was not well-received. The anonymous reviewer was ruthlessly scathing and, despite being factually incorrect, the harsh words of their critique almost ended any intention I had for ever writing again, right there and then. I was fortunate, however, to be working with supportive colleagues who had a good deal to say about these events and encouraged me to continue my work. I was both a beginner at writing for journals and working as a lecturer at the time. As luck would have it I was due to teach a class on discourse and positioning theory, so decided to bring my experience to class. The students were generous and skilful in deconstructing the discourses surrounding my experience, making visible the operations of power and privilege between myself and the reviewer, and naming the positions I had been invited into. They offered a few options for resistance too! Despite disagreeing vehemently with my reviewer and feeling moved to write a rebuttal for my personal reassurance, I took from the review what aspects of it I thought were valid and considered the rest a reflection of the edges of my reviewer's own knowledge.

But I have also received kindly worded critique that has been just as difficult to hear because I held considerable respect for the person offering it, or because I realised their observations were valid and felt embarrassed or inadequate as a consequence. These have ultimately been important learning moments, for which I am grateful. Offering difficult critique can be an act of generosity. Critique can and should be an integral part

of respect and care for the person, as well as making a significant contribution to the rigour of an academic or professional field.

I recently came across the following quote which, whilst written in the context of research methodology debates, sums the attitude up rather nicely:

any critical comments that I make are understood as a contribution to the developing debate rather than an attempt to kill the debate at birth. Whatever disagreements I do have, they are secondary to my wish to see the widest and fullest discussion possible. For those within different traditions, to engage in that discussion would be a great step forward. Even if we end up disagreeing we may also come to understand our differences and recognize, perhaps even respect, the bases of such difference. (Reicher, 2000, p. 2).

Attending to critique in intentional ways

This special issue has sought to attend to the matter of critique in several ways. It has brought together a wide range of perspectives, some of which conflict. Authors have been invited to consider how they are in some way offering a critique of the work of others and recognise that they may receive critique in return. The inclusion of a short piece by Kelsi Semeschuk, 'Refusing to separate critique from respect', about some of the ways she has thought about giving and receiving critique focusses our attention on this theme. Paying particular attention to maintaining a stance of respect throughout critique giving and receiving, centring relationship, and attending to care-taking without losing sight of the effects of practice understandings and decisions, we hope this special journal issue connects critique and debate to important values and ethical considerations.

Conclusion

This brings me to the conclusion of my introduction to this collection of exciting articles, full of ideas designed to stretch and challenge readers' thinking and practice. I anticipate readers will find this special issue inspiring, helpful, and thought provoking. I also trust it will contribute to a richer appreciation of salient issues, and to ongoing practices of reflection, discussion and rigorous critical engagement.

References

- Heath, M. (2012). On critical thinking. *International Journal of Narrative Therapy & Community Work*(4), 11.
- Reicher, S. (2000). Against methodolatory: Some comments on Elliott, Fischer, and Rennie. *British Journal of Clinical Psychology*, 39, 1– 6.

- White, M. (1995). Re-authoring Lives: Interviews and Essays. In *Re-authoring Lives: Interviews and Essays*. Adelaide, South Australia: Dulwich Centre Publications.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Refusing to separate critique from respect

by Kelsi Semeschuk



Kelsi Semeschuk lives in Adelaide, South Australia, where she is undertaking a PhD focused on Michael White's video archive. Kelsi also works as a narrative practitioner at Uniting Communities responding to people who have experiences of childhood sexual abuse. Kelsi can be contacted via email at ksemeschuk@student.unimelb.edu.au

Abstract

This paper provides a brief exploration of the notion of critique within the field of narrative therapy. It raises questions, considerations and dilemmas about how practices of critique might be engaged in without contributing to the dissolution of important relationships. The author draws on some of her own experiences with the hope of articulating how critique and respect can exist alongside each other.

Key words: *narrative therapy; critique; respect; agonism*

Is respectful critique possible?

Because we are right, so right, and they, like the villains in the western are wrong, so wrong. (Tompkins, 1988, p. 588)

Recent experiences have had me asking the following questions: Is it possible to critique ideas in ways that do not lead to the dissolution of important relationships? Is it possible, as Tompkins (1988) asks, to engage in critique that does not position myself as the *hero*, and the person on the receiving end of my critique as the *villain*? Is it possible to approach critique with respectful intentions and, more importantly, for that respect to be *felt* by the person receiving it?

Specifically, I have been thinking about the effects of critiquing ideas that are held close by respected colleagues and friends. I have been thinking about the potential consequences of critiquing the ideas and practices of the people who taught me narrative ideas in the first place – people who have given me their time, walked alongside me and believed in my potential when I couldn't see it. I have also been wondering about how we can engage in critique of our own practices, and the practices of others, without it diminishing the worth of the work we have engaged in with the people consulting us.

Hopes

These considerations have led to the creation of a list of principles that I hope to hold close in my future engagements with critique. My aim is:

- to communicate in ways that value questions over answers, and acknowledge the potential generativity of asking questions
- to hold respect for others (their skills, knowledges and preferences) at the centre of any questions, curiosities or critiques
- to remember that even though I am critiquing ideas, I am critiquing ideas that may be close to the hearts of certain practitioners
- to acknowledge that ideas must be understood in context, and thus 'one cannot separate the pursuit of knowledge from the community of scholars engaged in that pursuit' (Tannen, 2002, p. 1665)
- to remember that 'scholarly work is done by human beings' (Tannen, 2002, p. 1666), and

that hiding behind 'objectivity' can contribute to practices of critique that do not acknowledge this

- to step away from engaging in 'policing' practices in relation to the ideas of others
- to do my best to avoid practices of speaking for Michael White, David Epston or any other practitioner
- to avoid statements that speak to a 'capital-T' Truth of narrative therapy
- to engage in critique in ways that aim to avoid harming relationships
- to consider not only the content of our critique but also where that critique *goes* – where it *lands* and upon whom it *lands*; as Alcoff noted, 'One cannot simply look at the location of the speaker or her credentials to speak, nor can one look merely at the propositional content of the speech; one must also look at where the speech goes and what it does there' (Alcoff, 1992, p. 26)
- to be aware of the influence of the ritual of aggressive opposition in academia, and the historical underpinnings of such practices, which are grounded in military, combative and adversarial metaphors (Tannen, 2002)
- to engage in critique with the hope of collectively 'doing better'
- to ask myself:
 - How can I avoid being 'righteous' in my ideas?
 - How can I 'practice what I preach' and take these ideas *outside* of myself and others? (i.e. the postmodern and social constructionist underpinnings of narrative therapy)
 - How can I have conversations about my work in ways that do not convey the message that I believe I am *more* 'political', 'feminist', 'respectful', 'honourable' or 'informed' than others?

Approaching critique with these principles in mind is my attempt to pour energy into something that feels generative, worthwhile and aligned with what I value about narrative ideas; namely, that nothing is above critique, deconstruction and questioning. On this topic, I often like to reflect on what Michael White (2011) wrote about his continuous practice of critiquing and reflecting on his work:

I am not diminishing my work, and I am not putting myself down. It is because I love my work that I am highly motivated to identify any abuses of power and to root them out. I believe that if one is not tripping across abuses of power in one's therapeutic practice, it means that one has gone to sleep. (White, 2011, p. 31)

In addition to his (2011) assertion that critique of one's practice can be linked to 'love' of one's practice, White also noted that 'if people are standing for something, then there's a history to it' (White, 2002). What this phrase has come to mean to me is that we do not develop ideas in isolation, and we do not become skilful in our practices in isolation. Rather, as we take a *stand* – or a seat (with the person consulting us) – there is a history to it. This history, which is founded on relationships, warrants recognition. In this way, the opportunity to engage in critique relies upon the very relationships it can threaten.

In advocating for a type of critique that centres relationships, I am not arguing against the right to disagree, as this can result in a sort of 'agonistic'¹ ideal that 'puts too much emphasis on identities and less on the political issue itself' (Tryggvason, 2018). Rather, my perspective is in alignment with Belgian political theorist Chantal Mouffe's (2000) concept of 'agonistic pluralism'. Mouffe (2000) wrote that the aim of such a perspective is to:

Construct the 'them' in such a way that it is no longer perceived as an enemy to be destroyed, but an 'adversary', i.e. somebody whose ideas we combat but whose right to defend those ideas we do not put into question ... An adversary is an enemy, but a legitimate enemy, one with whom we have some common ground because we have a shared adhesion to the ethico-political principles of liberal democracy: liberty and equality. (Mouffe, 2000, p. 15)

Although these ideas from Mouffe have their origins in the context of democratic politics, I find them quite relevant to engagements with critique within the narrative field. That is, to borrow Mouffe's language, the *ethico-political principles* underlying narrative ideas are so richly described and so central to the work we do that even when we disagree, there is a common ground upon which we stand.

Concluding thoughts

In her critical essay on the topic of critique, Tompkins noted that 'it's difficult to unlearn the habits of a lifetime, and this very essay has been fuelled by a good deal of the righteousness it is in the business of questioning' (1988, p. 590). Similarly, I want to acknowledge that I do not see myself as exempt from engaging in practices of *righteous* critique, and I am not immune to the *sting* of receiving critique from others. However, I believe that having the opportunity to reflect on our own practices, to gain a sense of clarity about our ideas, and to be able to do this collectively and in relationship, is a special sort of gift, worthy of recognition and respect.

Note

¹ There are varying definitions of the term 'agonism', one of which is presented through my discussion of Chantal Mouffe's work on 'agnostic pluralism'. A general description is that: 'Agonism is irresolvable disagreement over political meanings and actions, in which each party does not deny the legitimacy of the other to have an opinion. It is a form of political engagement that acknowledges the permanence of conflict and views this as necessary for democratic politics to function rather than detrimental to it' (McClymont, 2011, p. 3).

References

- Alcoff, L. (1991). The problem of speaking for others. *Cultural critique*, (20), 5–32.
- McClymont, K. (2011). Revitalising the political: Development control and agonism in planning practice. *Planning Theory*, 10(3), 239–256.
- Mouffe, C. (2000). *Deliberative democracy or agonistic pluralism*. Retrieved from nbn-resolving.org/urn:nbn:de:0168-ssoar-246548
- Tannen, D. (2002). Agonism in academic discourse. *Journal of Pragmatics*, 34(10–11), 1651–1669.
- Tompkins, J. (1988). Fighting words: Unlearning to write the critical essay. *Georgia Review*, 42(3), 585–590.
- Tryggvason, Á. (2018). Democratic education and agonism: Exploring the critique from deliberative theory. *Democracy and Education*, 26(1), 1–9.
- White, M. (2002). *Untitled*. [Video recording]. Michael White Video Archive (Tape 21). Adelaide, Australia: Dulwich Centre.
- White, M. (2011). Turning points and the significance of personal and community Ethics. In M. White (Ed.), *Narrative practice: Continuing the conversations* (pp. 27–44). New York, NY: Norton.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Travelling down the neuro-pathway:

Narrative practice, neuroscience, bodies, emotions and the affective turn

by David Denborough



David Denborough is a community worker, teacher and writer at Dulwich Centre, and is the coordinator of the Master of Narrative Therapy and Community Work at The University of Melbourne. He can be contacted at daviddenborough@dulwichcentre.com.au

Abstract

In recent times, a complex interplay of factors has led to the social sciences grappling with neuroscience, affect/emotion and embodied experience in new ways. This paper engages with the following four questions: How does narrative therapy fit with neuroscience? How does narrative practice engage with emotion? How does narrative practice relate to the affective turn? How does narrative therapy engage with the body/somatic experience/embodied experience? Throughout this paper examples from Michael White's therapy practice and contemporary examples of collective narrative practice are discussed.

Key words: neuroscience; affect; affective turn; affective practice; emotion; bodies; embodied practice; narrative therapy; collective narrative practice

This paper started with a concern, about how neuroscience ideas are being engaged with in the field of narrative practice, and then became a bit of an adventure. It was as if I started travelling down a neuro-pathway and unexpectedly found myself detoured into writings by feminist theorists (such as Ann Cvetkovich, Clare Hemmings, Ruth Leys, Margaret Wetherell and Deborah Gould) and diving into early writings and videos of Michael White that relate to how narrative therapy engages with bodies and emotions. I've really enjoyed the adventure, and I have the narrative practitioners who are engaging with neuroscience to thank for this. I hope I can convey some of my enjoyment and intellectual delight in the following pages.

A personal connection to science

My father, Michael Denborough, was a medical researcher and doctor. I'll always be able to evoke the sensation of his stethoscope on my back. His kind bedside manner was significant, but it was his intellect and rigour that made you feel safe. You knew your health and your life was in good hands. My father and the team with which he worked at the John Curtin School of Medical Research rigorously sought and found answers to a mystery relating to previously unexplained deaths under anaesthesia. To do so they convened a 'breakthrough committee' which met regularly. Every day, through these years, Dad would come home and ask his children, 'were there any breakthroughs today at school?' I tell you, life becomes a lot more interesting when you're constantly seeking breakthroughs. The breakthroughs he and his team made in the laboratory, which came about as a result of years of rigorous, methodical, dedicated research, continue to influence practice in every operating theatre in the world, and have literally saved thousands of lives. That's quite something, isn't it?

I mention this at the outset of this paper to make it very clear that I have profound respect for science and medical researchers. In fact, I would not be alive without the researchers who contributed to ways of treating childhood asthma. In this paper, I ask questions about how ideas related to neuroscience are influencing the field of narrative therapy and community work. It is not the 'science' that I am questioning in the following pages, for I am not a neuroscientist, but rather the ways the 'science' is being mediated, interpreted and put into action far from the laboratory.

Why this paper?

In recent times, a complex interplay of factors has led to the social sciences grappling with neuroscience, affect/emotion and embodied experience in new ways. Influences as diverse as neurobiology and Deleuzian philosophy have been catalysts for a changed intellectual landscape, and tussles over history and politics (Leys, 2011).

In this wider context, students of narrative therapy and community work have occasionally asked me and other members of Dulwich Centre faculty the following sorts of questions:

- How does narrative therapy fit with neuroscience?
- How does narrative practice engage with emotion?
- How does narrative practice relate to the affective turn?
- How does narrative therapy engage with the body/somatic experience/embodied experience?

The more I explore these questions, the more I realise they are interrelated. So I've chosen to respond to all four questions by writing this paper in four parts:

- **Part 1:** 'Narrative practice meets neuroscience', in which I try to convey some of the potentials, complexities, ironies and hazards associated with linking narrative practice with neuroscience
- **Part 2:** 'Getting emotional: Narrative therapy and emotion/meaning/action', in which I try to describe how narrative therapy engages with emotions by not separating emotion from action or from meaning
- **Part 3:** 'Engaging with the affective turn', in which I explore what narrative practice has to gain from engaging with the affective turn in the social sciences, and how it's possible to understand narrative practice as a form of 'affective practice'
- **Part 4:** 'Narrative therapy and the body', in which I examine how narrative therapy engages with the body in ways that seek to escape a mind/body split.

Throughout this paper I include examples from Michael White's therapy practice (from his writings and video archive) along with contemporary examples of collective narrative practice. Because broader philosophical and social science debates are shaping these considerations in our field, I also draw on the writings of various social theorists.

Trying to respond to four different but related questions in one paper means that this has become a long piece! Perhaps it should come with an advisory notice: 'In order to take care of your body, mind, brain and emotions, please get physically comfortable and make a cup of tea or coffee before you begin ...'

Part 1: Narrative practice meets neuroscience

Michael White and David Epston (1990) developed narrative practice as a way to assist individuals, couples, families and communities to resist the specifications of modern power, to sponsor diversity and to foster the insurrection of alternative knowledges. For Michael White, narrative therapy was a form of politics¹ that was aligned with the political project of Michel Foucault:

He [Michel Foucault] says that it's in the periphery, at the extremities, that these techniques of power become most available for our inspection ... we can see these techniques operating in relationships between husbands and wives, in schools and clinics, and so on ... it's very important that we challenge the techniques of power on the local level ... [this] idea of a political program is ... to be involved in the local level helping people challenge the techniques of power and the subjugation to those techniques. And instead of the insurrection of persons, this is the insurrection of the subjugated knowledges, this is an insurrection of alternative knowledges. (M. White, 1989)

It is now 35 years since the death of Michel Foucault, and 11 years since Michael White's death. During the last decade, the operations and specifications of modern power, which both these writers were seeking to describe, have continued to change. Strategies of modern power do not stand still, especially within the disciplines of psychiatry, psychology, social work and so on, which are at the forefront of our contemporary disciplinary society. Technology, science and their accompanying discourses are constantly changing, bringing new possibilities for the subjugation of selves. Fortunately, tactics of resistance are also constantly changing.

Locating contemporary ideas in history and culture

In this paper, I wish to explore a couple of contemporary realms of intellectual interest – neuroscience and the affective turn. But first, I want to share Michael White's humorous ways of historicising contemporary taken-for-granted notions. The following extract is even funnier if you watch the video², in which you can see Michael's facial expressions, see him raising his hand and hear the engaged laughter of the workshop participants.

How many of you have psychological needs? Just raise your hand if you have psychological needs. I'm not asking you to confess these, okay. Although that could be very interesting [laughter]. But I just would like to know whether you have them or not. I can see many people agreeing. I'm not surprised because, in Western culture, people have had psychological needs since 1929. They've been around since 1929. And they're increasingly popular; today more and more people have psychological needs. So, this was a new understanding. Action as a surface manifestation of a psychological need is a relatively new idea. In the history of the world's culture it's a novel idea.

How many of you have relationship dynamics? Raise your hand if you have relationship dynamics? [laughter] I'm not surprised at that either, because these have been around since the 1960s. And a lot of people have relationship dynamics these days. In fact, they're becoming increasingly popular ... Relationship dynamics have been very successful ... I'm not saying that before the onset of relationship dynamics ... people were happier in their relationships with others. At times they were still miserable and in conflict [but] it wasn't constructed in terms of dynamics, is that clear? That's a new construction.

Earlier on we talked about personal properties like strengths ... How many of you have resources, personal resources? These have been around for longer than psychological needs; they've been around for a couple of hundred years or so. It's been a growing development ... The whole idea that we have these personal properties is associated with the development of modern liberal theory. Liberal theory provides the basis of the Western democratic state ... One of the cornerstones of liberal theory was ... the recognition and preservation of the individual's right to own property, to possess property. It also preserved the individual's right to capitalise on their property ... by mining it, and to bring to the surface these resources, or by cultivating their property to improve its assets. Now around the same time, there was this new idea that maybe ... we have a self that's like personal property that we can own in the same way that we can own actual property: land. And so we can actually mine the self to discover the resources and to bring those

¹ For more information about the politics of narrative practice see Denborough (2019).

² Michael White's 'Funny Moments' video can be viewed at: www.vimeo.com/260519508.

resources to the surface, and to put them into circulation. So how many internal miners are there in this group? How many of you have found yourself in situations where you had to dig deep, to get in touch with your resources and to put them into circulation? Internal miners in the group? [laughter] ...

These are relatively new understandings ... this is all part of a tradition that ... is often referred to as structuralist. Action in life as a surface manifestation of some element or essence that comes from the centre of who we are. And these ideas are now taken for granted. It's just naturally assumed that action is the surface manifestation of strengths, resources, psychological needs, relationship dynamics and so on ... That is almost never questioned.

Now, I'm not saying that they're bad ideas, is that clear? I think some of those ideas are very beautiful ideas. But I think it's important to understand that these ideas have been developed and constructed in history and in culture³. If we understand that, we're not chained to the ideas, we're not tied to them. We can think outside of them. (M. White, 2018)

This extract is from a video titled *Funny moments*, a compilation of both humorous and profound teachings by Michael White, which was created at the suggestion of his daughter, Penny White. There is a long history within narrative practice of seeking to use humour to draw distinctions between different traditions of thought. I have started this paper with this extract because I think it clearly demonstrates how narrative practice was developed to question contemporary taken-for-granted psychological/cultural notions, so much so that some have described it as 'post-psychological' (McLeod, 2005, 2007).

These days, within psychological fields, in addition to talk of psychological needs, relationship dynamics, and personal properties there are new concepts in town. These days it is quite common to hear that we have a 'reptilian' part of our brain, that our cerebral hemispheres may be functioning at a diminished level of integration, and/or that our neural pathways may be in need of increased connectivity or rewiring. In addition to these concepts, with which I am sure you are familiar, I have recently heard people offering their services to assist others to maximise/optimize/capitalize on their 'brain real estate' and even to work on their 'relationship plasticity'⁴.

How are we as narrative practitioners to engage with these concepts?

One possible approach is to try to understand the histories of these developments. If this interests you, then I would highly recommend the writings of Fernando Vidal (Vidal, 2009; Vidal & Ortega, 2017) as he traces histories of the 'cerebral subject', 'brainhood' and 'neurocultures'. Rather than these evolving due to neuroscientific discoveries, Vidal argues it is the other way around:

A good number of 20th- and 21st-century neuroscientists seem to think that their convictions about the self are based on neuroscientific data. In fact, things happened the other way around: brainhood predated reliable neuroscientific discoveries, and constituted a motivating factor of the research that, in turn, legitimized it. Thus, even though the rise of the cerebral subject is irreducible to the history of the brain sciences, any attempt to understand how it became a central figure of modernity must give this history a central role. (Vidal, 2009, p. 14)

Interestingly, Fernando Vidal describes brainhood and the development of the cerebral subject as ideologies that sustain and reproduce individualism:

³ Just as contemporary understandings of identity are influenced by history and culture, so too our understandings of our brains. Cornelius Borck (2012) has described how technological inventions - such as the camera, the phonograph, the tape recorder, telephone exchange, and the computer - have all functioned as analogies within brain research.

⁴ Rose & Abi-Rached (2013) describe how the 'neurobiologization of the self' is leading to new ways to manage/optimize our selves through our brains. In contemporary Western culture, there is an increasing imperative to care for the self through care for the brain:

The wish to fashion the self is not a recent phenomenon, nor is the belief that the continuous work of improving the self is a virtuous exercise of freedom. In the liberal societies of the West, from around the 1960s, at least for some of the middle classes and for many young people, such self-fashioning became no longer the privilege of the elite, the philosopher, the dandy, or the aesthete. The radical democratization of self-fashioning over the closing decades of the twentieth century has been taken into new territory with the spectacular diversification of authorities of the self in the age of the Internet. What is novel, then, is not the aspiration to shape, improve, fashion oneself, but the source of authority that underpins it, the technologies that it deploys, and the target or substance upon which it operates - the brain itself. (Rose & Abi-Rached, 2013, p. 224)

The individualism characteristic of western and westernized societies, the supreme value given to the individual as autonomous agent of choice and initiative, and the corresponding emphasis on interiority at the expense of social bonds and contexts, are sustained by the brainhood ideology and reproduced by neurocultural discourses. (Vidal, 2009, p.7)

According to Vidal, this is a process linked to contemporary colonisation:

Brainhood seems to be an exclusively western phenomenon, albeit now universally exported through the globalization of originally European forms of science and medicine. As far as I can tell, no other culture has proposed the reducibility of self to an organ of the body. But 'western culture' is a dynamic process that includes the very notion of self, and the emergence of brainhood is part and parcel of the history of views about selfhood. (Vidal, 2009, p. 11)

Narrative therapy meets neuroscience

Within this broader historical context, a wide range of narrative therapists (particularly in North America) have become enthused about the possibilities of bringing understandings from neuroscience to their therapeutic practice. This interest is perhaps best exemplified in the recent publication of two books. *Collaborative therapy and interpersonal neurobiology: Emerging practices* (2017) is a collection of chapters by different authors⁵, edited by Marie-Nathalie Beaudoin and Jim Duvall. *Neuro-narrative therapy: New possibilities for emotion-filled conversations* (2018) was written by one author⁶, Jeff Zimmerman. Both these books seek to extend and enhance the field of narrative practice and collaborative therapies by engaging with neuroscience⁷.

I have great respect for the practitioners who are linked to these two books. In fact, it is because of the high regard in which I hold them, and the considerable influence that they have within the field, that I have written this paper. I respect these authors' intentions to continue to expand the field of narrative practice and to ensure its relevance and resonance in contemporary culture. And I appreciate the ways in which some of these authors acknowledge that their proposals about bringing narrative practice and neuroscience together are speculative:

Although the consilience of psychotherapy and neurobiology offer much hope and possibility, our proposals are speculative and embedded in an evolving social and scientific context. (Duvall & Maclennan, 2017, p. 18)

While there is a great diversity of ways in which narrative practitioners are engaging with neuroscience, it will become clear that I have some broad concerns about the ways in which narrative practice and neuroscience are meeting. In this paper, I speak more about these concerns⁸ than I do about what may be gained through engagements with neuroscience. The reason for this is quite simple. There are many articles and book chapters in which narrative practitioners describe the possibilities they see in engaging with neuroscience – including within this journal issue (see Beaudoin, 2019) – while this paper, to my knowledge, is one of very few pieces within the field of narrative practice that raises concerns⁸. It's my hope that this paper can foster discernments and discussions. In fact, these have begun. Prior to the publication of this piece, I really appreciated feedback from, and dialogue with, Marie-Nathalie Beaudoin. I look forward to continuing conversations about these realms with anyone who is interested.

⁵ These authors include Marie-Nathalie Beaudoin, Pam Dunne, Jim Duvall, Robert Maclennan, Maggie Carey, Jan Ewing, Ron Estes, Brandon Like, Sara Marlowe, Karen Young, Jim Hibbel, Jaime Tartar, Mercedes Fernandez. Gene Combs wrote the foreword. Tom Strong (2017) contributed a social constructionist discourse analysis entitled 'Neuroscience discourse and the collaborative therapies?'

⁶ Karl Tomm wrote the foreword to this book and Chené Swart, Stephen Madigan, David Nylund and Bill Madsen offer endorsements on the back cover.

⁷ These books build on earlier writings by Beaudoin & Zimmerman (2011), Zimmerman & Beaudoin (2015), and Zimmerman (2017).

⁸ There are, to my knowledge, three other pieces that raise concerns:

David Marsten, David Epston and Laurie Markham (2016) have raised significant questions about whether neuroscience is serving to exacerbate existing discourses of mother-blame.

Tom Strong's (2017) social constructionist discourse analysis poses questions in relation to the broader field of collaborative therapies. And David Marsten and Laurie Markham (2017) share concerns about how neuro-scientific influences within psychotherapy can promote privatising tendencies:

'On the road to becoming the 'sciences' they aspire to be, dominant strains of psychology and psychiatry appear to have fallen in step with privatizing projects as an outgrowth of the political climate of the past 40 years ... Instead of perceiving our woes within broad fields of power, we are objectified and left to consider the consequences of our own faulty thinking, genetic predispositions, and flawed neural circuitry.' (p. 2)

Breakthrough (for me at least!) #1: Science is being mediated through psychology

It was a breakthrough, for me at least, to realise that the 'neuroscientific' ideas that certain narrative practitioners are drawing on are often cited through the writings of developmental psychologists/psychoanalysts (including Daniel Stern, 2004); cybernetic writers (including personality theorist Silvan Tomkins, 1991); and psychiatrists trained in attachment and systems theories (including Dan Siegel, 2007, 2010). Therefore, the neuroscience ideas that narrative practitioners are engaging with are often mediated through developmental psychology, cybernetics, attachment theories and psychodynamic theories (Papoulias & Callard, 2010, p. 33). This has led to the return of metaphors that were questioned some years ago in the narrative practice field for their cultural specificity. These include:

- Integration metaphors: these invite us to 'integrate' hemispheres of the brain and/or to 'integrate' relationships, for example 'young people are understood as 'needing' to separate as individuals while also maintaining a connection with their parents' (Siegel in Beaudoin & Duvall, 2017, p. 7; see also Zimmerman, 2018, p. 15)
- Regulation metaphors: where once the dominant idea in the psychologies was to 'express' our feelings, now we are invited to 'regulate' them or 'tame' them: 'By naming our emotions we can tame⁹ their potential effect on us' (Marlowe, 2017, p. 54).

Understanding parts of ourselves as reptilian, capitalising on 'brain real estate', working on 'relationship plasticity', 'integrating hemispheres of the brain', or even 'regulating emotions' are all concepts that have been developed and constructed in history and culture. The ways any 'scientific knowledge' is taken up and utilised in practice are mediated through culture.

When one neuro-narrative practitioner (drawing on Jungian analyst Margaret Wilkinson), claims that:

when affect is brought forth and regulated in a secure relationship, a new coherent narrative emerges that is tied more to the present than to the past (Zimmerman, 2018, p. 20),

is this 'science' speaking or dominant Western cultural imperatives speaking through 'science'? Valorising 'regulation', 'coherence' and 'separating from the past' is only one way of conceptualising our emotional lives and identities. To imply it is the only way, and that findings from neuroscience 'validate' it, risks obscuring a great deal.

David Marsten, David Epston and Laurie Markham (2016) have also described how new understandings/technologies from neuroscience and epigenetics are being used to perpetuate old mother-blaming discourses¹⁰:

Of late, genetics would appear to be raising the banner of mother-blame, pointing to 'the fundamental way in which gene expression is determined by [early] experience' (Siegel, 2012, p. 112) ... Neuroscience may serve to further heighten tensions, pointing to the cost of 'failed mothering' in how '[t]he caregiving adult's mind and patterns of communication directly shape the organization of the developing child's brain' (Siegel, 2012, p. 103). Have we entered a new frontier, moving beyond mere theories about mothers as ruinous causal agents and into an evidential field—a scientific supreme court of sorts—in which every mother is a potential perpetrator who may be brought up on charges of genetic obstruction, brain injury, and even neuronal murder (Siegel, 2012)? Or might it be that these disciplines are using new technologies to perpetuate old biases, at least where mother-blame is concerned, and holding mothers' already scorched feet to the flames (Marsten, Epston, & Markham, 2016, pp. 198–99).

As Nikolas Rose and Joelle Abi-Rached (2013) describe:

neurobiological ways of thinking [have come] to infuse the analyses of problems of individual and collective human conduct in the many sites and practices that were colonized by the *psy*-disciplines across the twentieth century. (Rose & Abi-Rached, 2013, p. 226)

⁹ Of course, how we approach naming emotions and how they are named has many more effects than only 'taming' them. As Glenda Fredman points out, 'naming a feeling can move people towards new positions, different roles and alternative ways of experiencing ... [It also shapes] people's relationships with themselves' (Fredman, 2004, p. 41).

¹⁰ Cordelia Fine, cognitive neuroscientist and science journalist, has written eloquently about neurosexism (Fine, 2016).

If narrative therapy is to retain its commitment to contributing to decolonising areas of life from Western psychological understandings (see Drahm-Butler, 2015), then what sorts of cautions may be required if we choose to travel down a neuroscience pathway? Would it be possible to draw on learnings from neuroscience without these being mediated through Western psychology?

Let's consider in more detail how some narrative practitioners are engaging with neuroscience.

Narrative practice, neuroscience and avoiding neuro-conceal

There are two different ways that narrative practitioners are drawing on ideas from neuroscience. One is to explain and explore effects of existing narrative practices; the other to make changes to narrative practice informed by neuroscience. In both areas the intentions are noble. Let's consider them in a little more detail.

1. Explain narrative therapy premises and/or measure effects of narrative practice through neuroscience

Some narrative practitioners (e.g. Duvall & Maclennan, 2017) are using neuroscientific findings to explain the experience of naming problems using externalising conversations (M. White, 2007):

Naming stimulates the release of soothing neurotransmitters that calm the limbic amygdala, modulating the fight, flight, or freeze response (Creswell, Way, Eisenberger, & Lieberman, 2007; Siegel, 2014). The resulting positive emotions and sense of relief can enlist the right hemisphere's disposition toward novelty and insight, opening space for a pivotal experience (Beaudoin, 2015; Kounios & Beeman, 2009; Subramaniam, Kounios, Parrish, & Jung-Beeman, 2008). (Duvall & Maclennan, 2017, p. 21¹¹)

Other narrative practitioners are engaging in research to measure changes in brain function after narrative therapy sessions. This includes skilled narrative practitioner Karen Young and her colleagues (Young, Hibel, Tartar, & Fernandez, 2017). Their paper, 'Single Session Therapy and Neuroscience', describes how they are: 'interested in research that might demonstrate that conversations that included elements of scaffolding conversations have observable and measurable neurophysiological effects.' (Young et al., 2017, p. 109)

This same paper includes two thoughtful examples of narrative practice in relation to problems of Anorexia/'the self criticism' and 'refugee isolation and despair', but it's the authors' interest in biologically measuring the effects of narrative therapy scaffolding conversations that I wish to focus on here:

We expected that these single sessions, which were designed to invoke novelty, naming, enthusiasm, social engagement, and optimal arousal, would result in observable differences in cortisol, alpha-amylase and EEG readings ... we have analysed results from a cohort of 20 participants, 10 in the neutral situation and 10 in the narrative situation. Our results show statistically different patterns on both biomarkers ... despite a very small sample, we saw biological effects on markers of social engagement over the narrative conversations ... It appears that it is possible to demonstrate that scaffolding-based brief narrative conversations have neurophysiological effects, consistent with ideas proposed from the perspective of interpersonal neurobiology. (Young et al., 2017, p. 111)

While I am also interested in the effects of externalising conversations and scaffolding conversations within narrative practice, these explanations and explorations pose some significant questions. Is enabling people to name their experience in their own precise words and terms (within externalising conversations) significant because it releases soothing neurotransmitters? Or because it enables action in local culture? Or because we have a political/ethical commitment to people being able to name their own experiences?

Of course, there does not have to be only one explanation, but I am wary of explaining the significance of 'naming' in ways that are divorced from politics. From a neurobiological point of view, there may be little difference between a problem being named 'anxiety disorder' or it being named 'the voice of abuse'. But in narrative practice (and feminist politics) there is a world of difference.

¹¹ A number of other authors have also tried to make this link, for instance:

Naming an experience is associated with a reduction of amygdala activity and the brain's increased ability to regulate ... (Young et al., 2017, p. 108)

And if we wish to 'measure' change, on what sort of changes do we wish to focus our attention? Do we choose to measure changes in brain function or changes in relationships outside the therapy room? Do we want to measure the extent to which therapy has resulted in re-enforcing dominant discourse or opened space for alternatives (see White, 2011a, pp. 41-43)? My guess is that narrative practitioners engaging with neuroscience would be interested in all of these sorts of changes.

My concern is that if we choose to focus on changes in people's brains after therapeutic conversations, there is a risk that such studies could inadvertently conceal more than they reveal. By focusing on changes in the brain, one of the first things that could become concealed are considerations of politics (whether this relates to gender, race, class, poverty, sexuality or other relations of power). I don't mean that anyone would deliberately seek to conceal considerations of politics, especially narrative practitioners, just that a focus on neuro-scientific understandings promotes a limited field of vision which I sometimes refer to as 'neuro-conceal'.

Let me pose a couple of questions about the use of neuroscience to explain and/or measure the effects of narrative practice: Are there ways of doing so that won't contribute to neuro-conceal? Are there ways of drawing on neuroscience that won't privilege the micro-internal world (brain) over the effects of our practice on relationships, relations of power, privilege and normativity? I know that some narrative practitioners who are interested in neuroscience are trying to hold both frames in critical tension¹². So perhaps these are areas for future conversation and consideration.

2. Trying to enhance narrative practice's clinical effectiveness through neuroscientific understandings

The second way which in some practitioners are engaging with interpersonal neurobiology is by using its understandings to try to enhance narrative practice by encouraging practitioners to:

- expand, uplift, encode and strengthen positive affect during, right after and between therapeutic conversations¹³ (Beaudoin, 2017)
- ask more about embodied experience (Beaudoin, 2017; Zimmerman, 2018).

The interest of narrative practitioners in these two realms – emotion and bodies – has sparked my own. I will now turn to these themes of affect/emotion and the body/embodied experience in narrative therapy in some detail. First of all, let's get emotional ...

Key points from Part 1: Narrative practice meets neuroscience

- Narrative practice has always questioned contemporary taken-for-granted psychological/cultural notions.
- The ways in which neuroscientific understandings are being taken up in popular culture are leading to new ways to manage/optimize our selves through our brains.
- Various narrative practitioners are drawing on neuroscience ideas – often through the writings of developmental psychologists/psychoanalysts; cybernetic writers; and psychiatrists trained in attachment and systems theories.
- Neuro-scientific understandings are being used to either explain narrative therapy premises; measure effects of narrative practice through neuroscience; or try to enhance narrative practice's clinical effectiveness.
- One of the hazards of this is 'neuro-conceal'. By focusing on changes in the brain, one of the first things that can become concealed is consideration of politics (whether this relates to gender, race, class, poverty, sexuality or other relations of power).

¹² For instance, Marie-Nathalie Beaudoin (2019) and Jan Ewing, Ron Estes and Brandon Like (2017) seek to connect sociocultural discourses with physiology.

¹³ Jeff Zimmerman (2018) also encourages practitioners to invite clients to re-experience negative affect – more on this later.

Part 2: Getting emotional: Narrative therapy and emotion/meaning/action

One of the things that mesmerised me when I first witnessed narrative therapy interviews, was how moving I found them to be. Shivers running up and down my spine and tears on my cheeks were regular companions. It was often seemingly small turning points that were the most moving, when suddenly but gently, new meaning had been made. The act of having a cup of coffee was no longer ordinary, but a profound achievement in the face of anorexia. An act of care towards another survivor of abuse, which could have been overlooked, was now honoured as a continuation of a legacy of kindness that had been passed on from a neighbour many years prior. Or the realisation dawning on the face of a young man, that the outsider witnesses hadn't seen him as weird, but as someone holding onto dignity and resisting racism. It was those moments that heralded a change of meaning, a change in storyline, that time and again moved me, as a witness, to tears¹⁴.

And yet, despite this, sometimes it is misread, and I hear someone saying or writing, 'Narrative therapy doesn't deal with emotion'. Actually, narrative therapy deals with emotion in a particular way. It couples emotion and meaning, and refuses to separate them. It also refuses to separate emotion and meaning from action. In this way, emotion is also never separated from culture, politics and ethics¹⁵.

Here are two quotes from Michael White about this:

It's really to do with ... not thinking about the role of emotions but thinking of how all expressions are expressions of experience, units of feeling, units of meaning, units of action, not divided up into one or the other. So there's a refusal to get into this dualism around feeling versus meanings, or feelings versus action. (M. White, 2002)

I've always avoided talking about feelings in the literature because it gets taken up into that time honoured dualism ... if someone is expressing powerful emotion I'm interested in that expression but I'm also interested in where that expression is taking them to that they might not have otherwise gotten to, if they hadn't been expressing that. And I think that's a lot more honouring of what we call 'emotional expression' because it's not just discharging something, it's also an action that's taking someone to a certain place. There's also a meaning and a sentiment expressed in it. You know, that person is opening their life to me, and taking a step in their relationship with me as well. (M. White, 2002)

Significantly, narrative practice is also interested in the real effects of how 'emotions' are understood and practiced in particular times, places and cultures. In the 1970s and 1980s, as narrative therapy developed, there were at least two dominant ideas about emotions in therapy (based on humanistic/structuralist psychodynamic/psychoanalytic understandings):

- that psychological problems were due to 'repression' of emotion that therefore needed to be 'expressed' or 'discharged'
- that the therapist should not show any emotion themselves¹⁶.

The repression/expression discourse was one of the key reasons why Michael White didn't use the conventional language of the time in relation to 'expressing emotion'. It was true then, and is still true now, that talking about emotions within therapeutic realms requires care not to slip into a valorising of 'emotional expression' or 'discharge': to avoid separating emotional expression (performance) from the meanings given to or associated with that expression/performance.

One hazard of therapy based on repression/expression discourse is the possibility of exacerbating problems of memory for those who are invited to revisit the site of trauma without first establishing a safe territory to stand in, and without any

¹⁴ I am referring here to witnessing the therapy sessions of Michael White.

¹⁵ As I was writing this section I recalled the time I sought therapy when I was 19 years old. Early on I realised that the male therapist wanted to elicit in me a particular emotion – anger – and wanted me to express it in a particular direction: towards my mother. I didn't need to be particularly perceptive to work this out as he kept inviting me to take a pillow and to remonstrate with it or hit it to 'express' the anger I must have towards my mum. I also realised that he must do this with every person who came to see him, as I hadn't mentioned my mother (or any other member of my family for that matter). When I simply said, 'you have obviously never met my mother', cut the session short, and said I wouldn't be returning, it wasn't me who was angry. Everything about that interaction was about emotion. Everything was also about politics, culture and ethics.

¹⁶ John Winslade points out that 'This was particularly influential within psychoanalytic thinking – the 'blank screen' of the therapist was seen as the best way to receive client projections of emotion on to the therapist.' (J. Winslade, personal communication, January 21 2019)

revision of meaning¹⁷. A second hazard of any approach that splits emotion from meaning involves increasing the likelihood of engaging in psychological colonisation without realising it, thinking that we can interpret someone's emotions in ways that are removed from our cultural biases. Another way of saying emotion is inseparable from meaning is to say it is mediated by culture¹⁸.

Emotions/meaning/action in narrative practice

What does keeping emotion/meaning/action together look like in practice? Let's take an example. If someone sheds tears in narrative therapy:

- the therapist may explore what value is being expressed through those tears (linked to the concept of the absent but implicit, see M. White, 2000a)
- the therapist may honour the possible significance of the person taking the step of sharing those tears and sorrows with the therapist
- the therapist may ask variations of the question¹⁹ 'if those tears could speak, what might they say?'

In the following short story, Michael White offers a number of such variations.

As Ashley began to describe these episodes of tearfulness, she began to cry. In response to this development, she said, 'See, there I go again, I'm just hopeless'. Instead of turning away from these tears, I asked Ashley if it would be okay for us to have a conversation that might contribute to a wider understanding of them. She gave her assent, and I began to ask some gentle questions about them:

If we were to think of these tears as little capsules that were thought-filled, what thoughts are you aware of at this time that might not be available to you at other times?';

'If these tears contained other pictures or perspectives on your life, on what your life might be about, are you experiencing anything that might provide us with a clue to these?';

'If this flow of tears is reflective of a different attitude towards your own life and to yourself, not one that is so rejecting, what sense do you have of what this attitude might be?';

'If these tears are in part a reaching out to the world, and an opening of your world to others, what's your guess about the nature of the connections they might build?';

'If we were to think of these tears as potentially transporting of you to another place in life, somewhere away from that familiar desperation, where might this place be?' (M. White, 2003, p. 42)

Of course, I have lifted those questions from a longer story of practice, and any such explorations will vary profoundly depending on the context, but I think they offer a glimpse of how Michael White in practice, far from avoiding emotion, turned towards expressions of emotion (such as episodes of tearfulness) in ways that did not separate emotion from meaning or action.

¹⁷ This is a theme I return to later in this paper.

¹⁸ Glenda Fredman, in her thoughtful book, *Transforming Emotions*, provides a helpful distinction between 'autonomous' and 'relational' emotion discourses:

an autonomous discourse locates emotions within the individual and therefore views emotion as innate, universal, subjective, personal and essentially bodily. Autonomous emotion practices would therefore most likely focus on the sensation and distinction of the emotion like the naming, interpreting and encouraging expression of emotion ... A relational discourse on the other hand approaches emotion as created between people and therefore communal and connected with cultural logic. Relational emotion practices would therefore focus on co-ordinating with others and on how emotion stories are created in the contexts of relationships and cultures. (2004, pp. 2–3)

Glenda also provides a very helpful table outlining the differences between relational and autonomous emotion discourses (see Fredman, 2004, p. 14)

¹⁹ Others variations include:

- Could you speak a little to those tears that you are experiencing? (White, 1997, p. 165)
- Would you mind saying a little about those tears? (White, 2001, p. 63)
- Would you say something about those tears? Would you help me understand what they are about? (White, 2001, p. 81).

There are two other aspects of narrative practice I want to mention in relation to emotion.

Within externalising conversations, when exploring the real effects of problems, narrative therapists seek to richly acknowledge the emotional effects of whatever hardships are being experienced. These effects are traced, named and acknowledged through many domains – emotional, physical, spiritual. Externalising conversations also include exploration of how the problem is affecting the person's view of themselves and thoughts about themselves. This includes effects on the actions people are taking or not taking. This also includes effects on relationships and on the lives of others. The ways in which narrative therapists honour the effects of problems don't separate emotional effects from effects on meanings, actions or relationships. These are interwoven²⁰.

Additionally, outsider witness practice (M. White, 1999) involves a form of e-motion. When outsider witnesses respond to a person's or family's testimony, they will describe how they have been 'moved' by this session. In narrative practice, such 'movement' relates to katharsis with a k²¹, rather than catharsis with a c, in that it doesn't elevate a discharging of emotion, but instead honours how the witnesses have been moved, changed or transported. This may include being moved to new understandings (meanings) and/or different actions into the future. Perhaps this would be clearer if it were referred to as e-motion. This, again, is a form of emotion that does not separate feeling from meaning or action.

Above, I speculated about what a therapist might do if someone were to shed tears in a narrative therapy²² session. I want to offer one other example.

The following transcript is from a re-remembering conversation (M. White, 2007) that I mentioned above, between Chris, Jussey Verco and Michael White (M. White, 2000b). In this conversation, Michael has asked Chris about the histories of the comforting skills (which she has named 'gossamer threads') that she had been offering to other women who were also a part of the Silent Too Long group for women survivors of childhood sexual abuse (Silent Too Long, 1998, 2000, 2001). In the course of the conversation, Chris traced the history to her childhood neighbours, one of whom she had given the name Auntie Mary. In the following extract, Jussey, who is the facilitator of Silent Too Long and also a friend of Chris's, acts as an outsider witness.

Michael: So, Auntie Mary – if Auntie Mary could be here and listening to this conversation, and she was just hearing a little bit about some of these links and about how Chris has sort of stepped into this and is, you know, taking up some of these skills in her comforting and healing others, and there's a link between that and what Auntie Mary stood for. How do you reckon Auntie Mary would be feeling if she was here? What would she be thinking about, her life, and

Jussey: Her life, oh, I think she would be deeply touched at maybe the loving and the tenderness that she had shown that little girl who we could predict was probably quite terrified, you know, and that she offered that loving to her and welcome to her, and that to see that little child now as an adult woman doing the same for other very hurt and wounded women. I think that Auntie Mary would be deeply touched by that, mmm.

²⁰ As well as exploring and acknowledging diverse effects of problems, narrative practitioners seek to make visible the ways in which people respond to problems (Wade, 1997; White, 2004c; Yuen, 2009; 2019). This is also territory that involves emotions/meaning/ action together.

²¹ It was Penny White who introduced Michael White to this classical version of catharsis (see White, 1999).

²² I chose to focus on the expression of tears because tears are readily assumed to be an appropriate emotional expression within therapy. I could have, alternatively, offered an example of laughter in narrative therapy, but expressions of mirth or joy are not as privileged within a therapeutic milieu. Of course, sometimes tears and laughter go together, as the Aboriginal people of Port Augusta convey in their message 'Responding to so many losses: The special skills of the Port Augusta Aboriginal community':
Tears and Laughter – For us, tears and laughter go together. As well as sharing sorrow together, we also re-tell the funny stories from a person's life. It's important we don't forget these funny stories. We talk about the good times, we laugh, this makes us feel sad, and then we laugh again. Sometimes looking at a particular photograph might bring tears, another time a burst of laughter!
For us, tears and laughter go together. There are many very funny stories. For instance ... when we asked one of our young ones if he could remember his grandfather's voice and what he used to say, this young one said: 'Yes, sure, I remember him. I remember him saying ... Can you shut up you bastard!' It was very funny! Another time, we were coming back from a funeral on a bus and there was a lot of laughter as we hurried along. As the bus was going a little too fast one young guy yelled out: 'I don't think grandpa wants to see us again quite so soon ... we only just said goodbye to him!' There are many ways in which we grieve with tears and laughter. (Port Augusta Aboriginal Community, quoted in Denborough et al., 2006, p. 24)

Michael: Do you reckon she'd think that her life was for something?

Jussey: Oh, absolutely, yes.

Michael: Yeah, even though she got cut off from Chris?

Jussey: Even though the fence got built, yeah.

Michael: Yeah.

Chris: This is, oh dear, it's beautiful (teary).

Michael: What's beautiful Chris?

Chris: Oh, to think that I could do something to honour her.

Michael: Yeah.

Jussey: Mmm, mmm.

Chris: Oh wow!

Michael: Your sense is that she'd be, what, how would she be feeling towards Chris over the steps that Chris has taken?

Jussey: Um, well, probably quite tender I think, Michael.

Michael: Tender towards her?

Jussey: Yeah, delighted, overwhelmed, probably, know what I mean. Like, because like to see what Chris does with the women, and that these are all women who've been subject to horrific events, and to see the healing that Chris brings into their lives, and so I think Auntie Mary would be blown away by it all! [laughter]

Chris: I just never thought that I was even on the same planet as everyone – I didn't think I could do anything to say thank you [teary].

[Jussey passes Chris a tissue and also takes one for herself as they are both teary]

Michael: Yeah, yeah.

Jussey: What greater thing could you do for them?

Chris: Mmm. Yep.

Jussey: Do you want a tissue too, Michael? (laugh)

Michael: I wouldn't mind one actually. [Jussey passes Michael a tissue as he too is teary]. Mmm. I was thinking a lot about their sadness over the loss of their connection with Chris and what it would mean to them to know that that wasn't really lost, and that it was some of those gifts that were also now being expressed to other women in Chris's special way of doing that. So, that's what I was thinking about, yeah.

Chris: So that's where the gossamer threads [comforting skills] come from? Wow, I never knew.

...

Michael: Their images [the neighbours] will stay with me as well. I just have this image of their sadness of losing their connection with you and this image of, you know, their comforting skills and my sense of what you brought to their life, and what Jussey helped draw out. This will stay with me, it's very beautiful.

Chris: Mmm. (M. White, 2000b)

I include this example because here is an extract from a powerfully 'emotional' narrative therapy conversation in which all three participants (including professionals) are in tears and sharing tissues²³. This 'emotional expression' relates to an alternative storyline, a history that became visible in this conversation, a history that created a more 'usable past' (Wertsch, 2002, p. 45). Great care is taken about the real effects of the expression of emotion, what meaning is being made in relation to this expression, and what this action of expression and meaning-making makes possible.

As I mentioned earlier, far from 'not dealing with emotion', narrative therapy has rigorously challenged two pervasive ideas about emotion in therapy:

- that psychological problems are due to 'repression' of emotion(s) that therefore need to be 'expressed' or 'discharged'
- that the therapist should not show any emotion themselves.

And narrative therapy has gone further in refusing to separate emotion from meaning or action, or from culture. Crucially, narrative practice also acknowledges that the way in which any therapy conceptualises emotion also shapes the relationships formed in the therapy room and beyond. As Michael White described:

an emotional expression is also a self-in-relationship forming activity as well ... so if we just focus on emotion we obscure the fact that this expression is shaping of something. (M. White, 2002)

If a therapy encourages or implores clients to express or discharge their emotions while the therapist is not to show any of theirs, this forms particular sorts of relationships (for more about the position of the therapist in narrative therapy see M. White, 1997)

Far from not dealing with emotion, every aspect of narrative practice is about emotion/meaning/action.

Hazards of 'privileging' emotion and a return to catharsis

The underlying thread of Neuro-Narrative work is emotion, a critical distinction from Narrative work, which has traditionally used Poststructuralist ideas as a foundational structure. *Emotion, emotion, emotion* has become my mantra; not surprisingly, emotion is considered to be the focal organizer of brain functions. (Zimmerman, 2018, p. xiv)²⁴

'emotions should be privileged in this work' (Zimmerman, 2018, p. 37)

As discussed above, there were many reasons why narrative therapy departed from the commonly held perspective of separating emotion from meaning. One of these was that in numerous therapies, the 're-experiencing' and 'expressing' of emotions was seen as a necessary part of 'healing'. This ties into a notion of catharsis that can (and does) contribute to retraumatisation.

Jeff Zimmerman, however, argues for a 'privileging' of emotion – implicitly and explicitly separating such emotion and/or affect from meaning – and speaks of the importance of inviting clients to 're-experience' emotions associated with problems:

the client is asked to pick a time when the Problem has had the effect they were concerned about, and go through this experience in detail, reexperiencing the MOMENT all the way. (Zimmerman, 2018, p. 46)

²³ I have chosen to include this particular example because we are still in touch with both Chris and Jussey who have spoken about the long-term significance of this consultation.

²⁴ This quote is interesting because it echoes wider discussions in the social sciences.

Clare Hemmings (2005) described the ways in which social theorists Masumi and Sedgwick in heralding the 'affective turn' construct a critical history at the same time as they dismiss it. Positing affect as a 'way out' requires that poststructuralist epistemology have ignored embodiment, investment and emotion, and that the academic reader recognize their own prior complicity and current boredom with Theory's straight-jacketing of thought As neither theorist can afford to acknowledge, there is a vast range of epistemological work that attends to emotional investments, political connectivity and the possibility of change. (Hemmings, 2005, p. 557)

There is a quality of reverie when clients are back in the MOMENT²⁵ – you can feel it happening in the room. (Zimmerman, 2018, p. 52)

once he was able to reexperience the affect associated with her death (Zimmerman, 2018, p. 23)

important distinction between reporting and reexperiencing (Zimmerman, 2018, p. 48)

This 'privileging' of emotion is influenced by Dan Siegel's (2011) emphasis on the value of 'emotional arousal' in therapeutic engagements, with which a number of other narrative writers concur²⁶ (see Dunne, 2017).

Much of my work is with groups and communities who have experienced profound hardships, including abuse, war, imprisonment and torture (See Denborough, 2008, 2018). I know that narrative practitioners interested in neuroscience would share my concerns about retraumatising people (see Beaudoin & Zimmerman, 2011, p. 6; Zimmerman, 2018, p. 61); however, I believe that 'privileging' emotion and/or 'emotional arousal', separating emotion/affect from meaning, and inviting people to 're-experience' problematic emotions or situations in the therapy room run a profound risk of returning people to the 'site of trauma', a risk that Michael White spoke about vividly and clearly:

First things first. There is no excuse for people to experience retraumatisation within the context of therapy. Distress yes, re-traumatisation no. I believe that the notion of healing practices based on the imperative of returning to the site of the abuse in order to re-experience this is a highly questionable notion, and, as well, dangerous. This notion is often justified by the theory of catharsis, and this is a theory that obscures the critical dimension of meaning. To simply encourage people to return to the site of trauma can reinforce for them the dominant meanings that inform the self-destructive expression of the experience of abuse. And, this can contribute to renewed trauma and it can incite renewed actions of self-abuse.

Of course, there are many other reasons to question this idea about the importance of returning to the site of trauma. At the time that these people were subject to abuse, they had no power, they had no choice – they were trapped. In response to such impossible and agonising circumstances, many developed rather fantastic mechanisms that enabled them to escape the abusive context – not materially, but to spirit themselves away in mind. Others used what little manoeuvring space that was available to them to create experiences of self-sustenance – and, in circumstances such as these, this is simply an extraordinary achievement. Now let me pose a question. In requiring people to return to the site of trauma, are we not reproducing conditions that are entrapping, that are dispossessing people of choice? And there are other questions that we could ask about this. In requiring people to return to the site of trauma, are we not also unwittingly reproducing our culture's phobia about flight? Are we not being just too complicit with this culture's imperative of 'facing up'? And in this, complicity, are we not closing down the possibilities that might be available to people for the honouring of the special skills and the personal qualities that made it possible for them to navigate through the dark hours of their lives and into the present? (M. White, 1995a, p. 85)

Interestingly, in one of the first papers exploring the implications of neurobiology and narrative practice, Marie-Nathalie Beaudoin and Jeff Zimmerman (2011) concurred about the hazards of inviting people to re-experience traumatic memory, and drew on their readings of neuroscience as they did so:

Our brain's memory is altered by each revisiting of an experience (Sousa, 2006). The memory of an event, for example, becomes infused with the various meanings, and moods, of each revisiting event (more intense moods having a greater effect than neutral ones). This implies that once the memory of an experience is retrieved in therapy, and discussed in meaningful ways, it automatically goes back into storage in an altered way (LeDoux, 2002), either stronger or weaker. *Stronger if the discussion reinforced the problematic experience and enriched it with unhelpful details, such as the process of reviewing a trauma, a practice strongly discouraged in narrative therapy* [emphasis

²⁵ John Winslade draws attention to how some ways of conceptualising 'the present' or 'the moment' privilege a particular view of time: 'one in which the present is regarded as more real than the past or the future. I think this is questionable. I think narrative practice is actually in line with what Deleuze refers to as a reading of time as aion, not the more common chronos. In aion the past is still alive. It flows into and through the present.' (J. Winslade, personal communication, January 21 2018)

To read more about this see Hedtke & Winslade, (2016).

²⁶ Pam Dunne (2017) is focusing on 'emotional arousal' in relation to 'positive' emotions. I return to this theme a little later.

added] (Beaudoin, 2005; Duvall & Béres, 2007; White, 1995a, 2007). Weaker if the re-authoring conversation allowed the client to examine the 'problem highway' in a way that linked alternative experiences with affective responses, and brought forth skills that were initially invisible in the original story. (Beaudoin & Zimmerman, 2011 p. 6)

Far from inviting people to 'privilege' emotion, separate emotion from meaning and 're-experience' problematic emotions or situations, I am interested in diverse forms of narrative practice that create a sense of honouring, acknowledgment and/or *communitas* in relation to the real emotional, spiritual, physical, mental, intellectual and relational effects of the horrors people have endured; practices that honour people's responses to hardship, that do not always require people to speak in the first person about such hardships (let alone re-experience them), and that elicit and richly describe local, personal, collective and cultural healing ways²⁷.

Affect-infused unique outcomes

Before going further, I want to express my interest in the writings by Marie-Nathalie Beaudoin and Jeff Zimmerman (2011) about what they call 'affect-infused' unique outcomes (p. 9) and the ways in which Marie-Nathalie Beaudoin (2017) is seeking to expand, uplift, encode and strengthen positive affect during, right after and between therapeutic conversations. These efforts to develop richer sensory experiences of unique outcomes and to 'intensify the preferred self' (Beaudoin, 2019) avoid the hazards of inviting people to re-experience problems and provide additional options for practitioners.

Escaping basic emotions theory

While considering emotion, narrative practice and neuroscience, there are two further themes to discuss. The first relates to what's known as basic emotions theory. Social psychologist Margaret Wetherell (2012) has outlined a series of what she describes as 'wrong turns' within neuroscience-informed research on affect. One of these 'wrong turns' relates to the continuing influence of 'basic emotions' theory, which underpins the work of some neuroscientists (whose work is, in turn, being drawn on by narrative therapists):

Throughout the 1980s and 1990s, anthropologists and social psychologists, particularly social constructionist researchers, were finding in study after study huge variability and contingency in emotional lives, and in how people across the globe narrated and interpreted their physiological states. Psychologists and neuroscientists, on the other hand, typically dealt with only a small set of what were seen as universal and genetically determined 'psychological primitives'. The basic emotions paradigm that dominated psychobiology of affect was a deep investment in the idea that emotion routines are programmed, that affect templates are innate residues of archaic parts, and that the 'colour wheel of affect' falls into relatively discrete patterns. (Wetherell, 2012, pp. 17–18)

Margaret Wetherell describes how 'basic emotions' thinking ... still percolates throughout celebrated popular science accounts of emotion ... ' (Wetherell, 2012, p. 17; see also Leys, 2011, p. 439). As a result, basic emotions thinking also percolates through the writings of some narrative practitioners who are engaging with neuroscience:

Panksepp's model suggests the brain is guided by seven emotional systems: SEEKING, FEAR, RAGE, PANIC/ GRIEF, LUST, CARE, and PLAY (Zimmerman, 2018, p. 39)

If narrative practice is to engage with neuroscience, how can we ensure we escape 'basic emotions' thinking?²⁹ Perhaps one way is to avoid separating emotion from story.

²⁷ For examples see Denborough (2008, 2018).

²⁸ There are many alternatives to basic emotions theory that fit well with narrative practice. Margaret Wetherell (2012) draws upon the work of Burkitt:

Following Gregory Bateson, Burkitt emphasises that an emotion, like anger or fear, is not an object inside the self, as basic emotions research assumes, but is a relation to others, a response to a situation and to the world. An emotion is above all a relational pattern and as such, I would say, is automatically distributed and located across the psychosocial field. (Wetherell, 2012, p. 24)

Weaving stories of emotion

Glenda Fredman, in her book *Transforming emotion* (2004) describes an approach of 'weaving stories of emotion' which:

involves inviting people to situate their feeling in a sequence of action (How did the feeling come about? When did it begin? How did it develop?) and in the context of interactions (Who else was involved? How did they respond? If I, or anyone else, was with you, what would you want us to notice about this feeling? What would you like us to do with this feeling?) (Fredman, 2004, p. 112)

Glenda Fredman's approach also involves weaving threads of (bodily) experience, action and judgement to generate a richer, more textured 'emotion story':

Questions like, 'How do you know you are feeling what you describe?', 'Who else would give it this name?', 'Where do you get your ideas about this emotion from?', 'How were you taught these ideas?' and 'Who shares your views?', can bring forth layers of contexts like relationship, culture, family or gender, through which we can weave different threads of the emotion story. (Fredman, 2004, p. 114)

To me, this is entirely congruent with the longstanding narrative therapy tradition of not separating emotion from meaning or action. I believe this tradition means that narrative practitioners are in a unique position from which to engage with the affective turn.

Key points from Part 2: Getting emotional: Narrative therapy and emotion/meaning/action

- Narrative therapy is emotional!
- Narrative practice couples emotion with meaning, and refuses to separate them. It also refuses to separate emotion and meaning from action. In this way, emotion is also not separated from culture, politics and ethics.
- Narrative practice is also interested in the real effects of how 'emotions' are understood and practiced in particular times, places and cultures.
- Within narrative practice great care is taken about the real effects of the expression of emotion, what meaning is being made in relation to this expression, and what this action of expression and meaning-making makes possible.
- 'Privileging' emotion and/or 'emotional arousal', separating emotion/affect from meaning, and routinely inviting people to 're-experience' problematic emotions or situations in the therapy room run the risk of returning people to the 'site of trauma' and consequent re-traumatisation.
- Rich possibilities for practice are found when we avoid separating emotion from story.

Breakthrough (for me at least!) #2: Coming across fantastic feminist writings about the affective turn including Ruth Leys, Ann Cvetkovich, Margaret Wetherell, Clare Hemmings and Deborah Gould . . .

Part 3: Engaging with the affective turn

I agree wholeheartedly with Jeff Zimmerman (2018, p. 182) that Michael White was particularly skilled in being attuned to affect in the therapy room. In this section, I wish to explore opportunities for the field of narrative practice that are associated with what's become known as the 'affective turn' – let me explain.

Over the last 20 years, a number of authors in the social sciences and humanities have begun to explore non-conscious affect and its relationship with conscious emotion. This movement, which also places an emphasis on bodily or embodied experience, is referred to as the affective turn³⁰.

As part of the affective turn, writers across various disciplines have become very interested in making distinctions between affect and emotion. Here is Deborah Gould's explanation:

I use the term *affect* to indicate nonconscious and unnamed, but nevertheless registered, experiences of bodily energy and intensity that arise in response to stimuli impinging on the body. *Registered* in that the organism senses the impingement and the bodily effects, but nonconscious in that this sensing is outside the individual's conscious awareness and is of intensities that are inchoate and as yet inarticulatable ... Where affect is unfixed, unstructured, and nonlinguistic, an emotion is one's personal expression of what one is feeling in a given moment. An expression that is structured by social convention, by culture. (Gould, 2010, pp. 26–27)

Why is this relevant to narrative practice? Well, I believe that narrative therapy can be understood as a form of 'affective practice' (Wetherell, 2012, p. 22) – a way of traversing affect to emotion in particular, careful ways. Here is Deborah Gould (2010) again:

The distinction here between *affect*, as bodily sensation that exceeds what is actualized through language or gesture, and an *emotion* or *emotions*, that which is actualized, can be illustrated through a discussion of one way we get from the one to the other. Affect is to the side of conscious thought rather than within it, but, as sensory intensity, it can stir an inchoate sense that we are experiencing something, a vague stirring that, if forceful enough, can induce efforts – more or less conscious – to figure out what we are feeling and how to express it. In that figuring, we necessarily draw from culturally available labels and meanings and from our habits and experiences, through which a gesture or linguistic naming that 'expresses' what we are feeling emerges. This 'expression' is never complete, never an exact representation of our affective experience ... it is better thought of as an approximation.

In this process of naming or approximately expressing what we are feeling, a transformation occurs, a reduction of an unstructured and unrepresentable affective state with all of its potential into an emotion or emotions whose qualities are conventionally known and fixed ... An emotion, in other words, squeezes a vague bodily intensity or sensation into the realm of cultural meanings and normativity, systems of signification that structure our very feelings. (Gould, 2010, p. 27)

There is a reason why I am drawing so extensively on the work of Deborah Gould. Her work engages with the politics of emotion (Staiger, Cvetkovich, & Reynolds, 2010) more than any other writer I have found who is engaging with affect. This is because Deborah Gould has a long history of engagement in ACT UP and Queer to the Left and is a founding member of the art/activist/research collaborative group Feel Tank Chicago. She is interested in how considerations of affect can assist in understanding social movements. Here, she writes about the consciousness-raising groups of women's liberation:

consider the 'emotion work' that occurred in women's consciousness-raising groups in the late 1960s and early 1970s. Feminists challenged individualized understandings of what many women were experiencing as an inchoate sense of things simply not being right – what many called depression – and pointed to the social origins of that feeling state, renaming it anger. That interpretive emotion work encouraged women to understand themselves and their situations

³⁰ Ann Cvetkovich explains it this way:

the affective turn has been signifying a body of scholarship inspired by Deleuzian theories of affect as force, intensity, or the capacity to move and be moved. Crucial to such inquiry is the distinction between affect and emotion, where the former signals precognitive sensory experience and relations to surroundings, and the latter cultural constructs and conscious processes that emerge from them, such as anger, fear, or joy. (Cvetkovich, 2012, p. 4)

in new ways and indeed to *feel* differently, to feel angry rather than depressed and self-questioning. The sentiments that many women had been feeling might best be understood as affective states that arose from the conditions of life in a male supremacist order, were attuned to the contradictions within that order, if only inchoately, and had the potential to reinscribe that order or inspire challenges to it. The context of the women's liberation movement helped direct that potential by naming a complex affective state as anger ... Movement contexts are important sites where amorphous affective states get translated into named emotions. (Gould, 2010, p. 34)

To my mind, therapy is another key site in which 'amorphous affective sites get translated into named emotions' (Gould, 2010, p. 34). One way of conceptualising narrative therapy is to see it as involving a weaving between acknowledging affect and drawing it into emotion/meaning. As I mentioned earlier, I agree with Jeff Zimmerman (2018, p. 182) that Michael White was attuned to affect and took great care in how this became named in language (transformed to emotion).

While some ways in which people are describing affect seem antithetical to narrative practice (and more in sync with psychodynamic notions of the unconscious³¹), others that emphasise affect as not unconscious³² but rather nonconscious, not irrational but non-rational, provide encouragement to narrative practitioners to take extra care in negotiating meaning and naming experience. Encouragements that I draw from the affective turn include:

- to never rest with only one 'emotion' named, but instead to richly explore multiple (possibly contradictory) effects of any particular experience
- to be aware of how any naming of emotion is perhaps also a closing down of other possible namings that might have value at other times

³¹ If you want to read more about the different ways in which particular social theorists are conceptualising affect, I highly recommend the paper by Ruth Leys (2011). Leys locates the ways in which some affect theorists are seeking to separate affects from cognition or meaning in a historical context in ways that I find most helpful:

Here a historical perspective is useful. The anti-intentionalism so pervasive today in affect theory has a genealogy that for our purposes can be traced back to developments in the psychological sciences beginning in the early 1960s. At that time two very different scientific approaches to the emotions were simultaneously proposed. One approach, associated with a famous (if problematic) experiment by Stanley Schachter and J. Singer, published in 1962, claimed to demonstrate that affect and cognition are indissociable. A rival approach, also first published in 1962, was associated with the work of Tomkins, who argued that the affects and cognition constituted two entirely separate systems and that accordingly the emotions should be theorized in anti-intentionalist terms. At first Schachter- Singer's "cognitive" model prevailed. But, for various reasons that have yet to be adequately evaluated, over time Tomkins's approach displaced the cognitive model with the result that by the 1990s his had become the main-stream position. What we are witnessing today is the embrace by the new affect theorists in the humanities and social sciences of the same anti-intentionalism that for more than twenty years now has been entrenched in the sciences of affect. (Leys, 2011, p. 469)

To my mind, narrative practitioners have always been aligned with the intentionalist paradigm re emotions that does not make the error of separating affect from meaning.

The present situation therefore offers to the historian and critic the engrossing phenomenon of an ongoing clash between competing ways of thinking about the emotions. What is especially striking is that scientific researchers who have been formed by and trained in Ekman's presuppositions and research methods are expressing doubts about the anti-intentionalist paradigm. But as powerful and even intellectually decisive as these scientists' objections may be, it will not be simple or easy for them to overthrow the anti-intentionalist paradigm. The latter's solidarity with evolutionary theories of the mind; the agreement between its assumptions about the independence of the affect system and cognition and contemporary presuppositions about the modularity and encapsulation of brain functions; the congruence between its image-based approach to the emotions and neuroimaging techniques; the convenience of Ekman's methods, based on the use of standardized posed photographs of expression as test stimuli, in facilitating research – all these and other factors help explain why the Tomkins-Ekman approach remains firmly entrenched in contemporary neuroscientific work on the emotions. How long this strange state of affairs will prevail is an open question. (Leys, 2011, p.471)

³² John Winslade drew my attention to the ways in which the work of Deleuze and Guattari is sometimes misread:

'Deleuze and Guattari heavily critiqued psychoanalysis for its pathologising aspects, targeting its emphasis on emotions as 'lack' (in Deleuze & Guattari, 2004). They argued for desire as foundational, disconnected it from an exclusive emphasis on sexuality on the one hand and from lack on the other, saying that desire was the impetus of life to continually produce difference and to do so rhizomatically. Such difference was always political. All of which goes to suggest that there is at times a profound misreading of Deleuze. He argued that affect was something all ontological beings experienced (including rocks) which makes it quite different from the notion of the unconscious within psychoanalytic tradition. (Winslade, personal communication, 21 January 2018)

And most significantly,

- to ensure we are making room for experiences to be named in ways that are outside normative culture, so that our affective practice is actually expanding culture rather than requiring acquiescence to it. This, of course, is part of the narrative practice tradition of never relying on existing terminology but instead ‘exoticising the domestic’³³ (M. White, 2004a, pp. vi–vii) so that people can name their experiences in their own words and terms.

A vivid example of such careful, non-normative affective practice is illustrated in David Newman’s collaborations with young people in Uospace, an inpatient youth mental health service in Sydney³⁴ (Newman, 2008, 2015, 2016a, 2016b). If ever there is a context in which the naming of experience requires exquisite care to avoid replicating normativity, inpatient mental health services are probably it.

David Newman and the young people are in a continual collaborative process of creating a living ‘dictionary of obscure experiences’ (Newman, 2019). Its introduction reads:

Sometimes we have experiences that are hard to find words for, that are unique, complex or obscure. Below we have started a dictionary for such experiences. This dictionary is a way to bring forward these experiences, and even find unique words for them. There might be many reasons for why this is important to do and the following comments offer some:

‘When I go to a really professional doctor and they can’t find anything wrong I’d feel really yucky, like what I’m feeling doesn’t exist. If I could label this experience, then it gives me permission to feel what I’m feeling when it happens again. It will still be there and it will still feel like crap. However, it makes it easier to go back to my life’.

‘I can feel silly or crazy for having these experiences. It’s good to hear other people experience something similar. I can then see it as normal and that I’m not a weird alien.’

Here I will include the four entries in this ever expanding dictionary (as at the time of writing this article) that start with the letter D:



Dali’s death sentence:

Loss or distortion of time due to depression.

© Salvador Dalí, Fundació Gala-Salvador Dalí/VEGAP.
Copyright Agency, 2019

Density: When anxiety shrinks your world to the point where even the most mundane things are terrifying.

Diagnostiny (Ref: ‘diagnosis destiny’): Those moments when diagnosis becomes destiny.

Drooping: A heaviness in your head when nothing’s happened. It often begins in the morning so you don’t even have the option of starting your day on a good note.

³³ Michael White (2004a, pp. vi–vii) drew on this concept of Pierre Bourdieu’s.

³⁴ For more information about David Newman’s work see: www.sydneynarrativetherapy.com.au

Initiatives like David Newman's dictionary of obscure experiences are a continuation of a narrative practice tradition of traversing affect to emotion in particular, careful, non-linear ways³⁵ that:

- sponsor diversity not conformity
- do not seek to fix affect into singular emotion
- do not rely on existing global terminology for emotional experiences.

In this way, I think narrative therapy can be understood as a form of 'affective practice'³⁶ seeking to traverse 'the body, the discursive, social contexts, histories, personal stories and affect's movement' (Wetherell, 2012, p. 26).

It's my hope that such a conceptualisation can provide a way for narrative practice to engage with non-conscious affect while still prioritising 'conscious purpose and intention, considered choice, cherished beliefs, personal values, nourished wishes, and preferred hopes' (White, 2000c, pp. 14–15).

Politicising emotion

There is another possibility that opens for the field of narrative practice when we acknowledge the ways that narrative therapy has always engaged with emotion (not separating emotion from meaning and from action). This relates to the possibility of joining with political emotion³⁷ projects!

Breakthrough (for me at least!) #3: I feel really good about public feelings projects!

Here are possible new friends for us as narrative practitioners to play with ...

³⁵ The ways in which Michael White worked with children can be read as assisting them to bring into language the ways they were struggling with unnamed affective experience. For instance, when Richard, a boy of seven years of age, came with his mother, Jane, to consult with Michael, he was generally fearful, quite frail, considered to be 'school phobic', and was suffering from a condition that was believed to be 'psychosomatic'. He was also experiencing persistent insomnia. It was only after Michael invited Richard to paint 'the fears' that were taking away his sleep, and then engaged in externalising conversations about them, that Richard devised a plan to 'educate them' (which involved the creative use of a box) and went on to become the President of the 'Fear Busters and Monster Tamers Society of Australia and New Zealand' (see White, 2006). To my mind, this is an example of skilled affective narrative practice.

³⁶ I have drawn the term 'affective practice' from Margaret Wetherell, who in turn borrows from Valerie Walkerdine's work on 'affective communities' (Wetherell, 2012, p. 23). Interestingly, conceptualising narrative practice as an 'affective practice' is perhaps in accord with what Marie-Nathalie Beaudoin and Jeff Zimmerman (2011) described in a paper they wrote together some years ago: 'We have begun to consider the usefulness of thinking about the process of deconstruction as the linking up of implicit affect (affect as it has been absorbed from our experiences without us necessarily having had conscious awareness that we are doing so), to the explicit or factual, personal or cultural knowledges we might have about our lives.' (Beaudoin & Zimmerman, 2011, p. 5)

³⁷ In refusing to separate emotion from politics, narrative practice has a long history of drawing on feminist considerations (see C. White, 2016). This, for instance, is what shapes Michael White's (2001) questions in relation to Larry's 'anger': Imelda and Eric decided to seek further consultation following a recent crisis. In a 'fit of anger' Larry [their 13 year old son] had held a knife to his mother's throat. This was the 'last straw' for Imelda. In response, she packed her bags and left the family home, vowing never to go back. She stayed with a cousin for a couple of days, and then returned, stating that she would give things one last try. Consulting me was part of the terms of this one last try. In the early part of my consultation with this family I heard about how angry Larry gets towards his mother, and I learn that it is not at all unusual for him to threaten her at these times. In response to this I seek information about the specificity of his actions when angry:

M: Okay, so I am hearing about how angry you get towards your mother. I'm curious.
Do you ever get this angry towards your father?

Larry: Yeah.

M: Would you say more angry, less angry, or about the same?

Larry: Same.

M: So, have you ever held a knife to your father's throat?

Eric: [shakes his head]

Larry: No.

M: Would you ever consider it?

Larry: No

Eric: [shakes his head]

Refusing to separate emotion from meaning and action can enable exciting collaborations between narrative practitioners and those who are seeking to politicise emotion, such as queer activists and others involved in 'public feelings' projects. Among other activities, public feelings projects like Feel Tank are organising around the concept of 'political depression':

The concept of political depression is not, it should be emphasized, meant to be wholly depressing; indeed, Feel Tank has operated with the camp humor one might expect from a group of seasoned queer activists, organizing an International Day of the Politically Depressed in which participants were invited to show up in their bathrobes to indicate their fatigue with traditional forms of protest and distributing T-shirts and refrigerator magnets carrying the slogan 'Depressed? It Might Be Political!' The goal is to depathologize negative feelings so that they can be seen as a possible resource for political action rather than as its antithesis. (Cvetkovich, 2012, p. 2)

These public feelings projects are a site of resistance to the current happiness/positivity trend in Western psychology in that they depathologise negative feelings such as shame, failure, melancholy, and depression and rethink categories such as utopia, hope, and happiness as 'entwined with and even enhanced by forms of negative feeling' (Cvetkovich, 2012, p. 5).

In doing so, options for different action then become possible, as First Nations poet Billy-Ray Belcourt describes in their book of poetry, *This wound is a world*:

In *The Alphabet of Feeling Bad*, Cvetkovich and Karin Michalski ask: 'Is it possible to share the feeling of being lonely or alone as a way to make new forms of collectivity?' This *Wound is a World* insists that it is. It insists that loneliness is endemic to the affective life of settler colonialism, but that it is also an affective commons of sorts that demonstrates that there is something about this world that isn't quite right, that loneliness in fact evinces a new world on the horizon. (Belcourt, 2018, p. 59)

I think it's worth considering how Ann Cvetkovich (2012) and others are seeking to politicise depression:

Public Feelings takes up depression as a keyword in order to describe ... *how capitalism feels* ... [in order to understand] culture as a 'way of life' and 'a structure of feeling' ... The richer accounts of the ordinary sought by the Public Feelings projects are also new ways of providing the more systemic accounts of power that have been central to cultural studies. Depression, or alternative accounts of what gets called depression, is thus a way to describe neoliberalism and globalization, or the current state of political economy, in affective terms. (Cvetkovich, 2012, p. 11)

One of the aims of the public feelings projects is to try to make connections between personal and collective despair:

The obscurity of the connections between our own despair and the collective despair that is present in the places where we live adds to our confusion and (political) depression. (Cvetkovich, 2012, p. 81)

And so Ann Cvetkovich and others are seeking particular forms of testimony:

I've been looking for forms of testimony that can mediate between the personal and the social, that can explain why we live in a culture whose violence takes the form of systematically making us feel bad. Ideally, I'd like those forms of testimony to offer some clues about how to survive those conditions and even to change them, but I'd also settle for a compelling description, one that doesn't reduce lived experience to a list of symptoms and one that provides a forum for feelings that, despite a widespread therapeutic culture, still haven't gone public enough. (Cvetkovich, 2012, p. 15)

To my mind, narrative therapy and collective narrative practice are perfectly located to respond to these calls from public feelings projects. We can use narrative therapy and collective narrative practices to create and engage in an affective commons to sustain lives and counter-cultural action.

Testimonies that mediate between the personal and the social

To illustrate this, I wish to include a recent example of a collective narrative practice document that acts as a form 'of testimony that can mediate between the personal and the social' (Cvetkovich, 2012, p. 15). It is a collective testimony from people who have come to Australia as refugees about the ways they are 'surviving the ocean of depression'.

It was developed as an initiative of Abdul Ghaffar Stanikzai, a doctor and human rights activist from Afghanistan who now lives in Adelaide (as he and his family were granted refugee status here). While working as an interpreter, Abdul Ghaffar Stanikzai met refugees who were residing in psychiatric wards after attempting to end their lives. After escaping violence in their homelands, and then enduring the violence and degradation of the Australian immigration detention regime, these men and women were now residing in the Australian community but their will to live was tenuous.

In the hope of offering something to those in despair, Dr Stanikzai proceeded to interview other asylum seekers and refugees who had also had to endure the ocean of depression and had taken steps to make new lives in this land. Together, he and I then created a collective testimony that is now available as an audio resource in Arabic, Dari, Farsi, Nepali and Pashto (See: dulwichcentre.com.au/surviving-the-ocean-of-depression/)

The testimony includes a number of themes, each illustrated with stories. I will include an extract here:

Surviving the ocean of depression

Country means to us like mother. If you leave your country, it is like leaving your mother, so there is always a vital reason behind that. We left our country based on a life-threatening situation. We were searching and asking for protection. We were chasing peace.

... Some of us came as refugees by plane. Some of us came as asylum seekers by boat. Some of us lived despairing in detention for years before we had a chance to start to make a life in the community ...

All of us wish to be active members of the Australian society in every aspect from work, social life and in making peace. But we have known times of great sorrow, worry, sadness ...

We have had times when we have lost hope – times when it has seemed too difficult to go on with life. Some of us have nearly drowned in the ocean of depression. Some of us have nearly been overcome by thoughts of ending our lives ... We want to share with you some of the ways we have survived despair, or depression, or worry ... If you are drowning, we hope our words reach out to you ...

Life studies

I thought that when I was in Australia, I would learn to speak English in six months and then finally start university. But life is not so simple. When I got here I learnt I would have to go back to high school and that this would take three more years. It was like going back to zero ... Negative things like this can get you down. They can steal your confidence. They can bring disappointment and make you think of yesterday. It is easy to become withdrawn. And so hard to leave the house. Then I realised that at high school I would not only be doing secondary studies (which I had completed in Iran), I would also be doing life studies. I would be learning about life and perhaps what I learnt could also help others. This has now come true.

The most important thing I have learnt through these life studies is patience. There is a saying in our culture, 'you cannot travel 1000 miles in a single night'. This is a helpful phrase.

I have also learnt the importance of having more than one goal. As well as having your main hope, have another one, a smaller one, at the same time. This will mean that after every failure there remains a hope of success. Not everyone can be a doctor, dentist or engineer. Doctors and dentists need patients, and sometimes the patients' jobs are just as important or even more important. Every engineer needs labourers to make the buildings. Society needs all of us together.

These two learnings from my life studies, about patience and about always having more than one goal, are ways of surviving when you are making a new life.

Tears and screaming

For me, tears are the only solution. Peace visits only after tears. For some of us mothers, screaming brings relief. When times are hard in my family, I start talking very quickly and loudly and then I scream in front of my husband, I tell him I won't listen to him. And then before too long I am laughing. Screaming and then laughing makes a difference, although my daughter finds this very strange ...

There are other things that help too ...

[Other themes not included here involve 'Bringing a smile to the face of others', 'Water can bring you fresh ideas', 'Taking refuge in the past', 'My friend's smile', 'Remembering and learning from my ancestors', 'Eating' and 'After each darkness there is light']

These are some of the ideas and skills that are helping us to survive the ocean of depression. We left our countries based on a life-threatening situation. We were searching and asking for protection. We were chasing peace.

We know about the ocean of depression and the ocean of worry. We know of great sadness.

After each darkness there is light.

After each night there is day.

If you are drowning, we hope our stories reach out to you.

We are waiting to meet you. (Stanikzai, Denborough, & Byrne, 2018)

The creation of this collective testimony and its circulation has been a particular form of public feelings project. It has sought to create a bridge between the intense personal and isolating experience of asylum seekers/refugees in psychiatric settings and others who have also experienced such an 'ocean of depression'. It seeks to honour and share not only despair but also insider knowledge and diverse skills and traditions of endurance and survival. In doing so, it seeks to use story to assist the listener to reconnect with their own survival skills.

At the same time, by circulating this testimony to a wider audience (including to you, the reader), we seek to make public the multi-textured hopes, commitments, sorrows and contributions of those who are 'chasing peace'. Hopefully, this provides a counter-story to the dishonouring accounts of the lives of asylum seekers that are routinely broadcast in Australia at this time in service of border imperialism (Walia, 2013).

I have included this testimony here because far from narrative therapy not engaging with emotion, narrative therapy is always engaging, and has always engaged, with emotions/meaning/action. In fact, at this time of the affective turn, I believe the field of narrative practice, as a form of poststructuralist practice, is a perfect site to bring together poststructuralist and discursive considerations and realms of affect and emotion. David Newman's dictionary of obscure experiences and the collective testimonies that can accompany public feelings projects to politicise emotions are just two examples of diverse forms of affective narrative practice.

Key points from Part 3: Engaging with the affective turn

- Over the last 20 years, a number of authors in the social sciences and humanities have begun to explore non-conscious affect and its relationship with conscious emotion. This movement, which also places an emphasis on bodily or embodied experience, has been called the affective turn.
- Narrative practice can be understood as an affective practice – a process by which non-conscious affect is drawn into emotion through careful naming and meaning-making.
- This way of understanding narrative practice provides encouragement for practitioners to never rest with only one 'emotion' named, but instead to richly explore multiple (possibly contradictory) effects of any particular experience; to be aware of how any naming of emotion is perhaps also a closing down of other possible namings that might have value at other times; and to ensure we are making room for experiences to be named in ways that are outside normative culture.
- This way of understanding enables narrative practitioners to consider and engage with non-conscious affect while still prioritising conscious purpose and intention.
- By refusing to separate emotion/meaning/action narrative practitioners are aligned with the work of feminist social theorists who see emotional/affective states like 'depression' as both personal and social/political.
- Recognising this can enable narrative practitioners, like those involved in Public Feelings projects, to seek ways of mediating between the personal and the social/political.
- Narrative methods such as the dictionary of obscure experiences and multi-storied collective testimonies can be understood as two forms of affective narrative practice.

There is one further question I now wish to respond to: how does narrative therapy engage with the body, somatic experience and embodied experience?

Breakthrough (for me at least!) #4: There's a long (untold) history of embodied narrative practice!

Part 4: Narrative therapy and the body

One of the reasons that some narrative practitioners are drawn to neuroscience relates to an interest in embodiment:

For my part, I am fascinated by embodiment, and think it's extraordinary to have a sense of what happens in the brain and body under externalizing language (Marie-Nathalie Beaudoin, personal communication, 7th June, 2019).

I share Marie-Nathalie's interest in these realms. In this section, in the hope of contributing to discussions about narrative practice and embodiment, I take a look at the long history of narrative therapy engagements with the body. Interestingly, one of the primary contexts in which narrative therapy initially developed was with children and young people who were struggling with bedwetting, encopresis, what's known as 'conversion disorder' (in which children were displaying blindness, paralysis or other physical symptoms that could not be explained medically), anorexia and life-threatening, chronic and often disabling asthma (Epston, 1999).

There are a multitude of ways in which narrative therapy engages with embodied experience. I have already mentioned how narrative practitioners respond to the physical expression of tears – by not separating emotion, meaning and action³⁹. Just as narrative therapy refuses to split emotion from meaning and action, narrative practices engage with the body in numerous ways that do not further a mind/body split⁴⁰.

To demonstrate this, I have turned back to the writings of Michael White to explore the multiple ways in which his work engaged with the body. I have included below six different ways in which narrative therapy engages with bodily experience, and have included direct quotations of questions to illustrate these. I am sure there are many others and I would welcome hearing from you if you have additional ideas.

1. Externalising conversations include considerations of the ways the problem is affecting how people are treating and relating to their bodies

In relation to self-hate:

What is this self-hate talking you into about yourself?

What seeds is it planting in your mind about who you are? How does it have you treating your own body?

Does it invite you to nurture your body, or does it require you to reject your body?

Does it have you treating your body with compassion, or does it encourage you to take a hierarchical and disciplinary approach to your body? (M. White, 2004b, p. 125).

³⁹ The sorts of questions Michael was asking are similar to those posed by Ogden (quoted in Zimmerman, 2018)

'what does that feeling in your body want you to do? What conclusions is it encouraging? If the tension could talk, what might it be telling you? Why don't you ask your body how the tension wants you to move, pull in, push out, or push away? What image comes up when you picture this?' (Zimmerman, 2018, p. 92)

⁴⁰ For those interested in theory, it's worth considering how the idea that poststructuralist narrative practice does not engage with the body echoes a much wider discussion across disciplines in which certain cultural theorists have made a case that poststructuralist and discourse thinkers have ignored the body. Ruth Leys (2011) points out an irony in this situation in that the very cultural theorists who are currently privileging the body over the mind are doing so in ways that sometimes promote a continuation of a mind/body split:

[Massumi] comes across as a materialist who invariably privileges the 'body' and its affects over the 'mind' in straightforwardly dualist terms, forgetting that . . . the 'body' is not a pure state of being but rather a pragmatic classification of the operations of 'pure experience.' Just as the 'mind' is. (Leys, 2011, p. 468)

There are, however, other ways of understanding embodied experience that do not further the mind/body split. For instance, William James's notion:

in practical life no urgent need has yet arisen for deciding whether to treat them [affectual experiences] as rigorously mental or as rigorously physical facts. So they remain equivocal; and, as the world goes, their equivocality is one of their great conveniences. (Cited in Leys, 2011, p. 468, note 61)

I believe that narrative therapy works with this equivocality in ways that don't separate bodily experience from meaning.

When we were talking about how the self-hate had your treating your own body, you said that it required you to cut. I wanted to know what this was about, and you said that it was partly about disciplining your body. So my question is, what's this like for you? (M. White, 2007, p. 47)

2. Exploring how unique outcomes have influenced relationships to one's body

The following questions are drawn from the long history of narrative therapy in relation to anorexia:

How has this step in the reclaiming of yourself changed your attitude to your body?

Do you think this has undermined the claims on your body that others have made in the past? (M. White & Epston, 1990, p. 158)

Significantly, this second question also places the relationship with the body in the context of power relations.

3. Exploring how specifications of gender recruit people to act in relation to their bodies

The following questions relate to the influence of particular dominant conceptions of masculinity:

What sort of operations on your life, on your body, and on your soul does/did this way of thinking and this way of living require you to engage in? How do/did these ways of thinking and living have you relating to yourself? How do /did they shape your life? (M. White, 1992, p. 50)

4. As part of generating an experience-near characterisation of the problem, sometimes this is associated with a particular part of the body

The following extract is from a chapter entitled 'Externalizing and responsibility' (M. White, 2011b). It describes an externalising conversation with a young man who has been violent to his younger siblings, who was assaulting his mother and had attempted to assault his father. The acts of violence have been named as 'the hurting'. In assisting the young man to take a position in relation to 'the hurting', Michael includes considerations of the body. The young man's mother was also present.

At another point in the conversation, I ask him a little bit about how this 'hurting' affects how he feels, because I can see his mother's crying. So I ask, 'Well, how does it have you feeling? Does it make you sad?' He's not sure. We talk a bit more, and he says that it does make him sad. I ask, 'Well, does this show itself like it shows itself in your mother? Like with tears, or in a different way?' He says, 'Different way.' And I ask, 'Well, I can see where it is in her body; where is it in your body? Is it here, or there, or there? Where is it?' He chooses the heart out of a range of choices. Then I ask, 'What's it like when you're feeling that sadness in your heart?' and he says, 'I feel all alone at this time.' Now, he's never given voice to these understandings about life; this is entirely new. So, once again, this is an achievement: he's linking these acts of violence to 'hurting,' to sadness, to where that touches him in his body, to being all alone in life—and these are all new developments. (M. White, 2011b, p. 120)

5. Attending to embodied expressions in the therapy room

Sometimes, noticing and attending to embodied expressions in the therapy room is significant. In this story of practice, Michael first of all engages with a young man's shrugs and nods (bodily expressions) when no spoken word expressions were being offered, and then acknowledges the significance of a solitary tear.

This opened the door for our work together to become more collaborative. 'Daniel, what is it like for you to be talked into such negative things about yourself?' This time Daniel was shrugless in his response. He glanced at his parents, and, taking this as a cue, I asked them: 'What do you think it is like for Daniel to be talked into such negative ideas about who he is?' In response, Tom said, 'I guess that it makes him lonely – and miserable too'. 'I reckon that he is secretly sad about this', said Lucy, 'because I am sure that the wet patches that I sometimes see on his pillow in the mornings are from tears'. I looked at Daniel, wondering whether or not he would confirm this. Suddenly I saw a tear surfacing in the corner of his eye. We all saw it. Daniel turned his head aside, his tear evaporators working overtime. When he looked back the tear had vanished. But things were never the same after this tear. There was a way forward. The existence of this tear was a signal that Daniel had taken a position on the trouble that everyone

else had taken a position on. Now, for what seemed like the first time, there was an opportunity for the members of this family to be joined together, with me, in their efforts to break their lives from what had become such a terrible predicament. (M. White, 2004b, p. 123)

6. Assisting people to bypass mind/body impasses

In their early work with children, Michael White and David Epston described numerous ways of bypassing the mind/body impasse (See M. White & Epston, 1997). Sometimes this involved moving between embodied experience to meaning in ways that honoured what people (including their bodies) gave value to:

Martin, age 8, and his parents consulted me about his fearfulness. This fearfulness had been a feature of Martin's life since he was 4, and it was becoming increasingly pervasive in its effects. It was associated with negative physical phenomena, including headaches and stomachaches, with profound insecurity in social contexts, with insomnia, and with a range of highly preoccupying worries. Martin's parents hadn't left a stone unturned in their effort to get to the bottom of this. However, all of their investigations had been to no avail, and they now risked concluding that he was simply a fearful boy.

We were quickly underway with an externalizing conversation, and for the first time Martin openly characterized his worries. I encouraged him to name each of these worries and to clearly distinguish them from one another, to graphically describe them, to develop an expose of their activities and operations, to provide an account of the consequences of those activities and operations, and to reach some conclusions about what this all said about what these worries had planned for his life. In this way the externalizing conversations rendered the intangible tangible; boundaries or borders were assigned to a problem that had previously had an all-encompassing presence in Martin's life. As we were all becoming more familiar with the nature of these worries, I found the opportunity to inquire about the forces that might be supportive of these worries. As the worries were now richly characterized, Martin had little difficulty in relating them to the context of his life. I learned from him that these worries were powerfully supported by global events, including the 2004 tsunami, the AIDS epidemic in Africa, the war in Iraq and Afghanistan, and suicide bombings in the Middle East. How had he come to be so well informed about these events? Unbeknownst to his parents, he regularly watched news of world events on television.

Martin now found himself in a conversation with his parents that validated his worries. These worries were no longer considered irrational. Not only did Martin now feel joined in his worries, but he also experienced an honoring of what he attributed value to in life, and felt his parents' pride in him over this. He was now not simply a fearful boy in their eyes, and their joining with him in conversations about these concerns and in making plans for addressing them was deeply relieving to Martin. The negative physical consequences of these worries quickly resolved, as did his insomnia and much of his insecurity, and although he remained highly concerned about world events, this concern was no longer in the category of preoccupation that made it impossible for him to proceed with his life. If, in the context of therapy, these worries had been construed in totally negative terms, Martin and his family might never have addressed his concerns in this way. (M. White, 2007, pp. 36–38)

This story of practice seems really significant to me. Through an honouring of embodied experience and an exploration of its meaning, what was previously being understood as irrational was not irrational. The mind/body impasse was bypassed.

Linking emotional postures, physical postures and story

Many others have written about narrative practice and embodied experience in ways that avoid a mind/body split. For instance, James Griffith and Melissa Elliot Griffith in relation to therapeutic dialogues for mind-body problems (1994); Yael Gershoni, Saviona Cramer and Tali Gogol-Ostrowsky (2008) in relation to sex therapy; Laurel Phillips (2017) in relation to chronic pain; Sue Mann (2004) in relation to sexual abuse; Carla Rice and colleagues (2005) in relation to diverse bodies and disability; Kaethe Weingarten (2001) in relation to illness narratives and Eleni Karageorgiou (2016) in relation to incorporating the body into narrative practice. The work of bigender, non-binary and transgender authors (Benestad, 2016; Sawyer, 2013) has also been influential⁴¹.

⁴¹ See the section 'Transgender experience and possibilities for practice' featuring articles by Jodi Aman, Julie Tilsen, David Nylund, Lorraine Grieves, Aya Okumura and Esben Esther Pirelli Benestad in the *International Journal of Narrative Therapy and Community Work* 2007 #3. Also significant to me is the writing of Joan Nestle (2003) in which she describes the ways in which as a lesbian pre-Stonewall, she realised that 'my body needed its own history' (p.64) and so she went about creating one.

In addition, I've particularly appreciated reading the work of Glenda Fredman (2004). Drawing on James Griffith and Melissa Elliott Griffith's (1994) notion of 'emotional postures' that involve our body's readiness to respond and focus our attention towards others and ourselves in different ways (Fredman, 2004, p. 77). Glenda Fredman explores ways of linking emotional postures, physical postures and story. For example, when Gavin associated his experience of depression with a particular physical posture, Glenda asked him the following question:

When have you felt this way before in your body? If you turn through the pages of your life, as if it were a book of your life story, what parts of your life are most connected with this body posture? (Fredman, 2004, p. 73)

Through re-authoring conversations, an alternative preferred posture was also identified, which came to be named 'Holding your head up':

Glenda: Holding your head up, mmm, so if we start leafing through your life story again. When did you have this feeling, how you are feeling in your body now, of holding your head up? (Fredman, 2004, p. 75)

This, it seems to me, is another way of working that refuses to separate bodies from meaning and from action⁴².

There is indeed much to be fascinated about in relation to embodiment and narrative practice. Before discussing some further examples of embodied narrative practice, there are a few things to consider when paying attention to the body.

A few things to be mindful of

In this particular cultural moment, the turn to neuroscience and the affective turn are also intertwined with an interest in mindfulness. Some narrative practitioners are now not only incorporating mindfulness within their practice (Marlowe, 2017) but, due to their own profoundly positive personal experience with meditation/mindfulness, believe it is unethical not to recommend it to their clients (Zimmerman, 2018, p. 25).

While I am extremely interested in diverse meditative practices⁴³ (more on this later), this raises a number of questions for me. First, mindfulness is linked to Buddhist traditions of mind training (see Percy, 2008). If practitioners have a very positive personal experience of a particular version of Christian meditative tradition or Islamic meditative tradition or Jewish meditative tradition or Hindu meditative tradition (such as yoga) or Indigenous meditative tradition or secular meditative tradition⁴⁴, would they feel similarly compelled in this cultural moment to recommend it to every person who consults them? Second, my childhood experiences of life-threatening asthma, in which there was enough focus on my breath for this lifetime, mean that I do not relate at all well to the predominant forms of mindfulness currently circulating as part of Western therapeutic culture⁴⁵. In no way do I wish to diminish the significance that mindfulness, meditation or focus on the breath may have for others. In fact, that is precisely my point, what is life-diminishing for me might just be life-saving for someone else. But isn't this the very reason that narrative practice seeks to stand apart from professionals recommending healing ways to others?

⁴² Glenda Fredman describes this in a slightly different way:

Since certain bodily experiences prime us for particular actions, our bodily sensations are inevitably connected with our display, how we do or show the feeling. Our judgements are also inextricably woven with the ways we 'do' emotion since our judgements inform how we show our feelings and the meanings and values we give to those actions. (Fredman, 2004, p. 76)

⁴³ I'd like to acknowledge the conversations I have shared with Graham Williams, Founder and Director of Lifeflow Meditation Centre, about diverse meditative practices and the complexities of transferring practices across cultures and contexts.

⁴⁴ John Winslade drew my attention to forms of meditation that Michel Foucault explored and documented, which instead of seeking to empty the mind sought to fill it with particular thoughts. For instance, meditations on death intended to sharpen the experience of life:

'In his 1981–1982 course at the College de France, Foucault devoted detailed descriptions to those ancient 'exercises of thought' known as praemeditatio malorum, meditation on future evils, and melete thanatou, meditation on or exercise for death. He interpreted the latter as 'a way of rendering death present in life,' an exercise by which the sage effects spiritual transformation' (Davidson, 2005, p.140)

⁴⁵ Of course, there are diverse meditation/mindfulness options, it's just that breath-focused options are overwhelmingly predominant at this time.

I certainly think there are congruent ways of bringing together meditative practices and narrative practice. For instance, it's possible to explore any moments in a person's life in which they have experienced a sense of freedom from the effects of particular thoughts, and we can use narrative practice to unpack and richly describe such moments or sensory experiences, what makes them possible and ways of fostering further such experiences. It's also possible to learn about, and richly explore, any meditative practices and/or traditions that the person is connected to. There are diverse meditative practices associated with all spiritual and religious traditions, as well as within the arts, with sports and physical quests, with engagements in nature and so on. Embodied experiences in any of these meditative realms can be honoured, drawn on and richly described through engagement with narrative practices.

There is also much to learn from narrative practitioners who are embedded in various meditative traditions. In his paper 'Awareness and authoring: The idea of self in mindfulness and narrative therapy' (2008) Ian Percy, who has studied and practiced both narrative therapy and Buddhist-informed mindfulness for some decades, speaks in interesting ways about a possible 'interplay and complementarity' in what he refers to as mindful attention to somatic experience, including gestures, within therapeutic conversations, to attend to non-discursive and discursive ways of knowing (Percy, 2008, p. 364; see also Percy, 2016, 2017).

What is interesting to me in Ian Percy's work is his acknowledgment of the social locations, histories and traditions of thought that inform both traditions, and his rigorous engagement with both similarities *and* differences between Buddhist teachings and narrative practice alongside what they may have to offer one another:

in Buddhist teachings it seems that there is a lack of understanding about the constitutive power of narrative and how it strongly shapes people's lives and relationships, including the pursuit of meditation. What's missing, in my view, is an appreciation of the inescapable multistoried lives we all lead and the potential for narrative to enhance meditation practice through the creation of supportive storylines including those that can connect people to ethical ways of being in the world. On the other hand, mindfulness challenges the privilege given to the linguistic relational domain in therapy. Incorporating mindfulness provides a different and direct way of relating to bodily sensations and the immediacy of emotional and mental states. (Percy, 2008, p. 363)

I also appreciate Ian's emphasis on how narrative therapy:

aspires to discern adverse community practices that contribute to the problems people face such as those that might occur around gender, sexuality, disability and ethnicity ... [and take] ... seriously the relations of power that are always at work when it comes to what stories can be spoken, who is authorised to speak them and how they are told ... (Percy, 2008, pp. 363–364)

as this sort of awareness can reduce the possibility of what I term 'somatic-conceal' – turning to the body at the expense of focusing on wider social forces⁴⁶.

Just as there is much to learn from a narrative practitioner like Ian Percy, who is embedded within a Buddhist-informed meditative tradition (mindfulness), I am also looking forward to learning from those from Islamic, Christian, Hindu, Indigenous, Jewish and secular meditative traditions about how these might shape diverse forms of narrative practice and ways of engaging with somatic experience.

Embodied narrative practice

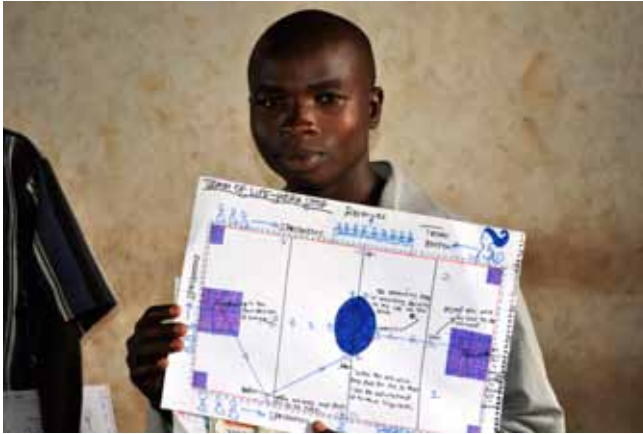
There is a further realm of narrative practice and the body that I wish to discuss. Anyone who has read the story of Michael White falling off his chair as nine-year-old Richard comes to rescue him by taking the wriggling box of fears out of his hands (M. White, 2006) would know that there is a long history of what could be called 'embodied narrative practice' – ways of not only talking about preferred identities, but taking physical action in ways that perform preferred identities.

⁴⁶ Feminist queer disability activists, like Alison Kafer (2013) are offering ways of examining embodied experience that make visible relations of power rather than obscuring them.

Merle Conyer has also drawn my attention to the writings of Rae Johnson (2017) who is the author of *Embodied Social Justice* and is interested in body-centered approaches that do not conceal broader relations of power.

Let me briefly mention a more recent form of embodied narrative practice. I'm particularly interested in forms of practice outside the therapy room in which different embodiment is sometimes possible. For instance, one of my favourite parts of the Team of Life narrative approach (Denborough, 2008), which was initially inspired by young people in a refugee camp in northern Uganda who loved football (soccer), is when we physically re-enact a 'goal' that each young person's 'team of life' has already scored.

Prior to this, each young person has created a 'team sheet' that depicts their life and identity as if it is a team and has also drawn a 'goal map':



A young person and their Team sheet – depicting their 'Team of Life'



A 'goal map' illustrating a goal this 'team' has already scored and different people's contributions to this goal

Goals that have been named by other young people have included 'staying together through hard times', 'staying in school', 'friendships', 'academic achievements' and so on.

Through the following extract (from Denborough, 2012), I will try to convey a little of the experience of a particular embodied celebration that took place on a camp here in Adelaide with young men who had arrived in Australia as 'unaccompanied minors' (refugees):

For this part of the Team of Life process we moved into a shed which was also a basketball court. There were initial scenes of organised chaos as a highly energetic basketball game and vibrant soccer game somehow managed to co-exist on the same field! When time-out was called, we gathered together and I asked the young men to tell me their favourite ways of celebrating goals. They came up with quite a list: clapping, shouting, cheering, drums, hugging, crying, back-flip, take the shirt off, climbing on each other, sliding on the ground, high five, patting on the back, fly kissing, thumbs up.

... Then came my favourite part. It was time to celebrate each of these team's goals. Each young man took a football, or basketball, and acted out the goal map! People stood in for the different contributors, we passed the ball between us, and then the young man kicked the ball out through the door of the shed to symbolise GOOOOALLLLLLLLL! We had asked each young man to tell us which form of celebration he wanted us to perform at this precise moment and so, as the ball passed through door (goals), we would burst into applause and cheering, or start running around, or blow kisses, or pretend to take our shirts off, or slide on the ground, or put our thumbs up, and so on. By now, the young men were very willing to take their turns in these performances of celebration. These are mini definitional ceremonies (Myerhoff, 1982). They are ceremonies of celebration that re-define the identities of these young men as members of teams that have achieved a great deal in the face of significant hardship. (Denborough, 2012, pp. 47–48)

The reason I include this description here is as an example of contemporary embodied narrative practice – a physical performance and witnessing of preferred storylines in which there was no separation between story, mind and body⁴⁷.

Cultural and collective considerations

In considering how narrative practice engages with the body, cultural and collective considerations come into play. To illustrate this, let's turn to the work of Rwandan narrative practitioners.

There is a quite a history of Rwandan practitioners stretching the field of narrative practice⁴⁸. Last year, in a training that took place on the shores of Lake Kivu, Beata Mukarusanga spoke of how Rwandans, if they seek counselling, often speak about a physical pain or ache that they are enduring. Beata described how this is routinely the starting point for counselling conversations.

Rwandan narrative practitioners therefore have a particular interest in how to use narrative practices when the problem is expressed as a physical ailment: when it is embodied. The following questions have been developed in relation to the Rwandan context. I include them here for two reasons. First, to bring attention to considerations of cultural diversity – how we can relate to our embodied experience varies enormously. You may notice questions in the following list that would not be relevant in your cultural context. For instance, ‘If this pain/ache was a song what song would it be?’ or ‘If you were to speak or sing back to this pain/ache what would you like to say or sing? What song would you sing to it?’ are very differently resonant in Rwanda where song is part of everyday life in quite a different way than in Australia. And second, I include the questions to bring attention to considerations of individual and collective experience. Quite often, conversations about bodily experience seem to focus narrowly on the individual’s experience of their individual body. And yet, in Rwanda (and everywhere else) there are opportunities to explore how one’s embodied experience might in some way relate to, or possibly contribute to, the experiences of others.

Here are the questions (those marked with an asterisk were proposed by Sister Seraphine Kaitesirwa):

- How long has this pain/ache been with you?
- How did it first come into your life?
- What was happening in your life/family/community/Rwanda at that time?
- What name would you give to this pain/ache? (From then on use the name the person gives)
- Where does it visit? Which part/s of your body?
- If you were to locate where the pain is by drawing a picture, what would it look like?*
- Do you know why it makes a home for itself in those places?
- What does it look like? Could you describe it to me? Does it have a shape? A colour? A sound?
- How does this pain/ache operate in your life?
- What strategies or tricks does it use?
- How does it affect you? Does it also affect others?
- Are these effects positive, negative or a bit of both? Why?
- If this pain/ache could speak, what do you think it would say to you or to us?
- What sorts of things do you hear the ache/pain say?*
- In what tone does it speak?
- Does this pain say different things at different times?*
- If this pain/ache were a song what song would it be?
- If you were to speak or sing back to this pain/ache what would you like to say or sing? What song would you sing to it?
- Do know anyone else whom this pain/ache also visits?
- Who is most likely to be visited by this sort of pain/ache?

⁴⁷ I am also really interested in forms of narrative theatre and narrative song – these too are examples of differently embodied narrative practice.

⁴⁸ See Denborough, Freedman, & C. White (2008) and Denborough (2010).

- Do you think it is fair that this pain/ache affects your life and perhaps also the lives of others?
- Is there anything you would like to say to others who are also living with this pain/ache?
- Is there anything you have learned that you would like to share with others who are also suffering?
- When is this pain/ache strongest?
- What is happening at those times? Where are you?
- Does it have any friends/allies that make it stronger (poverty, sadness, others being cruel)?
- Who/what is on the 'team' of this ache/pain?
- When is this pain/ache weakest?
- What is happening at those times? Where are you? What are you/others doing?
- Who/what is on your 'team' to diminish the ache/pain? (prayer, talking, singing as well as people)
- Are there any rituals, places, foods, songs, memories that bring comfort to your body?
- Who introduced you to these? Do you share any of these with other people?
- Could we do any of these together?

Embodying our speech

To conclude this paper, there is one further theme that seems significant to mention. Narrative practice is a form of politics, and one element of this politics is a challenge to the disembodied speech acts and claims of universal expert knowledge that make up a considerable portion of professional cultures. Michael White described the effects of these 'expert', 'disembodied' ways of speaking in one of my favourite interviews, which was conducted by Ken Stewart on the topic of 'Psychotic experience and discourse' (White, 1995b). I have included below an extended excerpt of this interview:

Michael: The devices that are associated with these 'expert' ways of speaking include those that (a) obscure the motives or purposes that are associated with one's speech acts, (b) delete all reference to the personal experiences through which one's knowledge claims are generated, (c) exclude information about the personal and interpersonal struggles and dilemmas that are associated with the construction of one's preferred realities (this includes the erasure of the personal experiences of contestation and argumentation through which one's knowledge claims are established), (d) divert attention from the personal investments that are informed by one's location in the social worlds of gender, race, culture, class, work, sexual preference, and so on, and (e) delete all reference to the history of controversy and dissent that surrounds all 'global' knowledge claims.

Ken: And what are the implications of this in this work?

Michael: Well, disembodied speech acts can be very disempowering of those who are subject to them. They are quite capturing. They severely limit and constrict possible responses. However, the persuasiveness and impressiveness of such speech acts can be undermined by the principle of embodiment; that is, by situating these speech acts within the context of the speaker's (a) motives and purposes, (b) personal experiences, including those that relate to dilemmas and other struggles that the speaker has experienced in the process of attributing meaning to their experiences of life, (c) investments that are informed by their location in the social worlds of gender, culture, race, class, sexual preference, and so on, and also by bringing forth the history of controversy that surrounds the speaker's objective knowledge claims . . .

To encourage speakers to situate their opinions in the context of their purposes, we could ask questions like: *So you have a strong opinion about what I should do. Tell me, in voicing your opinion in this way, what effect do you hope this might have on what I do?* Or maybe we could ask: *If you were to succeed in influencing what I do on this occasion, how would this fit with your overall goals for my life?* Or perhaps: *I think that I have some understanding of how you would like your opinion to shape what I do right now. How does this fit with your general purposes for my life? How does this fit with your plans for my life?*

To encourage speakers to situate their opinions in the context of their lived experience, we could try something like: *Could you tell me about some of your personal experiences of life that have played a*

central role in the formation of this opinion? This would be helpful to me, as I would then know more about how to take your opinion, and I might be able to identify those parts of your views that could fit for me. Perhaps I could then talk of some of my own experiences of life, and share with you some of the conclusions that I have reached from all of this.

To encourage speakers to situate their opinions within the context of their location in the social world, we might try something like: *In which circles are these sort of opinions most strongly held? Do all of the people in these circles agree with this opinion? If some of these people were here with us, how would they go about supporting your opinion? What do you think would happen if, in their presence, you were to dissent? What sort of pressure do you think you would experience to conform, to recant? What consequences do you think you would be facing if you didn't agree to do so?*

But this is just a small sample of the possibilities for ways of responding that are deconstructing of the 'truths' that are championed in disembodied speech acts. And I want to emphasise that these questions do not require an answer in order to be effective. In asking such questions, those who are subject to disembodied speech acts become less captive, and are confronted with new possibilities for action. (M. White, 1995b, pp. 128–130)

There are two reasons why I include this extended extract. First, to convey that the politics of narrative practice is based on embodiment. And second, because various disembodied global knowledge claims made in the name of neuroscience are now influencing the psychotherapy and narrative therapy field (see Lainson, 2019; Zimmerman, 2018). These include claims that those influenced by 'post-traumatic stress disorder' have 'very little direct access to right-brain information'; or that 'shyness is seen as excessive reactivity of the right brain and is likely genetic'; or that 'oxytocin, usually more abundant in female brains, leads females to tend and befriend, to be calm and connect'; or that anorexia may be the result of 'aberrant reward processing'.

One thing that characterises the narrative practice that I know and love is a vigilance in relation to questioning global knowledge claims. If there are claims I have made in this paper that seem over-blown, or for that matter illogical, or if they evoke strong emotions in you, dear reader, I look forward to your feedback, critique and conversation.

Of course, narrative practice is also about acknowledging diversity. Practitioners are engaging with neuroscientific ideas in diverse ways. I hope the ideas I have discussed here about 'Narrative therapy and the body' can generate conversations across differences about the fascinating topic of narrative practice and embodiment.

Key points from Part 4: Narrative therapy and the body

- There's a long (untold) history of embodied narrative practice!
- Just as narrative therapy refuses to split emotion from meaning and action, narrative practices engage with the body in ways that do not further a mind/body split and that seek to avoid 'somatic-conceal' – turning to the body at the expense of focusing on wider social forces.
- Some forms of embodied narrative practice involve not only talking about preferred identities, but taking physical action in ways that perform preferred identities.
- How we relate to our embodied experience varies enormously across cultures.
- Quite often, conversations about bodily experience seem to focus narrowly on the individual's experience of their individual body. And yet, there are opportunities to explore how one's embodied experience might in some way relate to, or possibly contribute to, the experiences of others.
- Narrative practice challenges the disembodied speech acts and claims of universal expert knowledge that make up a considerable portion of professional cultures. This includes disembodied claims made in the name of neuroscience.

Science and action

I began this paper by mentioning my father's work as a medical researcher and how it imbued in me a lifelong respect for scientific research. There was another equally significant aspect of my father's work, how his scientific research led to his anti-nuclear activism.

In 1970, the year I was born, my father came to learn from a colleague, Roger Melick, that every time an atmospheric nuclear test was conducted by the French government in the Pacific, the levels of radioactive iodine in the thyroid glands of Australian sheep would rise alarmingly. Across this country, we were all being irradiated by these tests. Michael Denborough and Roger Melick penned a letter to all national newspapers notifying the general public, and so began scientific protests and political protests that successfully forced such tests underground.

Then in 1983, Michael Denborough was offered the position of acting director of the Centre for Research and Environmental Studies (CRES). He wasn't going to accept this position until Erica (my mum) said to him, why not accept it on the condition that you can use this position to do something that you really want to do. So he did. As acting director of CRES he convened a symposium: 'Australia and Nuclear War'. My father decided to invite to this symposium leading figures who were protesting the nuclear madness from America, the Soviet Union and elsewhere. Patrick White and other distinguished speakers accepted his invitation, and all was coming together well, except for one significant problem: in 1983 it was profoundly difficult for someone from the Soviet Union to enter Australia.

Not to be deterred, my father headed to the Soviet embassy to request that an esteemed Soviet doctor attend the symposium. Little did he know what was to follow. In those days, directly across the road from the Soviet embassy, there was an ASIO (Australian Security Intelligence Organisation) surveillance office above a funeral parlour. And later that day an ASIO officer, Reilly, visited my dad in his office. 'Reilly', said Michael Denborough, 'you must be the ace of spies'. Reilly wasn't that impressed, and quickly got down to business. 'Michael, we would like you to collect information and spy on the Russians.' 'Look, I am trying to prevent nuclear war, why on Earth would I become a spy for ASIO?' The next day, Michael received a phone call. It was the KGB. 'We noticed that you were approached by ASIO. We would like you to accept their offer to spy on us but instead become a double agent.' My father's exasperated response: 'I am trying to prevent nuclear war, why on Earth would I become a spy for the KGB?' And yet, this wasn't the end. Both sides continued to approach him until one day Reilly was in Michael's office when the phone rang. It was the KGB. Without missing a beat, Michael handed the phone to Reilly, stating loudly, 'If you could both just start talking with each other, this world might become a safer place'. Neither side approached him again. And my dad continued to take action – in the laboratory and in the political sphere.

In 2003, at age 74, Michael Denborough – respected medical researcher – held a solo vigil for 52 days outside Parliament House to protest what so many of us knew then, and almost everybody admits now, was going to be an unjust invasion of Iraq. Hundreds of thousands of people were killed in that immoral war. Many of us knew it was going to happen. Michael set up a vigil and maintained it for 52 days. My dad, and the other most determined anti-nukes, didn't just campaign when there was a chance of winning. He would keep speaking out even though he knew there was no chance of preventing the madness and the massacre. What do you call that? I call it integrity.

Integrity through review and critique

The development of scientific understanding involves peer review and critique. In this paper, I have tried to offer transparent critique about some of the ways in which scientific language and concepts (mediated through psychology) are being brought to bear on narrative practice. Clearly, I have concerns about these developments. I wish to acknowledge again, however, the efforts that narrative practitioners who are interested in neuroscience are making to bring new knowledge to the field. I know that they are doing so with integrity and genuine hopes for the future of the field. Although our approaches and understandings may be different, I agree with them that we need to spend more energy describing how narrative therapy engages with affect, emotion and embodied experience.

Of course, review and critique is not a one-way process. Prior to the publication of this paper, three of the key authors whose work I refer to here, Jeff Zimmerman, Marie-Nathalie Beaudoin and Karen Young, were invited to read an earlier draft and offer their responses. Marie-Nathalie and Karen took up this invitation and their comments/critique on an earlier draft led to significant improvements.

If I were to critique this paper, I might draw attention to the way the author has evoked the presence of two senior men in their respective fields, Dr Michael Denborough and Michael White, and question whether this was done to bolster the article's credibility. I might also suggest that the author, in wishing to be respectful to colleagues, has not sufficiently named how explaining narrative practice through neuroscientific terms contributes to scientism and scientific reductionism⁴⁹. At the same time, I could also criticise this paper for not doing enough to consider possibilities that may come from engaging with neuroscience ideas (see 'Future possibilities?' on p. 46). While more could be said in both directions, this paper is quite long enough! I think it's time for me to stop.

My experience of writing this paper and acknowledgments

Writing this piece has been quite an emotional and embodied journey. Normally, I wouldn't mention this, but due to the topic it seems appropriate. Writing is an embodied experience. The sensation of thoughts being found through the act of fingers moving on keys is at times curiously meditative and satisfying. I know that when I am in the 'writing zone', my experience of time alters, and I alternatively run my fingers through my hair, close my eyes, stretch backwards and even place my palms together (as if in prayer!?) when trying to conjure the right words.

Writing is also a relational experience. I am grateful to those who offered company, encouragement and invaluable critique on earlier drafts of this paper.

Claire Nettle's editorial acumen was, as always, profoundly influential. Kristina Lainson, Gaye Stockell, Chris Dolman, Susanna Chamberlain, David Newman, Merle Conyer, David Marsten, Philippa Byers, Lou Harms, Jill Freedman, Gene Combs, Glenda Fredman, Jon Jureidini, Sarah Strauven, Tom Strong, Henrietta Byrne and Mark Hayward all offered rigorous, constructive feedback on initial drafts, which propelled me forward.

Along the way, conversations with Graham Williams about meditative practices and neuroscience professor John Willoughby about the possibilities and limitations of contemporary neuroscience were illuminating.

Kelsi (Sassy) Semeschuk's work as an archivist/researcher was influential in finding quotes from Michael's teaching tapes.

John Winslade was particularly significant in relation to this paper in three ways: in an initial conversation he introduced me to the work of Margaret Wetherell; he offered helpful comments on an earlier draft; and, as you will have noticed, he contributed a number of footnotes in relation to the work of Gilles Deleuze.

Throughout the process, Cheryl White's feminist thinking provided creative critique and reflection. Thanks Cheryl!

And I'd like to acknowledge Marie-Nathalie Beaudoin and Karen Young for their willingness to engage in honest, rigorous discussion across differences. I am sincerely grateful for this and look forward to continuing conversations.

Finally, dear reader, I'd like to thank you for making it all the way through to the end of this somewhat epic paper! I'll look forward to your feedback.

Breakthrough (for me at least) #5: This paper is finished!

⁴⁹ To read more about neuroscientific reductionism, see Rose (2012) and Kirmayer & Gold (2012).

Raymond Tallis (1999) describes the limitations of neurophilosophy and how neural theories of mind impoverish understandings of human consciousness and mental life. I'd recommend the episode of Madness Radio in which Will Hall interviews Raymond Tallis (Hall, 2012).

Future possibilities?

In considering possibilities for further collaborations between narrative practice and neuroscience, three possibilities come to my mind:

Firstly, I can imagine creative collaborations with those engaged with what's called 'critical neuroscience'. Suparna Choudhury and Jan Slaby, in the preface to their book, *Critical Neuroscience; A handbook of the social and cultural contexts of neuroscience*, describe how they and others are:

Taking seriously the relevance, but rejecting the primacy, of the brain in understanding behavior, we asked ourselves whether such analysis might contribute to more complex, theory-rich, nuanced explanations of behaviour. (2012, p. xiii)

This evolving field of critical neuroscience brings together 'young scholars with backgrounds in neuroscience, philosophy, history of science, anthropology, sociology, and psychology' (Choudhury & Slaby, 2012, p. xiii). Perhaps we can add narrative practice to that list?

Secondly, in talking with neuroscience professor John Willoughby, I was interested to learn that in neuroscience experiments there are invariably 'outlier' results that do not conform to the norm/average and so are generally disregarded. Joseph Dumit (2012) confirms this:

individual variability is often not represented at all in the resultant average brainset ... This is intentional. Individual differences are treated as noise in cognitive psychology, whose mission is to discover the baseline mental functions that are common to (most) normal people. (p. 208)

Because of this, brain research 'reveals only common features, and individual differences of great potential interest are obscured.' (Wise, Hadar, Howard, & Patterson, 1991 cited in Dumit, 2012, p. 208)

As a narrative practitioner, I wonder about these 'outliers'. Would collaborations with neuroscientists be possible that would seek to learn more about the outliers? These would be collaborations with the aim of richly describing neuro-diversity – rather than sponsoring neuro-conformity and neurotypicality. This would seem to be in accord with Erin Manning's (2016) call to 'better understand neurodiversity and to mobilize that understanding for research-creation and political activism' (Holland, 2017, p. S247).

Thirdly, as narrative practitioners, could we develop ways to assist people to negotiate neuro-discourses in ways that support their preferences and ways of living? This could be similar to the ways in which Michael White assisted people to discern their own position in relation to labels and medication. In the interview 'Psychotic experience and discourse' (1995b), Michael explained:

'I have witnessed drugs being used in ways that have a profound effect in opening up the horizons of people's lives, in ways that bring a range of new possibilities for action. And I have also witnessed drugs being used in ways that are primarily for the purposes of social control, in ways that subtract very significantly from people's possibilities for action, in ways that dispossess people of choice.' (p. 117).

He then went on to share a number of questions he used to assist people to discern their own position/experience in relation to medications. Perhaps these questions could serve as a starting point for us to develop ways to assist people to make discernments in relation to neuro-understandings.

In the extract below I have substituted the term neuro-understandings for where Michael referred to drugs or medications:

- *How might one go about assisting people to determine whether these neuro-understandings are contributing to their quality of life, or whether they are subtracting from this?*
- *How might one go about assisting people to determine which ways these neuro-understandings might be enabling, and in which ways they' might be disabling?*
- *How might one go about assisting people to evaluate the real effects of these neuro-understandings on their lives and in their relationships with others?*
- *How might one go about assisting people to establish what might be for them suitable criteria for such an evaluation?*
- *How might one go about assisting people to fully inform themselves about the various negative side-effects of these neuro-understandings?*
- *How might one go about assisting people to identify which people are most invested in compliance with regimes of neuro-understandings, which people are least invested in this, and the particular interests of these parties?*

(Adapted from Michael White, 1995b, p. 117)

References

- Beaudoin, M. (2017). Helping clients thrive with positive emotions: Expanding people's repertoire of problem counter-states. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 28–39). New York, NY: Routledge.
- Beaudoin, M. (2019). Intensifying the preferred self: Neurobiology, mindfulness and embodiment practices that make a difference. *International Journal of Narrative Therapy and Community Work*, in this issue.
- Beaudoin, M., & Duvall, J. (2017) Introduction: Merging soft and hard sciences. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 1–12). New York, NY: Routledge.
- Beaudoin, M., & Zimmerman, J. (2011). Narrative therapy and interpersonal neurobiology: Revisiting classic practices, developing new emphases. *Journal of Systemic Therapies*, 30, 1–13.
- Belcourt, B. (2018). *This wound is a world*. Calgary, Canada: Frontenac House.
- Benestad, E. E. P. (2016). Gender belonging: Children, adolescents, adults and the role of the therapist, Revised. *International Journal of Narrative Therapy and Community Work*, (4), 92–106.
- Borck, C. (2012). Toys are us: Models and metaphors in brain research. In S. Choudhury & J. Slaby (Eds.), *Critical neuroscience: A handbook of the social and cultural contexts of neuroscience* (pp. 113–133). Oxford, England: Wiley.
- Choudhury, S. & Slaby, J. (2012). Preface. In S. Choudhury & J. Slaby (Eds.), *Critical neuroscience: A handbook of the social and cultural contexts of neuroscience* (pp. xiii–xv). Oxford, England: Wiley.
- Cvetkovich, A. (2012). *Depression: A public feeling*. Durham, NC: Duke University Press.
- Davidson, A. (2005). Ethics as ascetics: Foucault, the history of ethics, and ancient thought. In G. Gutting (Ed.), *The Cambridge companion to Foucault* (pp. 123–148). New York, NY: Cambridge University Press.
- Deleuze, G., & Guattari, F. (2004). *Anti-Oedipus: Capitalism and schizophrenia*. London, England: Continuum. (Original work published 1984)
- Denborough, D. (2008). *Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma*. Adelaide, Australia: Dulwich Centre Publications.
- Denborough, D. (2010). *Working with memory in the shadow of genocide: The narrative practices of Ibuka trauma counsellors*. Adelaide, Australia: Dulwich Centre Foundation International.
- Denborough, D. (2012). The Team of Life with young men of refugee backgrounds. *International Journal of Narrative Therapy and Community Work*, (2), 44–53.
- Denborough, D. (2018). *Do you want to hear a story? Adventures in collective narrative practice*. Adelaide, Australia: Dulwich Centre Publications.
- Denborough, D. (2019). *A political dictionary for the field of narrative practice*. Adelaide, Australia: Dulwich Centre Publications.
- Denborough, D., Freedman, J., & White, C. (2008). *Strengthening resistance: The use of narrative practices in working with genocide survivors*. Adelaide: Dulwich Centre Foundation.
- Denborough, D., Koolmatie, C., Mununggirritj, D., Marika, D., Dhurrkay, W., & Yunupingu, M. (2006). Linking stories and initiatives: A narrative approach to working with the skills and knowledge of communities. *International Journal of Narrative Therapy and Community Work*, (2), 19–51.
- Drahm-Butler, T. (2015). Decolonising identity stories: Narrative practice through Aboriginal eyes. In B. Wingard, C. Johnson, & T. Drahm-Butler (Eds.), *Aboriginal narrative practice: Storylines of pride, strength and creativity* (pp. 25–46). Adelaide, Australia: Dulwich Centre Publications.
- Dumit, J. (2012). Critically producing brain images of mind. In S. Choudhury & J. Slaby (Eds.), *Critical neuroscience: A handbook of the social and cultural contexts of neuroscience* (pp. 195–225). Oxford, England: Wiley.
- Dunne, P. (2017). Insights on positive change: An exploration of the link between drama therapy and neural networks. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp.62–74). New York, NY: Routledge.
- Duvall, J., & Maclennan, R. (2017). Pivotal moments, therapeutic conversations, and neurobiology: Landscapes of resonance, possibility, and purpose. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 15–27). New York, NY: Routledge.
- Epston, D. (1999). Co-research: The making of an alternative knowledge. In *Narrative therapy and community work: A conference collection* (pp. 137–157). Adelaide, Australia: Dulwich Centre Publications.
- Ewing, J., Estes, R., & Like, B. (2017). Narrative neurotherapy (NNT): Scaffolding Identity States. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 87–99). New York, NY: Routledge.
- Fine, C. (2010). *Delusions of gender: How our minds, society and neurosexism create difference*. New York, NY: Norton.
- Fredman, G. (2004). *Transforming emotion: Conversations in counselling and psychotherapy*. London, England: Whurr.
- Gershoni, Y., Cramer, S., & Gogol-Ostrowsky, T. (2008). Addressing sex in narrative therapy: Talking with heterosexual couples about sex, bodies, and relationships. *International Journal of Narrative Therapy and Community Work*, (3), 3–11.
- Gould, D. (2010) On affect and protest. In J. Staiger, A. Cvetkovich, & A. Reynolds (Eds.), *Political emotions* (pp. 18–44). New York, NY: Routledge.
- Griffith, J. L., & Elliott Griffith, M. (1994). *The body speaks: Therapeutic dialogues for mind-body problems*. New York, NY: Basic.
- Hall, W. (2012). Beyond biological reductionism: Raymond Tallis. Retrieved from www.madnessradio.net/madness-radio-beyond-biological-reductionism-raymond-tallis/

- Hedtke, L., & Winslade, J. (2016). Elastic time. In L. Hedtke & J. Winslade (Eds.), *The crafting of grief: Constructing aesthetic responses to loss* (pp. 147–168). New York, NY: Routledge.
- Hemmings, C. (2005). Invoking affect: Cultural theory and the ontological turn. *Cultural Studies*, 19(5), 548–567. doi: 10.1080/09502380500365473
- Holland, E. W. (2017). Review: The minor gesture. *A Contemporary Political Theory*, 17(Suppl. 4), S244–S247.
- Johnson, R. (2017). *Embodied social justice*. New York, NY: Routledge.
- Kafer, A. (2013). *Feminist, queer, crip*. Bloomington: Indiana University Press.
- Karageorgiou, E. (2016). Stories of the body: Incorporating the body into narrative practice. *International Journal of Narrative Therapy and Community Work*, (3), 1–7.
- Kirmayer, L., & Gold, I. (2012). Critical neuroscience and the limits of reductionism. In S. Choudhury & J. Slaby (Eds.), *Critical Neuroscience: A handbook of the social and cultural contexts of neuroscience* (pp. 307–330). Oxford, England: Wiley.
- Leys, R. (2011). The turn to affect: A critique. *Critical Inquiry*, 37, 434–472.
- Mann, S. (2004). The questions posed by our work with women who have experienced sexual abuse. *International Journal of Narrative Therapy and Community Work*, (4), 3–12.
- Manning, E. (2016). *The minor gesture*. Durham, England: Duke University Press.
- Marlowe, S. (2017). Supporting young children visited by big emotions: Mindfulness, emotion regulation, and neurobiology. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 50–61). New York, NY: Routledge.
- Marsten D., & Markham L. (2017). Deconstruction in narrative couple and family therapy. In: Lebow J., Chambers A., Breunlin D. (Eds.) *Encyclopedia of couple and family therapy*. Cham, Switzerland: Springer.
- Marsten, D., Epston, D., & Markham, L. (2016). *Narrative therapy in wonderland: Connecting with children's imaginative know-how*. New York, NY: Norton.
- Marsten, D., & Markham, L. (2017). Deconstruction in narrative couple and family therapy. In J. L. Lebow, A. L. Chambers, & D. Breunlin (Eds.), *Encyclopedia of couple and family therapy*. New York, NY: Springer.
- McLeod, J. (2005). Counseling and psychotherapy as cultural work. In L. T. Hoshmand (Ed.), *Culture, psychotherapy and counseling: Critical and integrative perspectives* (pp. 47–63). Thousand Oaks, CA: Sage.
- McLeod, J. (2007). Narrative thinking and the emergence of postpsychological therapies. In M. G. W. Bamberg (Ed.), *Narrative – State of the art* (pp. 237–245). Amsterdam, Netherlands: Benjamins.
- Nestle, J. (2003). Responding with history and story: An interview. *International Journal of Narrative Therapy and Community Work*, (1), 61–65.
- Newman, D. (2008). 'Rescuing the said from the saying of it': Living documentation in narrative therapy. *International Journal of Narrative Therapy and Community Work*, (3), 24–34.
- Newman, D. (2015). Honoring not categorizing of action and crafting collaboration: Some ways of working with young people. *Journal of Youth Research*, 3(3), 90–104.
- Newman, D. (2016a). Explorations with the written word in an inpatient mental health unit for young people. *International Journal of Narrative Therapy and Community Work*, (4), 45–57.
- Newman, D. (2016b). How we deal with 'way out thoughts': A living document: Ways of talking with young people about suicidal thoughts. *International Journal of Narrative Therapy and Community Work*, (4), 59–65.
- Newman, D. (2019). *Dictionary of obscure experiences* [Unpublished working document]. Sydney, Australia: Sydney Narrative Therapy.
- Papoulias, C., & Callard, F. (2010). Biology's gift: Interrogating the turn to affect. *Body and Society*, 16(1), 29–56. doi:10.1177/1357034X09355231
- Percy, I. (2008) Awareness and authoring: The idea of self in mindfulness and narrative therapy. *European Journal of Psychotherapy and Counselling*, 10(4), 355–367. doi:10.1080/13642530802577109
- Percy, I. (2016). *Mindfulness in counselling and psychotherapy: Narratives from practitioners in Bhutan and Australia* (PhD thesis). Retrieved from hdl.handle.net/20.500.11937/1346
- Percy, I. (2017, September 1). *Mindfulness and narrative therapy by Ian Percy* [Video file]. Retrieved from dulwichcentre.com.au/mindfulness-and-narrative-therapy-by-ian-percy/
- Phillips, L. (2017). A narrative therapy approach to dealing with chronic pain. *International Journal of Narrative Therapy and Community Work*, (1), 21–29.
- Rice, C., Zitzelsberger, H., Porch, W., Ignagni, E., & Erickson, L. (2005). Envisioning new meanings of difference. *International Journal of Narrative Therapy and Community Work*, (3 & 4), 119–130.
- Rose, N., & Abi-Rached, J. M. (2013). *Neuro: The new brain sciences and the management of the mind*. Princeton, New Jersey: Princeton University Press.
- Rose, S. (2012). The need for a critical neuroscience: From neuroideology to neurotechnology. In S. Choudhury & J. Slaby (Eds.), *Critical neuroscience: A handbook of the social and cultural contexts of neuroscience* (pp. 53–66). Oxford, England: Wiley.
- Sawyer, K. (2013). Explorations in trans* subjectivity. *International Journal of Narrative Therapy and Community Work*, (3), 33–38.
- Siegel, D. (2007). *The mindful brain*. New York, NY: Norton.
- Siegel, D. (2010). *The mindful therapist*. New York, NY: Norton.
- Siegel, D. (2011). *Mindsight*. New York, NY: Random House.

- Siegel, D. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guilford.
- Silent Too Long. (1998). Your voices inspire mine. *Dulwich Centre Journal*, 4, 2–8.
- Silent Too Long. (2000). Embracing the old, nurturing the new. *Dulwich Centre Journal*, (1&2), 62–71. Reprinted in Dulwich Centre Publications (Ed.). (2003). *Responding to violence: A collection of papers relating to child sexual abuse and violence in intimate relationships* (pp. 71–91). Adelaide, Australia: Dulwich Centre Publications.
- Silent Too Long (2001). Trust. In Dulwich Centre Publications (Ed.), *Working with the stories of women's lives* (pp. 85–82). Adelaide, Australia: Dulwich Centre Publications.
- Staiger, J., Cvetkovich, A., & Reynolds, A. (Eds.) (2010). *Political emotions*. New York, NY: Routledge.
- Stanikzai, A. G., Denborough, D., & Byrne, H. (2018). *Surviving the ocean of depression*. Retrieved from dulwichcentre.com.au/surviving-the-ocean-of-depression/
- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York, NY: Norton.
- Strong, T. (2017). Neuroscience Discourse and the Collaborative Therapies? In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 116–127). New York, NY: Routledge.
- Tallis, R. (1999). The poverty of neurophilosophy. In R. Tallis. *On the edge of certainty: Philosophical explorations* (pp. 127–154). Basingstoke, England: Palgrave Macmillan.
- Tomkins, S. S. (1991). *Affect imagery consciousness, Volume III. The negative affects: Anger and fear*. New York, NY: Springer.
- Vidal, F. (2009). Brainhood, anthropological figure of modernity. *History of the human sciences*, 22:1; 5–36. doi: 10.1177/0952695108099133
- Vidal, F., & Ortega, F. (2017). *Being brains: Making the cerebral subject* (forms of living). New York, NY: Fordham University Press.
- Walia, H. (2013). *Undoing border imperialism*. Oakland, CA: AK Press.
- Weingarten, K. (2001). Making sense of illness narratives: Braiding theory, practice and the embodied life. In Dulwich Centre Publications (Ed.), *Working with the stories of women's lives* (pp. 111–125). Adelaide, Australia: Dulwich Centre Publications.
- Wertsch, J. V. (2002). *Voices of collective remembering*. Cambridge, England: Cambridge University Press.
- Wetherell, M. (2012). *Affect and emotion: A new social science understanding*. London, England: Sage.
- White, C. (2016). Feminist challenge and Women's Liberation. In C. White (Ed.), *A memory book for the field of narrative practice* (pp. 47–65). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1989, November 5). 'On power and Foucault': *Public workshop by Michael White* [Video recording]. Michael White Video Archive (Tape 255). Dulwich Centre, Adelaide, Australia.
- White, M. (1992). Men's culture, the men's movement, and the constitution of men's lives. *Dulwich Centre Newsletter*, (3&4), 33–53.
- White, M. (1995a). Naming abuse and breaking from its effects (interviewer C. McLean). In M. White, *Re-authoring lives: Interviews and essays* (pp. 82–111). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1995b). Psychotic experience and discourse (interviewer K. Stewart). In M. White, *Re-authoring lives: Interviews and essays* (pp. 112–154). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1997). *Narratives of therapists' lives*. Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1999). Reflecting-team work as definitional ceremony revisited. *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice*, (2), 55–82. Reprinted in M. White (2000a), *Reflections on narrative practice: Essays and interviews* (pp. 59–85). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2000a). Re-engaging with history: The absent but implicit. In M. White, *Reflections on narrative practice: Essays and interviews* (pp. 35–58). Adelaide: Dulwich Centre Publications.
- White, M. (2000b, December) *Untitled* [Video recording]. Michael White Video Archive (Tape 193). Dulwich Centre, Adelaide, Australia.
- White, M. (2000c). Children, children's culture, and therapy. In M. White, *Reflections on narrative practice: Essays and interviews* (pp. 1–22). Adelaide: Dulwich Centre Publications.
- White, M. (2001). Folk psychology and narrative practice. *Dulwich Centre Journal*, (2), 1–37. Reprinted in M. White (2004). *Narrative practice and exotic lives: Resurrecting diversity in everyday life* (pp. 59–118). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2002, August 6). *Untitled* [Video recording]. Michael White Video Archive (Tape 192). Dulwich Centre, Adelaide, Australia.
- White, M. (2003). Narrative practice and community assignments. *International Journal of Narrative Therapy and Community Work*, (2), 17–55.
- White, M. (2004a). *Narrative practice and exotic lives: Resurrecting diversity in everyday life*. Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2004b). Narrative practice and the unpacking of identity conclusions. In *Narrative practice and exotic lives: Resurrecting diversity in everyday life* (pp. 119–147). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2004c). Working with people who are suffering the consequences of multiple trauma: A narrative perspective. *International Journal of Narrative Therapy and Community Work*, (1), 45–76. Reprinted in D. Denborough, (Ed.). (2006). *Trauma: Narrative responses to traumatic experience* (pp. 25–85). Adelaide, Australia: Dulwich Centre Publications
- White, M. (2006). Narrative practice with families with children: Externalising conversations Revisited. In M. White & A. Morgan (Eds.), *Narrative therapy with children and families* (pp. 1–56). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2007). *Maps of narrative practice*. New York, NY: Norton.
- White, M. (2011a). Turning points and the significance of personal and community ethics. In D. Denborough (Ed.), *Narrative practice: Continuing the conversations* (pp. 27–44). New York, NY: Norton.

- White, M. (2011b). Externalizing and responsibility. In D. Denborough (Ed.), *Narrative practice: Continuing the conversations* (pp. 118–122). New York, NY: Norton.
- White, M. (2018, June 25). *Michael White, narrative therapist: Funny moments* [video file]. Retrieved from vimeo.com/260519508
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.
- White, M., & Epston, D. (1997). The bypass operation: An approach to feeding problems in young children. In J. Freeman, D. Epston, & D. Lobovits (Eds), *Playful approaches to serious problems: Narrative therapy with children and their families* (pp. 75–93). New York, NY: Norton.
- Young, K., Hibel, J., Tartar, J., & Fernandez, M. (2017). Single session therapy and neuroscience: Scaffolding and social engagement. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 103–115). New York, NY: Routledge.
- Yuen, A. (2009). Less pain, more gain: Explorations of responses versus effects when working with the consequences of trauma. *Explorations: An E-Journal of Narrative Practice*, 1, 6–16. Retrieved from: www.dulwichcentre.com.au/explorations-2009-1-angel-yuen.pdf
- Yuen, A. (2019). *Pathways beyond despair: Re-authoring lives of young people through narrative therapy*. Adelaide, Australia: Dulwich Centre Publications.
- Zimmerman, J. (2017). Neuro-narrative therapy: Brain science, narrative therapy, poststructuralism, and preferred identities. *Journal of Systemic Therapies*, 36(2), 12–26. doi: 10.1521/jsyt201736212
- Zimmerman, J. (2018). *Neuro-narrative therapy: New possibilities for emotion-filled conversations*. New York, NY: Norton.
- Zimmerman, J., & Beaudoin, M. (2015). Neurobiology for your narrative: How brain science can influence narrative work. *Journal of Systemic Therapies*, 34(2), 59–74. doi: 10.1521/jsyt.2015.34.2.59



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

*All enquiries should be made to the copyright owner at:
Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000
Email: dcp@dulwichcentre.com.au*

Thank you! We really appreciate it.

*You can find out more about us at:
www.dulwichcentre.com*

*You can find a range of on-line resources at:
www.narrativetherapyonline.com*

*You can find more of our publications at:
www.narrativetherapylibrary.com*



Reflections on narrative, neuroscience and social engagement

by Karen Young



Karen is the director of the Windz Institute, operated by Reach Out Centre for Kids' in Ontario, Canada. She has been teaching narrative and brief narrative therapy for over 30 years and is a therapist with 36 years' experience working with children and families. She has particular expertise in the application of narrative in brief and walk-in therapies. Karen has a great deal of knowledge and passion for narrative practices and is one of the few trainers who can teach the traditional aspects of the approach and new evolutions in thinking.

I really appreciated the points in David Denborough's paper, 'Travelling down the neuro-pathway: Narrative practice, neuroscience, bodies, emotions and the affective turn', about the importance of speaking and writing about the intentions of narrative therapy as they relate to deconstructing meaning, power and knowledge, and how ideas from neuroscience create explanations that move away from these purposes. As a narrative practitioner, I am much more interested in the politics of narrative practices, for example, externalising practices, in terms of the ethics of a depathologising naming and unpacking practice as opposed to a pathologising naming practice (such as internalised diagnostic language) and the knowledge and actions that externalising practices make possible. I have written about this often (see Young, 2018).

I also agree with the sentiment that more than one explanation is possible. I do not think that exploring multiple explanations conceals the many other ethical and political explanations, as long as these other more important explanations are being written and talked about.

This has me thinking that a publication that offers multiple explanations for narrative practices would be very useful, for example multiple explanations for the powerful effects of externalising practices. That way we would not be limiting our vision and exclusively focused on neuroscience.

I also agree that research in relation to narrative therapy is important and that this research should not only focus on the brain. To this day, research that I continue to be the most enthused about is research that keeps the client's experience and words at the centre such as the research I engaged in with Scot Cooper (see Young & Cooper, 2008).

I joined Jim Hibel, Jaime Tartar and Mercedes Fernandez in writing the chapter, 'Single session therapy and neuroscience: Scaffolding and social engagement' (2017) because I was interested in participating in publishing evidence that would stand up in the scientific arena. In Canada, narrative practice is often seen as lacking in scientific evidence. We are increasingly seeing mandates (including from service funders) for therapists to only practice using certain more 'evidence-based' practices, so I think that science explanations that support current narrative practices are important given the power that is currently being placed on scientific explanations. I like the discernment made in 'Travelling

down the neuro-pathway' that some of us are interested in evidence that supports existing narrative practices and others are more interested in evidence to change or add to practices.

These considerations of science that supports narrative practices remind me of the first time I heard Michael White talk about memory theory in relation to narrative conversations addressing the effects of trauma. Michael spent a whole morning of a five-day training talking about memory theory, about which he later published (see White, 2004). I remember chatting with him during the break of this workshop and him jokingly saying, 'I'm guessing that you're wondering if you walked into another training and not one on narrative therapy'. It seemed that Michael was exploring explanations, which included findings from developmental psychologist Katherine Nelson and experimental psychologist and cognitive neuroscientist Endel Tulving, that supported certain narrative practices that he was already engaged with. Remembering this was part of what influenced me in my decision to help write the chapter.

The research by Jim Hibel and the team at Nova University included measurements of body enzymes to track 'optimal arousal'. This was not oriented around the idea of the client discharging or experiencing emotions, but was about the idea of emotional engagement in the conversation. What I was interested in about this research was the importance of people experiencing emotional engagement in therapeutic conversation. I'm interested in this because I have seen therapy sessions in which therapists are following a manualised approach or engaged in what John Shotter wrote about as 'tick-box' protocols (see Shotter, 2015), and in which the client is not meaningfully/emotionally/powerfully engaged in these conversations. In such situations, as I see them, there is no real possibility for impactful conversation that moves the person to new places or to what some might call therapeutic change.

So, in our chapter, we were not writing about the client expressing or feeling emotions but were more interested in the types of questions therapists might ask that create 'engagement'. For example, we wrote about the importance of therapy sessions facilitating a strong social connection, social engagement and an enriched environment. These are not individualistic, and are not to do with individual emotion, but are to do with the collaboration between people that creates this 'enriched environment'. The research focused on looking for biological/neurological effects relating to social engagement created by scaffolding conversations.

We were not privileging or valorising the expression or letting out of emotion, but the importance of the social engagement between the therapist and the client through questions that are novel, unexpected and invite focused attention on this novelty. We wrote that 'Relational involvement and social engagement seem to be at the heart of these processes [therapy conversations]' (Young, Hibel, Tartar, & Fernandez, 2017, p. 110). We wrote about our 'obligation to those consulting us to do more than just gather information' (2017, p. 104).

I remember many times hearing Michael White say, as we were watching a recorded session, and after he asked a particular question, 'Now I think I've got their interest'. It is this 'interest' that we were talking about in our chapter when referencing language in neuroscience such as 'enriched environment' and 'optimal arousal'.

We also wrote about focused attention, repetition, novelty and emotional arousal being important for learning and concept development. I see this as in support of one of the important backstories Michael White taught regarding scaffolding maps as they relate to Vygotsky's (1962) writings on concept development.

I have sometimes referred to the Hibel and team research when I'm teaching and making arguments for why it is important, when people show up at a walk-in therapy clinic, that they do not just receive a 'tick-box' set of questions to gather information (no meaningful engagement), but instead have a conversation that is highly meaningful, relevant and powerful. I liked that this research measured something that could be linked to certain types of narrative practices. I joined Jim, Jaime and Mercedes in this writing as I felt that I could assist in writing something that offered some scientifically measured evidence for the use of scaffolding maps in narrative therapy which are, along with many other narrative practices, precious to me in my work.

References

- Shotter, J. (2015). Tom Andersen, fleeting events, the bodily feelings they arouse in use, and the dialogical: Transitory understandings and action guiding anticipations. *Australian and New Zealand Journal of Family Therapy*, 36(1), 72–87.
- Vygotsky, L. S. (1962). *Thought and Language*. Cambridge, MA: MIT Press.
- White, M. (2004). Working with people who are suffering the consequences of multiple trauma: A narrative perspective. *International Journal of Narrative Therapy and Community Work*, (1), 45–76.
- Young, K. (2018). Narrative practice and the de-pathologizing of children's lives at a walk-in therapy clinic: An opportunity for socially just conversations. In C. Audet & D. Pare (Eds.), *Social justice and counselling: Discourse in practice*. New York, NY.
- Young, K., & Cooper, S., (2008). Toward co-composing an evidence base: The narrative therapy re-visiting project. *Journal of Systemic Therapies*, 27(1), 67–83.
- Young, K., Hibel, J., Tartar, J., & Fernandez, M. (2017). Single session therapy and neuroscience: Scaffolding and social engagement. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp. 103–115). New York, NY: Routledge.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Reflections on narrative, neuroscience and social engagement

by Gene Combs



Gene Combs is co-director of Evanston Family Therapy Center. With his partner in all things Jill Freedman, he has practiced, written about and taught workshops in narrative therapy for the last three decades. He may be contacted at Evanston Family Therapy Center 1212.5 Elmwood Avenue, Evanston, IL 60202, USA. email: narrativetherapy@sbcglobal.net, website: narrativetherapychicago.com

This journal issue comes at a time when some people who consider themselves to be narrative therapists have become concerned that narrative theorising and practices neglect 'the body', or that they privilege thoughts and words over affect. I have been mystified by this concern. As David Denborough lovingly documents in his paper 'Travelling down the neuro-pathway', the things that happen in the course of a narrative session have moved people to tears (and laughter, and righteous indignation, and awe, and . . .) since before this way of working had a name. In reading this paper, I was touched and transported to memories of encounters I witnessed over my years of study with Michael White. Denborough's eloquent account resonated with my own analyses and experiences of practicing narrative therapy, in which:

- narrative therapy has always attended to bodily experience
- good narrative practice does not separate mind from body, or feelings from thoughts and actions
- an over-focus on synapses and neurotransmitters can all too easily support a lack of focus on culture, context and community
- narrative therapy is committed to decolonising areas of life from Western psychological understandings.

I also believe that an over-focus on internal neurobiology risks leaving out important things: narrative's focus on culture, meaning, discourse and relationship; the witnessing of struggles; linking lives in solidarity to respond to pain, loss and trauma by standing for and giving value to our visions for a better world. I think the following words summarise this well:

narrative therapy deals with emotion in a particular way. It couples emotion and meaning, and refuses to separate them. It also refuses to separate emotion and meaning from action. In this way, emotion is also never separated from culture, politics and ethics. (Denborough, in this issue)

I was especially energised and inspired by the summary of the work of Glenda Fredman and of the feminist academics who are writing on the affective turn. I'm also interested in the narrative practice tradition of traversing affect to emotion in particular, careful, non-linear ways that:

- sponsor diversity not conformity
- do not seek to fix affect into singular emotion
- do not rely on existing global terminology for emotional experiences.

These ideas have already increased the subtlety and persistence with which I will unpack labels like 'depression'. My appetite has been whetted to read more from the work of these authors.

Finally, I appreciated reading the compelling examples from Michael White's work and the reminder that Michael turned *towards* expressions of emotion (such as episodes of tearfulness) in ways that did not separate emotion from meaning or action.

To me, Michael's riffs on 'if your tears could talk' are poems, packed with possibilities for generating rich new experience – invitations to becoming other.

I found such gems scattered throughout this piece of writing.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Feelings, thinking and action as a coherent whole:
A reflection on 'Travelling down the neuro-pathway'

by Jill Freedman



Jill Freedman is co-director of Evanston Family Therapy Center in the Chicago area, and is on the international faculty of Dulwich Centre. With Gene Combs she co-authored Narrative therapy: The social construction of preferred realities and Narrative therapy with couples.... and a whole lot more!

In 2007, as part of a collaboration with Ibuka counsellors in Rwanda, I was privileged to consult to the Kigali Memorial Centre (see Denborough, Freedman, & White, 2008). The staff walked me through the museum, which had exhibits showing the context and history of the genocide. The very last room held only family photographs or whatever pictures could be found of people who had perished in the genocide. The director of the centre told me that it was not unusual for a visitor to walk into that room and be overwhelmed by the sheer number of people, or by the image of someone they had known personally, and to begin sobbing, often collapsing on the floor. I, too, felt tremendous grief on witnessing these photographs, so I could appreciate at least a little of the devastation people might experience when entering this room. If people did not compose themselves, the staff would try to comfort them. If they were unsuccessful, the only option that they had was to call medical services to bring these re-traumatized persons to a hospital. The director and staff members all wanted some other ways of responding. They hoped that I could offer some help. I was not the first consultant they had asked. The last consultant, the director told me, had suggested 'a sport called yoga'.

'We are sure that this is a very good sport', he said, 'but we don't know how it can help in this situation'.

When I hear narrative practitioners talking about neuroscience, I am reminded of this story. I have great respect for yoga, and I know that it is helpful to many people, but clearly it would not solve the problem that the group at the Kigali Memorial Centre faced. I don't know if it is a fair analogy, but while I am sure that neuroscience also has much to offer, I don't know how it can help with the situations I work with in therapy.

After my initial conversation at the Kigali Memorial Centre I got in touch with my colleague Yishai Shalif in Jerusalem, wondering if he knew insiders who had been to Yad Vashem, the Holocaust museum, who might offer experience that would be helpful to the Rwandans. When my plea reached Yishai, he was at a conference and he immediately set about filling in other narrative therapists there on my request. Quite quickly the group in Jerusalem composed a list of ideas to share with the staff at the Kigali Memorial Centre. They included suggesting that visitors to the museum enter in pairs, first having a conversation about how each might help the other if they were overtaken with grief; a proposal that groups sing a song of solidarity before beginning their visit; and a notice at the entrance of the museum describing the exhibits and giving suggestions about what has been helpful for others proceeding them,

including the possibility of not entering every room.

The ideas about how problems can be located in larger contexts and discourses, rather than in individual people, and that preferred stories can be developed in relational ways are central in what I appreciate about narrative therapy. I don't find these ideas in neuroscience, which I understand invites people to attend to amygdalas, cerebral hemispheres and the like – small waystations in much larger arcs of relationship – as if they are the source, or cause, or prime movers.

At a presentation I attended about narrative therapy and neuroscience I asked the presenter how neuroscience ideas changed his work. He talked about thinking about affect: making sure that people were feeling their stories. I was surprised and puzzled by this answer, as I have always experienced this as part of narrative therapy. In the very first paper about narrative therapy that Gene Combs and I co-authored (Freedman & Combs, 1993) we wrote:

We have found these two ideas – that questions can be used to generate experience and that people make sense of their lives by organizing them into stories – extremely helpful in guiding the questions we ask. The idea of using questions to generate experience reminds us to ask questions that require internal involvement and exploration to find their answers. The narrative metaphor guides us in asking questions that invite amplification of answers so that the experience generated has a past and a future, characters, a context, and meaning—in other words, so that it's a story. (Freedman & Combs, 1993, p. 295)

When people are experientially involved, they are having affective experiences. And from the beginning, in asking people to put their experience into words, as part of a story, we have focused on feelings, thinking and action as a coherent whole. This has always been an important part of our understanding of narrative practice.

One of the many things I thought was quite remarkable about Michael White was his ability to read theoretical material from other fields and use it as inspiration to develop practices that we could use in narrative work. After his death, I feared that we had lost this way of developing new practices. When people began talking about the implications of neuroscience, I was hopeful that they were doing something similar to what Michael had repeatedly done. I went to several presentations about narrative therapy and neuroscience hoping to hear ideas that would inspire new practice, but that

did not happen. I found my colleagues' interest in neuroscience puzzling and thought I must have missed or misunderstood something.

For me, the most important question as a narrative therapist in thinking about neuroscience is does it include ideas that will help in my work? Will it enhance my practice? I resonate with the concern David Denborough expresses that by focusing on changes in the brain we may miss considerations of politics. Consideration of politics is woven through my work and I fear that a focus on neuroscience could distract from

this. In reading David's paper, I found myself particularly drawn to the examples he gives of considerations outside of neuroscience. I am left thinking about public feelings projects and have found myself transported to imagining ways of making connections between what can be thought of as personal feelings and collective experience. So maybe yoga, or for that matter Rwandan forms of dance and movement, could be significant for people in distress, if it were practiced in groups as part of a public feelings project that made connections between personal and collective despair.

References

Denborough, D., Freedman, J., & White, C. (2008). *Strengthening resistance: The use of narrative practices in working with genocide survivors*. Adelaide, Australia: Dulwich Centre Foundation.

Freedman, J., & Combs, G. (1993). Invitations to new stories: Using questions to explore alternative possibilities. In S. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 291–303). New York, NY: Norton.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:
www.dulwichcentre.com

You can find a range of on-line resources at:
www.narrativetherapyonline.com

You can find more of our publications at:
www.narrativetherapylibrary.com



*Narrative therapy, neuroscience
and socio-emotional discourses:
Comments*

by Tom Strong



Tom Strong is a professor, couple and family therapist, and counsellor-educator at the University of Calgary who researches and writes on the collaborative, critically-informed and practical potentials of discursive approaches to psychotherapy. For more details on Tom and his research please consult: www.ucalgary.ca/strongt

I appreciate this opportunity to comment on two developments that have understandably been a focus of attention among narrative therapy's practitioner-authors. The two developments are discourses brought to supplement narrative therapy's primary metaphor or discourse: neuroscience and socio-emotional discourses.

I have been a counselling professor at the University of Calgary, an occasional contributor to the narrative therapy community and have long been interested in how social constructionist therapy ideas and practices may intersect (e.g., Lock & Strong, 2010). My interest in narrative therapy came about at the same time as I was coming to terms with postmodern and poststructuralist (i.e., social constructionist) ideas (Lyotard, 1984; Shotter, 1993). White's and Epston's (1990) embrace of these ideas was evident in their rigorous use of a narrative metaphor in highly creative dialogues. As accepted as the word 'metaphor' might be for narrative therapists, however, its use can seem problematic in our era of evidence-based practice.

Stephen Pepper (1942) long ago noted that science is engaged in an ongoing search for root metaphors. Root metaphors are those that scientists claim as foundational to their approaches to science. Therapy's history clearly indicates a related kind of root metaphor search with its many approaches or discourses of practice over the years. Metaphors, in this sense, are human constructions, ways to represent what matters to us discursively; rigorously developed and tested constructions that help us relate or intervene (Hacking, 1983). As human constructions, however, they are not 'mirrors of nature' (Rorty, 1979) or neutral reflections of reality as it is. Any use of metaphor is to be evaluated according to the possibilities it affords and constrains (Gibson, 1986) – and not just for humans (Latour, 2018).

Neuroscience has provided therapists with a relatively new root metaphor and related discourse of evidence for what therapy might accomplish. Its use has attracted many educators (e.g., brain-based learning, Jensen, 2008) and therapists (e.g., interpersonal neurobiology, Siegel, 2012). Relatedly, it has attracted the interest of some narrative therapists whose writing serves as a focus of David Denborough's paper 'Travelling down the neuro-pathway: Narrative practice, neuroscience, bodies, emotions and the affective turn'. My interest is not to provide a further review of the literature to which he referred, but to selectively comment on neuroscience as a metaphor and discourse. David read my recent chapter (Strong, 2017) in Marie-Nathalie Beaudoin and Jim Duvall's (2017) edited book and offered me (and

a number of other respondents) a chance to comment on his article in this issue. My words below extend that correspondence.

Neuroscience discourse affords therapists with new conceptual resources and potential evidence to support some cognitive activities that relate to what therapists discuss with clients. For example, is it helpful to know that practice using certain cognitive strategies can make reproducing those strategies outside of therapy easier to do outside of therapy? Yes, I'd say, and to know that parts of one's brain light up while doing those activities shows evidence that activities occur inside us as much as their counterparts occur outside us. What these correlated activities do not suggest, however, is what Peter Hacker (Bennett, Dennett, Hacker, & Searle, 2007) described as a 'mereological fallacy' common in some uses of neuroscience discourse: that particular brain parts *cause* activities external to the person to occur. This kind of causal language is rife in some kinds of neuroscience discourse, as if implying that my writing to you is because of some location or part in my brain. Put another way, however, I have no doubt that my writing to you is partly enabled by brain parts and activities, while also owing something to David's offer to comment, my wish to reach you, my reading of narrative therapy and neuroscience literatures – and so on. In cases from the therapy literature, therapists tend to draw on neuroscience discourses to justify their use of an intervention, informing clients how suggested activities engage and enhance the functioning of particular brain parts. It is in this sense that I refer to neuroscience as an evidence-based discourse. However, as working on my breathing in swimming or yoga has shown me, my lungs (or improved breathing) alone do not enable calmness in challenging circumstances.

Neuroscience was to furnish the root metaphor for psychopathology, enough for Tom Insel (2013), director of the United States National Institute of Mental Health, to abandon the DSM-5 for research purposes – just as it was going to publication. For Insel, mental disorders were brain-based – the neuro-mechanisms for psychopathology had yet to be found (same as today). Despite a failure to neuro-biologically anchor diagnostic understandings (see Harrington, 2019), neuroscience discourse in therapy can sometimes also turn attention away from what goes on outside people, privileging instead an inner focus on their neuro-cognitive functioning. This return to people's individual and inner functioning is a focus that narrative therapists tried to question from narrative therapy's early days. The 'problem is the problem' remains one of its most enduring and pithy phrases. It focuses narrative

therapists' conversational efforts on meanings and circumstances external to clients that somehow were problematically internalised as clients' symptoms and identity stories (Tomm, 1989). I like that neuroscience has invited more attention to our physiological functioning, yet there seems a challenging balancing act to be struck between conversations focusing on clients' inner and outer experiences. What does an emphasis on neuroscience discourse afford and what does it constrain in our helping conversations? How can the narrative metaphor best be practiced alongside the neuroscience metaphor, without making one metaphor subservient to the other? These kinds of questions come up for me when I consider narrative and neuroscience as root metaphors of practice.

I was also thankful to see David raise a focus in his article on affect, emotion and embodiment as areas unnecessarily marginalised in narrative therapy conversations. Meanings, like those of stories and discourses, can sometimes come across as mere information – a view easily dispelled when viewing therapists like Michael White engaging clients, as the cited examples illustrate. Margaret Wetherell (2012) distinguished between our affective experience and our emotional experience, the latter being where culture and language presumably bring a shareable familiarity to our felt experience. Affects were our primary means of communicating as infants. Attunement between parent and infant began as a kind musical and gestural challenge of relating before it became a verbal one (Trevarthen, 2002). Words, stories and discourses come later, offering a culturally and relationally recognisable emotional packaging for felt experience to be understood; however incomplete, illogical or challenging what anyone feels might be to share. Affects-becoming-shareable-emotions point to the messy inadequacies of already existing discourse; something always seems left out, and some traumatic and oppressive experiences seem to defy hear-able words (Scarry, 1985). This is why artistic projects like the public feelings project David raises (Cvetkovich, 2012) can be so important. Such public projects, as well as our therapy conversations, offer ways to relationally attune to others' suffering, to

find shared ways to probe and give recognisable form and still-needed action to the not-yet-said.

We are witnessing some awful political attempts to give form and articulation to felt experience (Massumi, 2015). If affects are our raw felt experiences and emotions are the culturally recognisable ways to express and act on what we feel, politics offers an arena in which felt experience is channelled or packaged as culturally shared emotional experience. The same could be said about emotion discourse in any form of therapy. In what ways does a therapist help clients find a language for their upsets and disquiets? What gets privileged as the best way to talk about feelings, and returning to the pre-verbal, who decides the intensity of what is being discussed? These are not easy questions, just as feelings are often difficult to be with together as they are happening and seeking some sort of share-ability.

My training as a therapist began just as a therapy era focused on catharsis (e.g., yelling at one's imagined mother in an empty chair) was on the wane. In its place another root metaphor was ascendant: the computational metaphor of cognitive therapy. This furnished a decidedly less emotional discourse for therapy. Narrative therapy began with a recognition that words, metaphors and stories are partial human constructions that afford some actionable possibilities while constraining others, especially at the level of identity stories. How narrative therapists supplement (braid?) their root metaphor with other discourses of practice, will be part of how the narrative therapy community continues to develop out of any rigid orthodoxies. Neuroscience discourse has helped to bring attention to cognitive and physiological experience, and it sometimes does this in ways that obscure external concerns, social injustices and dominant cultural discourses. That doesn't mean it can't find its place as a supplement to narrative practices that addresses such externalities as many recent authors have been showing. As for affective and emotional experience, I am thankful to see how new theoretical developments make these aspects compelling as a focus of practice. I am also appreciative of these sorts of exchanges and discussions and their role in sustaining a vibrant and diverse narrative therapy community.

References

- Beaudoin, M-N., & Duvall, J. (Eds.) (2017). *Collaborative therapy and neurobiology: Evolving practices in action*. London, England: Routledge.
- Bennett, M., Dennett, D., Hacker, P., & Searle, J. (2007). *Neuroscience and philosophy: Brain, mind, and language*. New York, NY: Columbia University Press.
- Cvetkovich, A. (2012). *Depression: A public feeling*. Durham, NC: Duke University Press.
- Gibson, J. J. (1986). *The ecological approach to visual perception*. New York, NY: Psychology Press.
- Hacking, I. (1983). *Representing and intervening*. New York, NY: Cambridge University Press.

- Harrington, A. (2019). *Mind fixers: Psychiatry's troubled search for the biology of mental illness*. New York, NY: Norton.
- Insel, T. (2013, April 29). Transforming diagnosis [Blog post]. Retrieved from www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml
- Jensen, E. (2008). *Brain-based learning: The new paradigm of teaching* (2nd ed.) Thousand Oaks, CA: Corwin.
- Latour, B. (2018). *Down to earth: Politics in the new climactic regime*. Malden, MA: Polity.
- Lock, A. J., & Strong, T. (2010). *Social constructionism: Sources and stirrings in theory and practice*. New York, NY: Cambridge University Press.
- Liotard, J-F. (1984). *The postmodern condition* (G. Bennington & B. Massumi, Trans.). Minneapolis, MN: University of Minnesota Press.
- Massumi, B. (2015). *The politics of affect*. Malden., MA: Polity.
- Pepper, S. (1942). *World hypotheses*. Berkeley: University of California Press.
- Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton, NJ: Princeton University Press.
- Scarry, E. (1985). *The body in pain: The making and unmaking of the world*. New York, NY: Oxford University Press.
- Shotter, J. (1993). *The cultural politics of everyday life*. Toronto, ON: University of Toronto Press.
- Siegel, D. J. (2012). *Pocket guide to interpersonal neurobiology: An integrative handbook of the mind*. New York, NY: Norton.
- Strong, T. (2017). Neuroscience discourse and the collaborative therapies? In J. Duvall & M-N Beaudoin (Eds.), *Collaborative therapy and interpersonal neurobiology: Evolving practices* (pp. 116–127). London, England: Routledge.
- Tomm, K. (1989). Externalizing the problem and internalizing personal agency. *Journal of Strategic and Systemic Therapies*, 8(1), 54–59.
- Trevarthen, C. (2002). Making sense of infants making sense. *Intellectica*, 34, 161–188.
- Wetherell, M. (2012). *Affect and emotion*. Los Angeles, CA: Sage.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:
www.dulwichcentre.com

You can find a range of on-line resources at:
www.narrativetherapyonline.com

You can find more of our publications at:
www.narrativetherapylibrary.com



A reflection on self-regulation and neuro-conceal

by Emma Van der Klift



*Emma van der Klift is an Autistic speaker and advocate within the disability rights community. With her husband and partner Norman Kunc, she travels extensively throughout North America and abroad providing in-service and other training in the areas of inclusive education, employment equity, conflict resolution and other disability rights issues. She has written for numerous journals, contributed to edited anthologies and co-written a book with Norman Kunc titled *Being realistic isn't realistic: Collected essays on disability, identity, inclusion and innovation* (2019). Her most recent book is *Talk to me: What educators (and others) can learn about de-escalation from hostage negotiators* (2019). Emma holds a master's degree in conflict management and analysis, and is a certified mediator and negotiator.*

I am an Autistic¹ person currently questioning and writing about the ethics and effects of various compliance-based behavioural therapies experienced by Autistic children, and am doing so from a narrative perspective. Many of the remedial programs I am looking at rely heavily on the language of neuroscience to bolster their credibility, and in this context I was fascinated by David Denborough's provocative article 'Travelling down the neuro-pathway: Narrative practice, neuroscience, bodies, emotions and the affective turn'. Although there are many ideas in this paper that warrant further discussion, several were of particular interest to me. In this reflection, I turn specifically to Denborough's discussion of *self-regulation* and *neuro-conceal*. However, before I do so, let me provide a bit of context.

I am part of a community of people typically described in common vernacular as 'puzzles'. Many fundraising and support agencies use the blue puzzle piece as a logo, and it has become synonymous with autism. This metaphor is likely intended as a neutral, humanistic and kind conception of autism, presumably free of some of the more pejorative labels that are often attached to us. However, despite these probable good intentions, like many Autistic people I find myself offended by the ramifications of this depiction. If I am a puzzle, it is implied that I am something to be examined, studied, understood and ultimately *solved*.

The metaphor of the puzzle is often further conceptualised as a brain puzzle. Not unexpectedly, this has led to a concerted search for where *exactly* in the brain things like theory of mind, self-regulation and even empathy (things we autistics are believed to lack) are located. But are there risks in turning to neuroscience for answers to these questions? What other explanations might this focus obscure?

I am troubled that perhaps those of us in the Neurodiversity/Neurodivergence community (Walker, 2014) have inadvertently been complicit in a narrow conception of autism, even though that has never been our intention. Although we have called our differences of embodiment 'neuro' issues, autism has not been proven to be a brain anomaly. Like schizophrenia, bipolar disorder and many other conditions, no specific area of the brain has been conclusively implicated in autism (Leary & Donnellan, 2012; Rose & Abi-Rached, 2013). There is speculation that these conditions may be genetic, but to date no specific genes have been found either.

An alternative explanation has emerged in recent years. Some researchers have moved away from a strictly 'brain-based' approach and are beginning to characterise autism more broadly as a 'movement difference' (Leary & Donnellan, 2012). Many Autistic people (including me) agree, and note that much of our embodied experience is best described as being characterised by difficulty in starting, stopping and switching activities, managing executive function issues and, most relevant to this discussion, regulating emotions (Leary & Donnellan, 2012, p. 175). Ido Kedar (2012), a young non-speaking Autistic activist, has written that 'it's like living in a body with a mind of its own' (2012, p. 17).

A narrow focus on brain function may not only lead us to miss important information and disconfirming evidence, it may also lead to a wholesale adoption of problematic therapies and approaches. Focusing on the brain in search of remediation, and perhaps even cure, may, in fact, conceal more than it reveals. In this context, David Denborough has brought our attention to the specific issue of emotional self-regulation – one area of increasing focus in treatments used with Autistic children and adults – and the possible consequences of what he aptly refers to as 'neuro-conceal'.

Self-regulation

Regulation metaphors: where once the dominant idea in psychologies was to 'express' our feelings, now we are invited to 'regulate' them or 'tame' them: 'By naming our emotions we can tame their potential effect on us' (Marlowe, 2017, p.54). (Denborough, 2019, in this issue)

Over the years, many Autistic people have used the language of self-regulation in positive and proactive ways to describe the strategies we use to cope with a world that is often too intense: too loud, too bright, too interactional. Although many of these strategies may look strange and incomprehensible to non-Autistic people, they have particular utility for us. For example, we may regulate through hand flapping or spinning, or use vocalisation in unusual ways. We may carry spinners or other fidget toys. We may need to retreat to safe and quiet places or try to carve out time to be alone in order to regroup and recover from stressful situations. We may avoid eye contact. These are all examples of ways in which

we attempt to actively cope with our environments and our emotional responses to a world that is often overwhelming.

However, the language of self-regulation has recently been hijacked in the name of neuroscience. Particularly (but not exclusively) in school settings, self-regulation is no longer viewed as a means to recover from overwhelming situations or manage stress, but is increasingly seen as a moral imperative – something that we must strive for and are expected to achieve. As in the quote above, children (and adults) are pressured to ‘tame’ and manage their emotional states, and in some instances, a lack of so-called self-regulation has even become the justification for forcible exclusion.

Let me provide an example as a cautionary tale. Where I live, in British Columbia, Canada, there is an increasing uptake by schools of a packaged program called ‘Zones of Regulation’ (Kuypers & Winner, 2011), with some schools even self-identifying as ‘zone schools’. This appears to be part of a wider movement to teach ‘social thinking’, ‘emotion naming’ and ‘behavioural regulation’. It is loosely tied to the current and wildly popular mindfulness movement. It is primarily, but not exclusively, directed at children who struggle with what are considered to be dysregulation issues. Many of these children are Autistic.

Zones of Regulation is a patented curriculum described by its authors as being based on solid brain research and the principles of cognitive behavioural therapy. Educators use the program ostensibly to teach children to recognise, mediate and develop strategies to manage their emotional states and, by extension, their behaviour. There are four zones, which are colour coded: Rest, Go, Slow and Stop. The Rest zone is blue, and describes experiences of shut down, sickness, boredom or sadness. Slow is yellow, and stands for agitation, silliness and distraction. Go is green, and considered the optimal zone for attention and learning. Finally, Stop is the red zone, and denotes acute distress like fear, anger and aggression. The authors state that all the zones are fine; however, it is clear that the preferred zone is green.

Sounds reasonable, doesn't it? What could possibly be wrong with an educational model supposedly based on current brain research? Doesn't it make sense to help children not only recognise and name their internal states, but to actively choose and

change them at will? Consider the following story, relayed to me by the mother of one of the children referred to within it. As you do, remember that ‘meltdowns’ are often the result of overstimulation and overwhelm, not a sign of wilful noncompliance.

Several third-grade classes gathered in the school library to listen to an author read from a book she'd recently written. One of the boys in the group became agitated and began to cry. Despite numerous attempts by his teacher to calm him – including both shushing and threats – his distress escalated. Soon he was crying loudly, and the author was forced to interrupt her presentation.

The teacher attempted to physically remove the boy from the room. The child flinched away from her touch and fell to the floor, crying even more loudly. Several teachers moved in to assist, trying unsuccessfully to pick the boy up by his arms and escort him out of the library. This only made the child more upset. Finally, in frustration, they converged on him and subdued him on the ground in a four-point restraint, grabbed him by the feet and dragged him kicking and screaming out of the room. They deposited him in a nearby library closet and locked the door. The child continued to cry loudly and bang on the door with his feet, begging to be let out. The other children were visibly distressed, and the author had to stop the reading and send the children back to their classrooms.

The next day, after being informed by the parent of one of the boy's classmates that the incident had traumatised a few of the children, the school principal visited the classrooms to debrief the incident with the students. She asked if the children had any questions. Furious, one of the third graders stood up and said, ‘How does it feel to know you've done something mean and illegal?’ The principal responded by explaining that the teachers' actions were justified because the boy had violated ‘the zones of regulation’, and added that such behaviour would not be tolerated. The objecting child went home and asked her mother, ‘Mommy, what would I have to do to be locked in the book closet?’

In yet another school, a principal was overheard admonishing a visibly distraught student. ‘I won't talk to you’, he said as he turned away from her, ‘until you're in the green zone!’

Perhaps neuroscientists, on reading the stories above, might be permitted to break into a rousing rendition of ‘Look what they've done to my song’. It

could easily be argued that these vignettes present instances in which a perfectly good concept has been misinterpreted and badly applied (and I don't dispute this), but is that the only problematic issue?

A little knowledge, it is said, is a dangerous thing. Take as an example the speed with which we have adopted metaphors like the brain as computer, and attendant notions that all of us possess neural 'hardware' and 'software'. These ideas have quickly become part of what Rose and Abi-Rached called the 'rhetoric of objectivity' (2013, p. 178). They have become the basis for a kind of borrowing of credibility through mobilising the discourse of neuroscience. Immersed now as we are in the taken-for-granted language of 'wiring' and 'miswiring', it is perhaps inevitable that the next question will be: if some people are miswired, how can we rewire them?

The stories above illustrate the dangers we face when we accept what even neuroscientists are unwilling to unequivocally endorse. Most of what we think we know about the human brain is still speculation. When we create models of practice based on a thin understanding of a complex science, we may unintentionally harm the very people we are trying to help.

Neuro-conceal

As Nikolas Rose and Joelle Abi-Rached remind us, 'We should beware of scientific or technological determinism' (2013, p. 3). Models like the Zones of Regulation are troubling, not just because they promote a reductionist view of human emotion, but because they fail to take into account the relational and even political nature of interaction. These programs seem to hold as given that emotions and internal states are self-generated. In this way, they privilege the idea of the encapsulated and skin-bound 'internal world' of the individual, and from there it is an easy stretch to insist that children (and adults) must learn to be responsible for 'taming' their emotions through a form of boot-strapping self-awareness and individual effort.

Unfortunately, the language of 'choice' is also hijacked in the process and, in this way, the political nature of relationships and even emotional response is obscured. The onus is on the individual to make 'good choices'. Children are told that they not only have the *ability* to 'choose' their emotional states, but also

the *responsibility* to do so. Lapses are considered personal failures. Unfortunately, for those who don't (or can't) comply, the inability to do so results in a predictable cascade of punitive responses: detention, suspension, expulsion and, as experienced by the boy in the above vignette, even restraint and seclusion. In this way, all that is old is rendered new again, but this time in the name of neuroscience.

David Denborough asked:

Is this 'science' speaking, or dominant Western cultural imperatives speaking through 'science'? Valorising 'regulation'...is only one way of conceptualising our emotional lives and identities. To imply it is the only way, and that findings from neuroscience 'validate' it, risks obscuring a great deal. (Denborough, 2019, in this issue)

He further noted that 'a focus on neuroscientific understandings promotes a limited field of vision which I sometimes refer to as "neuro-conceal"', and went on to add, 'By focusing on changes in the brain, one of the first things that can become concealed is consideration of politics (whether this relates to gender, race, class, poverty, sexuality or other relations of power)' (Denborough, 2019, in this issue).

Similarly, Ronald Purser, author of *McMindfulness: How mindfulness* became the new capitalist spirituality (2019), described how the ways in which mindfulness is often engaged are individualistic: 'the whole systemic and structural apparatus ... is completely untouched and not called into question' (Purser, interviewed in Siegel, 2019).

The goal of programs like the Zones of Regulation and of the mindfulness movement is ostensibly to assist people to achieve homeostasis – a state of equilibrium, wellbeing, happiness and harmony, not misery and exclusion. This is arguably a laudable goal. However, when we use these techniques without any attention to issues of power relations it is not only possible, but likely that when people fail to meet expectations, an identity of dysfunction will be imposed on them. When used to tell us that we must take on the arduous job of policing ourselves, our bodies and our emotional responses, brain research can become a blunt instrument of oppression.

Perhaps, as narrative practitioners, we would be wise to remember that

We are always already within complex patterns of social and symbolic relationships, and 'emotion' is a name we give to the multidimensional processes by which subjects navigate and *negotiate* within them. We 'feel' our way through life in an embodied engagement. (Kovecses, 2000, p. 53; quoted in du Toit, 2014, p. 5)

As an Autistic person, I couldn't agree more.

As David Denborough reminds us, 'Narrative practice challenges the disembodied speech acts and claims of universal expert knowledge that make up a considerable portion of professional cultures. This includes disembodied claims made in the name of neuroscience' (2019, in this issue). Patty Lather (1993) cautioned us to remember that research is important, not for what it can measure, but for what it can do. It is increasingly clear that neuroscientific research actually *does* things. Actions flow from it, decisions are made and reputations are both created and destroyed in its name.

In this context, I leave the last words to Michel Foucault (1983):

My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my

position leads not to apathy but to a hyper- or pessimistic activism. I think that the ethico-political choice we have to make every day is to determine which is the main danger. (Foucault, 1983, pp. 231–23)

Notes

¹ You may notice that I have used capitals in some instances when talking about myself or other Autistic people. Like Deaf people who identify with Deaf culture and view deaf people as a linguistic minority, many Autistic people in the Neurodiversity community prefer the capital letter as an expression of identity and pride. You may have also noticed that I have identified myself as 'an Autistic person', not 'a person with Autism'. Some may think that that this is an oversight or a politically incorrect gaffe. It is not. I have intentionally chosen to use identity first language (IFL) rather than the more commonly accepted person first language (PFL). PFL is often seen to highlight the person above the disability. I respect and honour this use of language and its tradition because I understand that many individuals with intellectual disabilities and their families have fought hard against stigmatising labels, and therefore prefer PFL. However, within the larger disability rights community, the Neurodiversity movement, the Deaf community and in critical disability studies, IFL is preferred. We use identity language because we believe that our disabilities are not separate from us or something to be hidden or ashamed of. This represents a move away from the commonly held perception of disability as a negative attribute, and towards the idea of disability as a something that can be openly acknowledged and claimed with pride.

References

- DiFranco, A. (1993). *My I.Q. On Puddle dive* [CD]. New York, NY: Righteous Babe.
- du Toit, C. W. (2014). Emotion and the affective turn: Towards an integration of cognition and affect in real life experience. *HTS Theological Studies, 70* (1), 1–9. doi: 10.4102/hts.v70i.2692
- Foucault, M. (1983). On the genealogy of ethics: An overview of work in progress. In H.L. Dreyfus & P.Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (2nd edition), pp. 229–252. Chicago, IL: University of Chicago Press.
- Kedar, I. (2012). *Ido in Autismland: Climbing out of autism's silent prison*. Author.
- Kuypers, L., & Winner, M. G. (2011). *Zones of Regulation: A curriculum designed to foster self-regulation and emotional control*. Santa Clara, CA: Think Social.
- Lather, P. (1993). Fertile obsession: Validity after poststructuralism. *Sociological Quarterly, 34*(4), 673–693.
- Leary, M. R., & Donnellan, A. M. (2012). *Autism: Sensory movement differences and diversity*. Cambridge, WI: Cambridge Book Review Press.
- Purser, R. (2019). *McMindfulness: How mindfulness became the new capitalist spirituality*. London, England: Repeater.
- Rose, N., & Abi-Rached, J. M. (2013). *Neuro: The new brain sciences and the management of the mind*. Princeton, N.J.: Princeton University Press.
- Siegel, Z. (2019, July 25). *Why corporations want you to shut up and meditate*. *The Nation*. Retrieved from www.thenation.com/article/ron-purser-mcmindfulness-mindfulness-meditation-book-interview/
- Walker, N. (2014). Neurodiversity: Some basic terms and definitions [Blog post]. Retrieved from neurocosmopolitanism.com/neurodiversity-some-basic-terms-definitions/



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Responding to David Denborough's paper:

A short interview with Marie-Nathalie Beaudoin

by Kristina Lainson



Marie-Nathalie Beaudoin directs a narrative therapy, neurobiology and mindfulness training center in San Jose, California, and offers therapeutic services to children, adults and families. For more information, see www.mnbeaudoin.com

Kristina Lainson is a narrative practitioner from Aotearoa New Zealand and is currently a PhD candidate at The University of Melbourne. She is also a member of the faculty at Dulwich Centre. Kristina has been involved in a variety of Dulwich Centre projects and is a tutor on the Master of Narrative Therapy and Community Work. She can be contacted at: Kristina.Lainson@icloud.com

A key theme of this special issue is considering ways to engage rigorously with practices of critique. As part of embracing this ethos, an invitation was extended to Marie-Nathalie Beaudoin, asking her if she would like to offer a critical response to David Denborough's paper, 'Travelling down the neuro-pathway: Narrative practice, neuroscience, bodies, emotions and the affective turn'. Marie-Nathalie kindly accepted the opportunity, and it was mutually decided that an interview format would work well. Kristina Lainson acted as interviewer on behalf of Dulwich Centre Publications, and the following interview sought to create space to represent divergent viewpoints and promote generative conversations about differences of opinion.

Kristina: Hi Marie-Nathalie, thanks for speaking with me today. Would you like to start by saying a little about what draws you to the ideas of neuroscience and how they assist you in your work?

Marie-Nathalie: I believe there are many aspects of neurobiology that can enrich our work. My work is still anchored in narrative therapy, but I have been expanding my repertoire of practices by better understanding various aspects of the brain and embodiment. We journey through life with this body and a brain, and we seldom consider what's happening inside; in many ways, not 'looking' inside is like travelling with a heavy backpack and never taking a peak at what's in there!

Being interested in the brain and the body has had many valuable implications in my work. For example, it's allowed me to expand on how I respond to affective, emotional and traumatic experiences. Similarly, a better understanding of how memory works has allowed me to make it easier for clients to find, notice and remember unique outcomes and string them together for re-authoring and remembering conversations.

It's worth mentioning that understanding how the brain and body operate helps me depathologise my clients. There are number of people who review their symptoms on the internet and bring with them a scientific model of their suffering. Or sometimes, a doctor has provided them with a psychiatric diagnosis. Having knowledge about the brain that is perceived as 'scientific' allows me to

stand up to the medicalisation of identity, and to challenge fixed psychiatric beliefs, by providing alternative explanations which are still biological in nature but much less pathologising.

Kristina: How so? How are neuroscience ideas visible in your practice? What might be noticeably different from more familiar narrative conversations?

Marie-Nathalie: It would depend on the client and the struggle. In general, the start of a therapeutic conversation could be very similar to the familiar version of narrative therapy: discovering wonderfulness, loitering in the client's experience, externalising, looking for meaning, values, effects, et cetera. What you wouldn't see but would be happening in my mind, however, is some affective double listening. Just as we tend to notice unique outcomes (even though we may choose to not comment on them right away), I would be noticing slight fluctuations in affective responses, and paying attention to subtle waves of affect-infused experiences. This would influence my choice of externalisation, which example I choose to co-investigate, the map of effects, which unique outcome to explore, and the type of re-authoring questions. I also ask a very wide range of questions about the body, related to both problem and preferred experiences, and use embodied practices to quickly reset the physiological state of a client walking in, for example, overwhelmed by panic and barely able to speak.

While narrative therapy traditionally asks only questions, I also sometimes make a few informational statements. There are some situations and therapeutic relationships in which the benefits of making a few statements significantly outweigh the risks of creating an imbalance of power and knowledge. For instance, a mother I was working with recently, and who had unfortunately been diagnosed as having a borderline personality disorder by her physician, shared with distress: 'I'm so messed up. What kind of mother would get angry enough to abruptly leave her husband and baby, without her phone, and go walking alone for a portion of the night to calm herself down?' After acknowledging her distress,

understanding the context, meaning and effects of this experience, etcetera, I asked her if she would be interested in different ways of understanding what she was describing, ways different to the diagnostic label she had been given (the timing of this question matters). She was. In a few sentences, I shared how scientific research shows that our brains tend to be wired to disconnect from people when very intense anger is triggered, and that most people can't think or remember well in that state; it's a common biological phenomena. This was both surprising and very reassuring to her. Suddenly, the problem was no longer about her identity being problematic, but rather reflected a common biological experience of intense anger, which, considering a stressful context of life, past oppression and frequent repetition, had become overly easy to trigger and too intense. I reminded her that the brain is neuroplastic, and that just as repetitive patterns reinforce certain problematic emotions, we could help her reclaim and cultivate the calm state and patient person that she preferred to embody. Sometimes I'll add that the brain is more readily neuroplastic with negative affective experiences than positive ones, but we can still influence our ways of responding to life. This client experienced this message as very hope promoting as it meant she could reclaim control over the anger (she stated: 'maybe the doctors gave the diagnosis too quickly!'). This brief explanation was just a brief parenthesis in my narrative conversation, but it had a significant effect on a person whose identity had already been medicalised (and, frankly, subjected to a patriarchal view of strong women which was deconstructed at a later time). While 'biologising' anger may not fit the theoretical intention behind externalising language, it has powerful helpful effects on some people, and can often accelerate the work. This has become very clear when clients are asked to comment on what they are taking away from our conversation, or what difference it made in their understanding of the problematic situation. Of course, some people are not at all interested in these sorts of explanations, and then I don't pursue it.

With this same client, I've also been helping her transition more effectively from states of

intense, out of control anger to her preferred self by doing what I call 'biological scaffolding'. There were situations where her anger lingered for hours and she knew acutely well that she didn't want this anger to be there; she even felt it was ridiculous to remain in this state. She externalised very well, was very clear that the anger was making her miss out on things and was distorting the meaning of everything. She knew where it was coming from in her past, knew she wanted to embody her preferred self but affectively struggled getting there. She hated getting stuck in this state but she couldn't shake it off emotionally. She struggled with embodying and living anything else at that very moment, and her intentions (coupled with preferred self and unique outcome knowledge) were often simply not enough to access different affective states.

Understanding the brain allowed me to engage in other practices, to facilitate the brain's affective transition, which in turn supported the narrative work.

Kristina: You recently read David Denborough's article 'Travelling down the neuro-pathway', in which he raises a number of concerns. Do you share any of his concerns?

Marie-Nathalie: I share many of the concerns David raises in his article, but there are nuances I would like to draw attention to. For example, there are many different fields studying the brain: neuroscience, brain science, cultural neuroscience, psychological neuroscience, neurobiology, etcetera. Some of these fields consider the impact of social context and relationships on people's experiences, and others seriously don't. Each has its own authors and debates, so it's tricky to put them all in the same bag. Same with narrative therapists interested in the brain and body: there are similarities, but also divergent views, and there is room for many voices. I don't actually identify myself as a neuro-narrative therapist, but rather as a narrative and collaborative therapist who reaches out for extra tools or practices in understandings of the brain.

A further nuance relates to a difference between *observation* and *interpretation*.

Research that looks at what happens in a person's brain via fMRI scans (for example, when exposed to anxiety-provoking images) or measuring cortisol during a narrative therapy conversation is *observational*, and that's very interesting to me. It's about expanding what we consider. But when it comes to using brain-based theories, or making generalisations about identity, or using fixed interpretations, I'm completely in line with David's article, and your article, Kristina (Lainson, 2019, in this issue). There are terribly limiting implications associated with inferring something fixed about a person's identity by a quick glance in their brain at a specific moment in a specific time and place in their lives; or by looking at genetic studies or assuming that everyone reacts the same way. I once heard on the radio that a researcher claimed to have found the gene for happiness! I found this statement extraordinarily concerning. There are research errors and limitations, as well as gender and cultural biases in many of these generalisations. Human beings are so complex, and much is lost by the reductionism and simplification embedded in many modernist conclusions.

My interest is not in brain theories, but rather in developing clinical practices that are helpful and that open therapeutic possibilities. For example, I have done quite a bit of thinking about how to specifically elicit and richly describe 'positive' emotions to help people flourish beyond classic re-authoring. There is space for more joy in many people's lives, especially those who have suffered for a long time and tend to live in a more neutral or problem state. These practices were inspired by brain-based positive psychology research and just expanded existing narrative practices.

Kristina: Are there any points of disagreement for you in relation to David's article?

Marie-Nathalie: Perhaps there are two theoretical points of slight differences. The first is around ideas of retraumatising, and the second on how narrative therapy addresses emotions.

With regard to trauma, as a clinician, my guiding principle is definitely: 'first do no harm'. For that reason I'm very attentive to how stories of trauma are discussed and

much prefer to emphasise re-authoring. But I've had a number of clients in the last decade with severe trauma, who I was unable to help with just my existing repertoire of narrative practices. This is partly because, in times of intense threat, the process of creating a narrative can get stuck due to the intensity of the experience and the focus on survival, and the brain may struggle to organise and story all the information afterwards. For that small group it was helpful to go back and revisit the moment of trauma. Paying attention to embodied manifestations during the revisiting process, and responding to them in certain ways, can be remarkably therapeutic. For example, just as someone's tears tell you something about their challenging experience, someone's broken speech about the event, such as, 'My brother ... phone rang ... I wonder ... yeah, I was in the living room, and all these people were there ...' gives information about the way this person's brain is processing the experience. I draw on understandings of the brain that tell us this type of expression is often associated with 'stuckness' and leaves people vulnerable to re-experiencing those intense feelings over and over again. If we can help someone articulate a more coherent account of the intensely painful experience, without retraumatising them, their brain becomes more able to organise the information, neutralises intense emotions, re-stores the event differently in memory, affectively infuses it with an experience of being supported (provided by the therapist), and can more effectively move on to richer re-authoring. I find brain understandings helpful here as I try to assist some clients in moving forward, and have seen very valuable effects on people.

I share these ideas very carefully, because I believe the majority of our work should focus on re-authoring to avoid retraumatising people. But I think that is an area about which David and I could have a great conversation one day. There are certainly some traumas that benefit from a carefully thought-out therapeutic trip to the past event, and some in which that should clearly be avoided.

The second point is in terms of emotions. I think there is room to further develop narrative

practices that help people with affective experiences – especially those intense emotions that play an important role in how people experience repetitive problems and get stuck. Often, these intense emotions have roots in contexts of life and sociopolitical discourses, which in turn have affected a person's childhood and family experience. I won't go in the past for the sake of dissecting childhood, or blaming parents, as is often done in mainstream therapies. I will go there only if there is a string of affective experiences that are repetitively associated with the problem or its effects and preventing the person from fully re-authoring. Depending on the situation, I may do this at the beginning of my work with someone, or much later, after having better articulated and increased awareness of the problem and its effects in the present time. For example, in these situations, I might ask about affect-infused moments, among other things, and where these intense emotional experiences take them in time, what it reminds them of in the past. Whenever relevant, as many narrative folks do, I will add the caveat that parents typically have done the best that they can with their own life experience and the challenges of their situation at the time, and scaffold the skills that were required to deal with challenging life circumstances.

Kristina: In David's article he coins the term 'neuro-conceal'. Are there ways in which neuroscience-informed narrative practice can escape 'neuro-conceal'?

Marie-Nathalie: As I mentioned to David, I feel that the term 'neuro-conceal' can imply an intention to hide something, and I don't believe that intention is present. I would linguistically prefer the concept of 'invisiblising' as I do agree that much research and particular theories are oblivious to the effects of cultural context and politics. To focus on brain structures alone without any other understandings can indeed ignore the important issues of culture, context and politics, which can have simplifying and harmful effects. I believe that remaining anchored in politics, context and analysis of cultural discourses, and by prioritising accordingly, helps avoid the risks David is describing.

Kristina: What about basic emotions theory: are there also ways to escape those limitations when drawing from the ideas of neuroscience?

Marie-Nathalie: I am concerned, as David is, about a list of primary emotions, or anything fixed such as genetic understandings, limiting statements about what is possible or not, generalisations about identity, or beliefs about specific emotions being present in all cultures of the world.

I think we can escape some of the effects of modernist theories if we keep a focus on our clients' experiences, meanings, emotions, thinking and the sociopolitical discourses in which they have evolved, as well as maintaining a critical eye on the discursive location of the research we are reading. By scaffolding our work with a careful and respectful attention to the effects of our work inside and outside the therapeutic session, and not accepting theoretically limiting beliefs on possibilities, I hope we can bypass many of the dangers and open our horizons. It's not because we are intrigued by some biological findings that we have to be married to all of this field's views.

Kristina: Are there any other aspects of David's article, or related matters, that you'd like to talk about?

Marie-Nathalie: I think bringing in embodiment and mindfulness to this work is really important. I've been practicing mindfulness for 20 years, but I don't suggest it to everyone. Some people are really not interested or have found it unhelpful in the past. I do, however, bring a form of embodiment to most of my therapeutic conversations.

There are a few people I worked with two decades ago whom I couldn't help then, because I didn't have organised embodied practices. In particular, I remember a 54-year-old Middle Eastern woman whose father had been catastrophically ill, between life and death, for two years, from giving her a hug on her fifth birthday when she had chicken pox. Although she had never been directly blamed, the trauma she had endured from living this devastating period had led her, for her entire life, to associate the merest

perceived abnormality in her own body with a debilitating terror of a deadly illness. This resulted in regular overwhelming panic attacks for which she had consulted countless therapists and doctors. She had extensive experience with meditation, and even owned a biofeedback program to monitor her practices, and that had not helped her. At the time, I didn't have any other embodied practices to help her, and narrative work was helpful, clearly, but not enough to completely abort intense physiological reactions that had been reinforced in her body for 50 years. Now, I would have more options.

I believe we can invite mindfulness and embodied practice to our work in order to be helpful to people. My hope is that we can generate conversations to stimulate and reimagine narrative therapy (as David Epston says!), and further expand our wonderful set of existing practices.

Marie-Nathalie: Thank you for this interview, Kristina. It is helpful for me too to reflect on these important matters, and constantly re-evaluate the effects and directions I'm undertaking in my work.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

*All enquiries should be made to the copyright owner at:
Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000
Email: dcp@dulwichcentre.com.au*

Thank you! We really appreciate it.

*You can find out more about us at:
www.dulwichcentre.com*

*You can find a range of on-line resources at:
www.narrativetherapyonline.com*

*You can find more of our publications at:
www.narrativetherapylibrary.com*



Narrative therapy, neuroscience and anorexia:

A reflection on practices, problems and possibilities

by Kristina Lainson



Kristina Lainson is a narrative practitioner and PhD candidate at The University of Melbourne. She is also a member of the faculty at Dulwich Centre. Her particular interests include responding to eating concerns and narratively informed, insider and double-storied research methodologies. She can be contacted at: kristina.lainson@icloud.com

Abstract

The effects of anorexia are serious and have significant consequences for people's lives. A prevalent concern among professionals working within these realms include that available therapeutic approaches may have limited usefulness for some people, especially when anorexia has been in a person's life for a long time. Both narrative therapy and neuroscience have contributed to ways of working with people's experiences of anorexia. This article responds to a current, broader, conversation between narrative therapy and neuroscience by exploring some of the implications of each in the context of working with anorexia. By establishing a series of tensions between the principles and practices associated with certain neuroscientific models of anorexia and what is offered by narrative therapy, a case is put for eating disorder services to favour therapeutic approaches that attend to the politics of experience, and that privilege insider experience and knowledge. This article argues that these possibilities also extend into the realms of academic research, and that they have the potential to generate hope.

Key words: *eating disorders, politics of experience, research methodologies*

Introduction

It has been almost a century and a half since physicians William Gull and Charles Lasègue categorised the food and eating-related attitudes and practices of some women as pathological, defining what is now commonly called 'anorexia nervosa' (Hepworth, 1999). Their recommendations for 'moral treatment' established a 'conflation of the medical with the moral' that 'not only elevated medical treatment as implicitly good but also denigrated women's practices of food refusal as implicitly bad' (Conti, 2013, p. 17). Medical models have continued to dominate mainstream approaches to anorexia despite recognition of their limited efficacy (Wonderlich et al., 2012), and despite providing few opportunities for hope in relation to long-term experience (Touyz & Hay, 2015). Described as protracted and tenacious, this problem called 'anorexia' has beleaguered many who have sought to reclaim their lives in relation to it, and confounded many who have sought to help them do so (Strober, 2004; Touyz et al., 2013).

In this context in which anorexia is viewed as an individual pathology, neuroscientific understandings have recently garnered considerable attention. Neuroscience is proposed by many as the way forward – so much so that it is becoming increasingly common to hear anorexia described as a brain-based disorder: a development I will present as being of concern. With neuroscience in ascendancy in the West (Rose & Abi-Rached, 2013), some narrative therapists have taken up the position that neuroscience can augment and complement narrative practice, that the two work well together (Beaudoin & Zimmerman, 2011; Beaudoin & Duvall, 2017; Zimmerman, 2018).

Since the 1980s, narrative therapy has offered an alternative approach to medical models. The worth of narrative responses to anorexia has been suggested by a number of writers (Craggs & Reed, 2007; Grieves, 1997; Kronbichler, 2004; Lainsou, 2016; Maisel, Epston, & Borden, 2004; Weber, Davis, & McPhie, 2006; White, 2007, 2011). However, narrative therapy, founded in social work and based in poststructuralist and feminist thinking (White & Epston, 1990), has not yet been readily embraced by mainstream eating disorder services, advocacy or research. Recent calls for 'a new paradigm' in anorexia research and practice (Touyz & Hay, 2015), and for practices that attend more carefully to insider voices (Conti, Rhodes, & Adams, 2016), provide impetus for mainstream services to consider what narrative therapy has to offer.

This paper reflects on how neuroscience and narrative therapy construct divergent versions of the experience of anorexia. It outlines some of the principles underpinning the two models and the practices that are shaped by them, and it explores some of the problems and possibilities for future responses to anorexia.

This paper will:

- assert that a brain-based disorder model of anorexia has the capacity to (1) obscure a range of injustices and forms of suffering that may make anorexia viable; (2) create injustices that may perpetuate suffering for the person with lived experience; and (3) replicate existing injustices and suffering in ways that risk being ultimately antithetical to their intention
- propose a case that neuroscientific models and narrative approaches have some significant incompatibilities that show up in their understandings of and responses to anorexia, and people who live with it
- demonstrate the potential contributions of narrative therapy to work with anorexia and show how its commitments and practices might also inform further respectful research methodologies.

In developing these points, I draw on three dimensions of myself as researcher and practitioner:

- as someone who has extensive insider knowledge of living with anorexia, of being confounded by mainstream therapeutic interpretations and interventions, and of benefiting from narrative understandings and approaches
- as a narrative practitioner who has walked alongside others as they make reclamations of life in relation to anorexia
- in my role as a researcher and doctoral candidate undertaking original research on insider responses to long-term experiences of anorexia.

My personal connections to this topic mean I often use the language of *we/us/our* rather than *they/them/their*.

At this point I find myself thinking of readers, and others, who have become invested in neuroscientific explanations for anorexia, who appreciate them as reasonable and compassionate alternatives to the myths and blames of the past. There are many advocates for brain-based models of anorexia: those who are making sense of their own experience and their families; people who have found them helpful; the parents

who find neurobiological explanations of anorexia profoundly relieving; people who feel freed from the burden of blame when we can say that anorexia is the consequence of a neurobiological peculiarity created by nature or genetics. Goodness knows parents (especially mothers) have taken enough unsubstantiated, unreasonable and unjustified castigation for somehow creating anorexia in their child. Embracing the one apparent avenue that seems to acknowledge their lack of culpability and relieve them and their loved ones of such stigma makes perfect sense to me. What I will argue, however, is that blame does not evaporate when we describe anorexia as a neurobiological condition, and that such understandings can bring with them significant unanticipated effects. Effects that can be avoided by alternative understandings and approaches.

Two schools of thought

Narrative therapy has a long and ongoing relationship with anorexia (Epston, Morris, & Maisel, 1995; Madigan & Epston, 1995; Maisel et al., 2004; White, 2011; White & Epston, 1990), and so, increasingly, does neuroscience (Braun & Chouinard, 1992; Hamsher, Halmi, & Benton, 1981; Kaye, 1996; Kaye, Wierenga, Bailer, Simmons, & Bischoff-Grethe, 2013; Kaye et al., 2015). Let's begin by establishing the very different ways these models understand and construct the experience of anorexia.

Pre-eminent eating disorder neuroscientist Walter Kaye (2008) wrote that anorexia nervosa is

characterized by aberrant patterns of feeding behavior and weight regulation, and deviant attitudes and perceptions toward body weight and shape ... an inexplicable fear of weight gain and unrelenting obsession with fatness, even in the face of increasing cachexia [and] clusters of other puzzling symptoms. (Kaye, 2008, pp. 121–122)

Asking how neuroscience might inform the development of treatments for anorexia (which they refer to as AN), Park, Godier and Cowdrey (2014) suggested that

altered eating in AN may be a consequence of aberrant reward processing combined with exaggerated cognitive control. ... It is suggested that in AN, weight loss behaviour begins as overtly rewarding, goal-directed and positively reinforced, but over time becomes habitual and increasingly negatively reinforced.

Excessive habit formation is suggested as one underlying mechanism perpetuating compulsive behaviour. [We] propose that future treatment innovation may benefit from the development of novel interventions targeting aberrant reward processing in AN. (Park et al., 2014, p. 47)

In other words, the problem of anorexia is perceived to be a consequence of individual biology, existing as an outcome of physiological brain activity and temperament 'traits' (Kaye, 2008, p. 121) as a neutral and natural inevitability of some people's being. Within this paradigm, initial eating restriction may have been appropriately directed, perhaps even a response to social injustices, but it is underlying faulty neural pathways that subvert our good intentions and render us victims of our 'deviant attitudes and perceptions' (Kaye, 2008, p. 121) and 'problem of aberrant reward' (Park et al., 2014, p. 48; see also Kaye et al., 2013). The experience of anorexia becomes defined in terms of behaviours and attitudes that are not rationally decided on and, over time, habitual action decreases opportunities for change. Anorexia is thus framed as meaningless suffering that is unlikely to be relieved other than by external intervention by those who know what is best for us.

Narrative therapy, by contrast, has spoken of anorexia as a 'disempowering cultural force' (Maisel et al., 2004, p. 10), and the outcome or effect of 'contexts of life that sponsor anorexia nervosa [and the] complicity of social institutions in this' (White, 2011, p. 89). Rather than emerging from neuro- or psycho-pathologies, narrative therapy has put forward that

Through careful therapeutic conversations, it becomes possible for people to describe and to speak about those sentiments of living that they value and to which they aspire. It is possible to honor these sentiments of living and to further develop them while, at the same time, enabling people to break free of the life-threatening and highly constraining aspects of anorexia nervosa. (White, 2011, p. 96)

Anorexia is thereby established as meaningful and, as intentional action that has been promoted by social and cultural contexts, there is ongoing scope for intentional change as new understandings and possibilities become imaginable – change that, importantly, aligns with the person's beliefs, values and hopes for life.

These are two very different positions, with significant implications for practice. My next steps will be to

argue that neuroscience's internalised and meaningless understandings of attitude and behaviour, at the expense of paying attention to context and intentional ways of being, are likely to be counter-productive to sustainable and meaningful change in reclaiming their lives from anorexia.

The eclipsing of power, culture and abuse

A difficulty that arises from brain-based models is how they can eclipse the very real effects that culture, power and abuse have on the lives of so many people who find themselves entangled with anorexia. Although not exclusively, anorexia often makes its first appearance in the lives of young women. I argue that any decision to neglect or minimise the conditions in which many young women live as they come to understand themselves and their options, and as they learn to navigate the world and the problems they encounter, is itself an act of power that not only renders invisible the contributing forces that conspire to create anorexia but, more importantly, closes off avenues that can lead to change.

Angel Yuen, writing more generally about her counselling work in schools, poses the pertinent question: 'What happens to young women?' (2019, p. 4). What indeed? I doubt it will take any reader very long to come up with a list of unwelcome things we know happen to many young women. In Angel Yuen's words:

Many have faced difficult and harmful experiences. A lot has happened to them in their young lives: not only one-time events but ongoing acts of injustice that have occurred in their homes and/or communities. Some have spoken of being raped, tormented daily by peers, trafficked, shoved and/or called 'bitch' and 'whore'. These are only a few examples of the countless humiliations, abuses, exploitations and put-downs that have been shared. By the time young women enter counselling, many are struggling with how to proceed with life. (Yuen, 2019, pp. 4–5)

I would add cognitive deference to this list: the art of yielding one's own thinking in favour of the ideas of others (usually men and boys) is routinely taught to girls from a young age (Nelson, 1996). These experiences do not end with youth. Women's stories of being the recipients of violence, abuse and everyday injustices as they navigate gendered expectations and oppressions

are so common that one might wonder what their relevance is to anorexia. After all, anorexia does not enter the lives of all women, and, as summed up by the name of one advocacy agency, 'Men get EDs [eating disorders] too'. However, narrative therapists do take seriously the imperative to investigate how such oppressive events and life conditions have the potential to impact a person's understanding of themselves and their place in the world. It is alarming that neuroscience should de-implicate so much that is material to a person's knowledge and experience of life in the genesis of problems, putting forward that our experiences of life are merely attendant to our biology, and focusing on what become defined as our problematic 'traits'.

A faulty pathway or an illuminating journey

In order to demonstrate how brain-based models of anorexia can become counterproductive, I will begin by posing two questions that illustrate how the ontological understandings, and some ethical commitments, associated with each of these approaches are incongruent and lead to entirely different ends, only one of which is favourable.

My questions are:

- (1) What commitments underlie a focus on establishing why people respond differently in similar contexts by asking what is going on in their brains?
- (2) What is the basis of a curiosity that asks what contexts are sponsoring/supporting problems, and what ideas and experiences enable people to take up particular responses to these problems?

To consider the first question, directed at approaches in which curiosity is centred on brain activity, let me share with you extracts from two neuroscientific articles on anorexia: 'Temperament and character in women with anorexia nervosa' (Klump et al., 2000) and 'Nothing tastes as good as skinny feels: The neurobiology of anorexia nervosa' (Kaye et al., 2013).

The determining characteristics that distinguish between those who remain restrictors and those who develop bingeing and purging are unclear. Temperament has been hypothesized to be one potential predictor. Clinical descriptions of

individuals with AN have characterized them as rigid, emotionally and behaviorally overcontrolled, and obsessive in nature. (Klump et al., 2000, p. 559)

Those with AN tend to have childhood temperament and personality traits, such as anxiety, obsessions, and perfectionism ... which often first occur in childhood before the onset of an ED and may create a vulnerability to develop an ED. In addition to pre-dating the disease, these traits often persist after recovery. The traits include anxiety, negative emotionality, perfectionism, inflexibility, HA [harm avoidance], and obsessive behaviors (particularly with order, exactness, and symmetry). This personality and behavioral profile may constitute an intermediate phenotype between genes and vulnerability to AN. (Kaye et al., 2013, pp. 110–11)

Given that these one-dimensional, fixed and limiting descriptions of personhood – these speculations posing as truths in the absence of specified genes or clearly delineated brain patterns - apply to me, as a person who has lived with anorexia, I feel justified in having some opinion. These descriptions pay no attention to what I give value to in life, what my intentions for action are, what I believe in, who and what I know and have known. In addition, as I consider what potential effects there may be of accepting these descriptions as truths, I notice that the language of predisposition establishes me, and others like me, as ticking time bombs. We are being invited to look inward and believe it is we who are faulty, and inherently so. This is powerful not only in its capacity to distract us from any injustices we face, but also by having us understand ourselves as inevitably precarious and problematic. I wonder what use this understanding of myself would be when tackling a difficult problem. I think I would find myself quickly overwhelmed by the challenge, believing myself ill-equipped. At best, I might become dependent on establishing whether my actions would likely meet the approvals of others, others who may be thus invited to view me and my decisions and actions in much the same way.

To consider the second question, directed at approaches in which curiosity is centred on contexts, ideas and experiences, Michael White's writings elucidate how some people may be drawn into particular problems:

Intentional state conceptions of identity are distinguished by the notion of 'personal agency'. This notion casts people as active mediators and

negotiators of life's meanings and predicaments, both individually and in collaboration with others. It also casts people as the originators of many of the preferred developments of their own lives: People are living out their lives according to intentions that they embrace in the pursuit of what they give value to in life; they are going about the business of actively shaping their existence in their effort to achieve sought-after goals. (White, 2007, p. 103)

Action thus becomes visible as an expression of a person's convictions about life, a conception that situates problems not in brain structure or function but within the contexts of people's lives and, as such, invites us to take an interest in a person's commitments; their knowledge and beliefs, their values and intentions.

In the light of this, I ponder the possibilities for what descriptions of selfhood may be made available according to the latter of these two approaches; descriptions such as those co-constructed through the re-authoring conversations of narrative therapy:

- unique and complex stories of identity and action that speak of what I know about myself and what it is possible to know
- stories that I hope people who know me might also offer, that stand in contrast to neuroscience's limited, homogenised, totalising and constraining accounts of my personhood
- stories that make visible my intentions, my beliefs, my hopes and that trace their histories in ways that enable me to decide what ideas are useful to me and what ideas may need adjustment or abandonment.

As I reflect on those possibilities, I can't help but notice how much more helpful the latter are to me: richly describing identity conclusions that are based on histories, heritages, commitments and knowledges to draw on as I consider my options for change.

In response to my original questions, I assert that curiosity about brain function in the context of anorexia is reductive, constraining and self-defeating, whereas curiosity about context and response is expansive, respectful and offers greater possibilities for emancipatory ways forward. Of course, this is not speculative as I am advantaged in knowing full well how each outcome has me viewing myself.

Pathologising anorexia: How histories of misogyny become replicated

Reductive and pejorative descriptions of people living with anorexia are nothing new, and it's worth briefly attending to how neuroscientific perspectives on anorexia, along with many preceding theories, are embedded in deeply misogynistic thinking that makes them unpalatable, and potentially very unhelpful.

A diagnosis of anorexia has long come with attendant accusations of multiple character transgressions (see Bruch, 1978) that have shaped our own and others' understanding of us. I am not alone in having been treated with suspicion and disdain by services. Like others, I have been accused of being manipulative, overly compliant, unreasonably competitive, recalcitrant, attention-seeking, deceitful, afraid of my sexuality, rule bound, subversive and unwilling to grow up, to name but a few. Media interest frequently represents anorexia as a disease of spoiled, vain teenage girls. Extreme dieting is juxtaposed with public imaginings of over-consumption. Like others, I have struggled to find myself in these descriptions that discount my experiences and understandings, yet I've found them difficult to disregard nonetheless. Nowadays, I might be more likely to be described as genetically predisposed to self-starvation or deluded thinking. Anosognosia (lack of insight into one's mentally ill state) is a new player in this field. This term appears to be replacing 'in denial' or 'resistant' as a means of describing (or discouraging) disagreement with one's clinician. These understandings of identity are not neutral; they have effects. With barely any theory of anorexia containing less than a character assassination and a vetoing of my reality, it would take a robust person to walk away unscathed.

Neurobiological conclusions that establish fixed personality 'traits' (Kaye et al., 2013; Klump et al., 2000) leave me stuck and/or constantly at odds with myself. Allegations of cognitive rigidity (Steinglass, Walsh, & Stern, 2006) and irrational or delusional thinking (Steinglass, Eisen, Attia, Mayer, & Walsh, 2007) do not easily support concepts of change or liberation, but instead render a cohort of (mostly) women as incapable of adequate thought and therefore dependant on the directions of others. These characterisations carry direct echoes of taunts and dismissals routinely received by many women from a young age: that we are 'frigid' when we don't appreciate someone's advances, 'uptight' if we dislike their offensive comments or jokes, 'highly strung' or 'hysterical' when angry or upset,

'neurotic' when worried or concerned (especially when it is inconvenient to a man).

Pathologising and misogynistic interpretations obscure alternative understandings. Might it be that a woman labelled 'perfectionist', whether by herself or others (Bastiani, Rao, Weltzin, & Kaye, 1995), simply sees possibilities for improvement and places a high value on her activities and principles, alongside sensing the potential for failure in a world that seeks to have her defer to men, and which treats her punitively for the slightest of arbitrary 'imperfections'? Framing perfectly intelligent responses to unjust circumstances as the negative effects of faulty brain wiring operates to silence women. Legitimising concepts such as 'aberrant reward systems' and accounts of abnormal 'character traits' diminish the daily contexts that promote many women's feelings of inadequacy and self-hatred, that complicate their relationship with ideas of accepting reward or seeking pleasure, and establish people living with anorexia (usually women) as inherently and biologically problematic. In so doing they continue a long legacy of misogyny.

Blame, blame go away!

Flowing on from histories of misogyny are long heritages of blame that many modern approaches to psychiatry and psychology actively seek to move beyond. The parent-blaming, and in particular mother-blaming, practices that were once highly prevalent in these fields are, quite rightly, being increasingly discredited though sadly their effects still linger. But neuroscientific explanations of anorexia do not simply eviscerate blame, nor are they benign. While it is wholly unacceptable to routinely treat families with suspicion, or claim that they have somehow produced anorexia, what is not always immediately apparent is how, in seeking to avoid unfair family criticism, there is an unanticipated shifting of blame to somewhere else it doesn't belong – a shift that continues to allow powerful invested forces to escape accountability.

An important part of neuroscience's appeal is that it appears to offer compassionate understandings that contradict notions of anorexia being personal choice:

Emphasizing the neurobiology of the disorders also reduces stigma ... and helps parents better understand how to support their children during treatment. 'Eating disorders seem very behavioral. Sometimes it even seems oppositional

when a child refuses to eat,' she says. 'Showing there are brain circuits that are not functioning effectively gives parents some pause, and helps them understand their child's illness.' (Weir, 2016, p. 39; quoting Nancy Zucker)

This thinking, however, represents a problematic oversimplification of the relationship between choice and action. To offer an either/or scenario – that behaviour is either at the mercy of a person's brain function, or else must be independently chosen and therefore blameworthy – is to ignore the highly complex interplay of individuals' intentions for living, the possibilities for action that they currently have available to them and the systems that constrain them. Which becomes victim-blaming by stealth. Sincere intentions to eliminate blame, reduce stigma and invite empathy can come with unintended 'side effects', and may not achieve their desired outcome. Biologically based understandings of mental health can actually serve to reinforce unhelpful attitudes, including reducing empathy in the very health professionals who are meant to be helping (Lebowitz & Ahn, 2014).

Perhaps even more alarming is how the scenario outlined by Weir, in which a parent is persuaded to envisage their child's brain circuits malfunctioning, is framed as a compassionate response yet results in the labelling of the child, and by implication every other person who has ever had a diagnosis of anorexia, as having some brain impairment without conclusive proof that this is in fact the case. These models are ideas, not facts. There are material and ongoing effects in a person's life from any diagnosis. Misdiagnosis of neurological impairment has immense potential for ongoing ramifications, yet it is common to see brain-based models promoted alongside advocacy for parents to push for their child to receive a diagnosis at first signs, as early intervention is increasingly thought of as the best way forward (Treasure & Russell, 2011). This leaves parents with a dilemma: do they seek support quickly to prevent the problem escalating, or hold off to avoid a diagnosis that may have implications for the rest of their child's life?

I have no doubt that public statements that anorexia is a brain-based illness are intended kindly, grounded in a belief that such understandings will discredit earlier myths about dysfunctional families, lifestyle choices or dieting gone wrong; a belief that neuroscientific models will reduce stigma and contribute to justice for 'sufferers and their families'. But such global claims, with neither proof nor qualification, lack caution. These claims can

have consequences for self-perception and perception by others; they have the potential to evoke fatalistic understandings and hamper efforts for change; they may affect access to health and life insurance policies, employment, study or immigration opportunities. As genetics become increasingly implicated in these debates (Anorexia Nervosa Genetics Initiative, 2016; Thornton et al., 2018), a person who has at some time in their life had a diagnosis of anorexia, or whose partner or close relative has, may come to doubt whether it would be responsible for them to have children of their own in case they too would carry a predisposition to anorexia.

Worrying 'progressions' of neuroscience

How we understand or conceptualise problems informs what we consider to be appropriate therapy. Recent progressions in neuroscientific approaches to 'treating' anorexia illuminate what profoundly disquieting conclusions these models can lead to.

Neuroscientific remedy requires that therapy in some way attend to what is happening in a person's brain. There are those who go so far as to advocate for the consideration of brain-invasive therapies such as deep brain stimulation (DBS) for long-term anorexia. This involves implanting electrodes into the brain to send electrical impulses to selected brain locations according to specific symptoms (Oudijn, Storosum, Nelis, & Denys, 2013). Of course, this recommendation is limited to those for whom the suffering is extreme: people who have lived with anorexia for more than 10 years, by which time hope for recovery is said to be limited (Herzog et al., 1999; Touyz & Hay, 2015; Wonderlich et al., 2012). I lived with anorexia for much longer than 10 years. During a particularly tough period it's conceivable that I would have become tempted by DBS had it been proposed. I am glad it never was.

Even without going so far as invasive treatment, the legitimisation of concepts of 'aberrant reward systems' as a cause of anorexia has led to the development of a 'novel' approach (Knatz, Wierenga, Murray, Hill, & Kaye, 2015) currently travelling the globe (UCSD, 2019): 'temperament-based treatment', developed by neuroscientists keen to support us in the management of our 'problematic temperament traits' by exploiting our so-called 'aberrant reward systems'. To quote Walter Kaye, one of the founders of this acclaimed temperament-based approach:

This insensitivity to reward and sensitivity to punishment, how can that be used in treatment? When you work with people with anorexia, rewarding them for gaining weight and maintaining weight doesn't work so well and that's what parents naturalistically do. Because most people respond to reward, and that's how you train dogs ... you reward a dog with food or praise. They learn that's great and they want to do it more. And if you punish them they tend to learn they want to do it less ... and it doesn't work that way with people with anorexia. They tend to be very sensitive to punishment. Now, it's not that we *want* [speaker's emphasis] to punish them, but we want to work with them together as part of the treatment team to make them aware of the consequences of not making their weight, losing weight, not eating ... and using that judiciously to help strategize to get them to maintain that weight. (UCSD, 2019)

These sentiments, which suggest that people can be trained out of anorexia like dogs through regimes of punishment, worry me greatly. As does:

Since little is known about punishment-based learning in AN, we examined whether AN is associated with altered learning from positive and negative outcomes. ... AN also performed better on punishment than reward-based trials ($p < 0.01$). ... Findings suggest both approach and avoidance motivation may influence learning in AN, with deficient reward learning rate and greater punishment learning over time. (Wierenga et al., 2018, p. 157)

Working 'with' a fear of negative consequence, which may have a lot more to do with past experiences of negative consequences than exaggerated imaginings or 'circuits gone awry' (Weir, 2016, p. 36), can only ever mean penalty: penalties meted out for suffering.

Those consequences aren't intended to punish patients, Wierenga says, but rather to help guide patients toward positive behavior. A patient who refuses to drink her nutritional supplement might be moved into a more controlled level of inpatient care, for instance.

'Sometimes [the negative consequences we use are] as basic as not being allowed to wear makeup or your favorite pair of jeans,' Wierenga says. 'Those are privileges that you have to earn back.' (Weir, 2016, p. 38)

The 'negative consequences' of anorexia include being in hospital when you are sick and missing out on friendships or opportunities due to anorexia's effects on life. They can be highlighted carefully and respectfully through skilful statement-of-position conversations (White, 2007). Removal of rights, freedoms and dignity for 'refusing' something that terrifies you is punishment – rights, freedoms and dignity being bartered in exchange for engaging in action that incites fear and self-disgust. Male experience of anorexia is frequently erased or particularly stigmatised (Botha, 2010), resulting in it being less of a consideration in the development of treatments. So, these practices are about inflicting punishment on (often young) women for failing to comply. And if that doesn't jog the reader's memory about my earlier paragraphs then let me make it plain: punishment for failing to comply with requirements about what a person (usually a woman) can or cannot do with their body is about patriarchy and control. Yet it is people living with anorexia who become portrayed as having an excessive need for control! This approach recruits the person's closest and most loved ones to exert this control. I am not alone in having spoken with women who have great difficulty forgiving the people they love, who could have been of immense support to them, for imposing similar regimes – regimes they simply overturned as soon as they could. I have also spoken with families who have been coerced into imposing such regimes, with multiple detrimental effects. In the case of an adult living with anorexia, the person made responsible for this exertion of control may well be their partner or spouse:

An example of an age-appropriate modified approach is to involve the patient and CA [carer] in a collaborative process to devise a behavioural contract. This serves as a motivation system that outlines the following: (i) specific guidelines for recovery and associated target behaviours (e.g. number of meals required and meal times); (ii) contingencies for target behaviours (e.g. negative consequence for food restriction and positive consequence for completing meal); and (iii) assignment of CA to a specific role in recovery by outlining how they can support and enforce target behaviours. (Kaye et al., 2015, p. 15)

Clinicians reshaping intimate partnerships into relationships of control is neither desirable nor safe. What recognition is there of gendered power relationships, of intensifying stress and the possibility for disastrous outcomes?

Feminism and narrative practice

I won't dwell here for much longer, just long enough to add that there is nothing new or novel about this approach. It is old news being rehashed as neuroscience. Practices of penalty for noncompliance were happening back in the 1980s and 1990s when I was unfortunate enough to be participating in the psychiatric system. That particular iteration was spoken of as a behavioural approach, in which 'privileges' could be 'earned' through compliant eating and weight gain. At least in those days it was a 'reward and punishment' system. The novelty factor of the current proposition is perhaps that there is no longer a need to bother with pointless incentives when your 'patient' will only respond to fear of punishment. I wonder what this might mean for other domains of life – education, employment, relationships – if I am to be understood as someone whose brain does not easily support rational thought unless supplemented by fear of punishment, that the only way I am likely to 'see reason' is to establish consequences for any alternative thought or action.

An approach touted as undermining blame has become co-opted to disempower and control, claiming that the person's best interests are at the heart of the requirement for compliance. As a person who has lived with anorexia, I can attest to this sounding very familiar. It raises a number of questions: Where exactly is the compassion we were promised by neuroscientific approaches? What happened to the benevolence and understanding? What space is there for kindness? I, and others I have spoken with in my research, recall how acts of kindness in difficult times can be incredibly meaningful. For me, they created moments of hope that anorexia may not actually be necessary for my survival, that I might be able to let it go or escape it, and I have heard others echo this sentiment. But, sadly, kindness has also been spoken of by many of my counselling clients and research participants as all too often lacking in psychiatric systems. We need less replication of patriarchal regimes in our therapies, and compliance is not a good solution to the problem of anorexia (Gremillion, 2003). We cannot support a 'cruel to be kind' mentality that obscures and risks so much.

In conversations about anorexia it can be profoundly unhelpful to contest the usefulness of an approach without offering a hopeful alternative, so I will now turn to our attention to feminism and narrative therapy.

Earlier in this paper, I described how narrative therapy – informed by feminism – provides an alternative way of conceptualising anorexia as a 'disempowering cultural force' (Maisel et al., 2004, p. 10), and the outcome or effect of 'contexts of life that sponsor anorexia nervosa [and the] complicity of social institutions in this' (White, 2011, p. 89), rather than trafficking in pathologies, or locating the problem in our brains. Something I have in common with a number of women I have spoken with in counselling and research conversations is that explorations of culture and feminism have been crucial to the reclamations of life that they identified as recovery.

Let me explain.

As cultural and contextual influences on experience, decisions, beliefs and sense of self become exposed, confusion and self-blame tend to disperse. As injustices and their impacts move into view, personal experiences can be linked to those of others allowing realisation that this isn't about me after all. It's about all of us. A narrative lens that enables the naming of significant (perhaps hitherto unrecognised) steps already taken according to treasured commitments, and the identification of acts of response and resistance as being connected to values, beliefs and heritages supports arrival at very different understandings of identity. Understandings that can illuminate new possibilities for living. Discoveries that pave the way for anorexia (which I controversially consider was never my adversary but the most logical response I had available to me, and a very useful and practical solution for my dilemmas for living) to become less needed. Without battle, contest or self-renunciation.

A feminist narrative lens also, very importantly, offers a return to dignity. If women are able to repudiate ideas of themselves as 'the problem', or 'a problem', this invites a relaxing of the intense self-surveillance that characterises the imperatives of womanhood and of anorexia.

In the next section, I share stories from my narrative counselling practice to demonstrate how re-authoring lives in accordance with treasured values, linking people around concerns, recognising action as a reflection of values and commitments, and illuminating injustices has led to the realisation of new possibilities in relation to anorexia.

Escaping individualised understandings of anorexia through collective considerations

I have written elsewhere about narrative practices that directly invite collective consideration of individual concerns about eating (Lainson, 2016). I introduced Natalia and Ruby, two young women who taught me a good deal about the lives of many young women today. Natalia and Ruby were, at different times, referred to me by others in their life who expressed concern about their wellbeing, remarking that they had not responded sufficiently to prior therapies and interventions. Neither was convinced that talking to me was necessary or even likely to be helpful. Both articulated a belief in the importance of looking a particular way as part of self-expression, of achieving highly in order to meet their aims for life and of being special or unique. All of which they spoke of as personal high standards, set by themselves for themselves. During our conversations, in which I enquired whether these values and beliefs might be shared by some of their peers, it became visible that many of their realities were almost certainly shared by many others, and they named ways in which these ideas were supported by their cultural, social and educational contexts, and by what Ruby identified as a bombardment of images and constant conversations about appearance. Both acknowledged that some of this felt unreasonable at times, but, if anything, they were more critical of it than many of their peers. As we talked, each spoke of other ideals they were committed to, ideals of caring and inclusion, of being socially aware and engaged. They were able to identify actions they took in line with these ideals, such as wearing selected outfits to 'annoy the fashion police' (Lainson, 2016, p. 7) and choosing to 'clap for everyone else who tried too' (2016, p. 10) in resistance to competition at school award ceremonies. By storying these alternative ways of being, Natalia and Ruby came to new understandings of themselves as capable of challenging the status quo and of contributing to preferred future realities for themselves and others, including making reclamations in their lives in relation to so-called 'anorexia', 'perfectionism', 'bad body image,' and 'severe depression'.

Celia Kitzinger and Rachel Perkins (1993) warned against 'allowing psychological [and I would now add neuroscientific] thinking to obscure the causes of our problems, and the full range of different solutions to them' (1993, p. 10). This is significant. Narrative practice exposes what psychology, and now neuroscience, has obscured. We *all* live steeped in discourse and

representations that infuse our daily lives, letting us know what is and isn't acceptable to know, feel, believe and want for our lives; who it is and isn't acceptable to be. This includes boys, men, trans people and nonbinary folk, some of whom also experience anorexia. There are roles we are required to perform, prescriptions for our lives and our personhood – almost invisible but no less insistent pressures and chidings that work to keep us in line until they are made visible and more available for scrutiny. Some feminist writers have found calling on these concepts a bit offensive or insulting in relation to anorexia, as if suggesting that women who have succumbed to anorexia are weak minded or overly compliant (Saukko, 2008). I have a good deal of sympathy with this sentiment because all too often media images and beauty ideals are the first (and likely the only) topic for discussion in relation to anorexia, and it would indeed be insulting if that were extent of analysis. However, we do well not to underestimate the force, tenacity and ubiquitous nature of discourse, and the operations of power, privilege and self-surveillance that support it. Alongside evidencing the creation of change, Ruby and Natalia's stories demonstrate how living with the ongoing influences of culture, discourse, power and privilege shapes our personal beliefs and values well beyond appearance. Understanding the ways in which normative ideas are so intricately woven into our lives requires more than critical media literacy, and even a decision to become politically active about these matters is not a simple matter. As we become increasingly cognisant of these pressures and insistences, our attempts to escape can co-opt us back in so that sometimes it feels like being caught up in a bramble patch!

Let me introduce you to Laura and share a story about how she and I became caught up in a metaphoric bramble patch.

Becoming tied up in knots

Laura was in her 30s, and a busy mum to a growing family. She had been diagnosed with anorexia in her teens and had undergone forced treatment that in-part restored her weight, but inadequate counselling conversations had (bizarrely, she felt) largely focused on her parents' relationship, which never resolved the problem. Laura gained a number of skills over time, which enabled her to discharge herself from medical services and continue to juggle anorexia and a hectic family life. However, she was increasingly finding that 'food rules' and regular dizzy spells were preventing her

from doing things she wanted and needed to do. She worried that her restricted diet was having an impact on her health as she got older, and about herself as a role model for her children. We didn't actually talk much about food or eating, and it was through deconstruction of everyday events in Laura's life that she/we began to recognise a pattern of Laura monitoring and adjusting herself continually to fit and meet expectations of her. She started to notice and name the discourses that kept her in check: discourses of being a good mother, daughter, wife; discourses that combined and conflicted in such a way that meeting all of their requirements was frequently impossible. Yet these discourses and expectations were almost impossible to rebut or, at times, to even recognise.

One day, Laura described her frustration at herself for not being able to 'get around' to making a nourishing meal for herself each day, despite being a 'full-time, at-home mum'. Together we counted up the number of activities she completed in an average day and were both astounded! I won't list them here but suffice to say she was rarely at home, and the title of 'full-time mum' obscured the considerable time she spent doing unpaid administrative work for a family business and volunteering in the community on top of the multiplicity of activities involved in bringing up a family on a small farm. Even acknowledging these things, it was difficult for both of us to escape being drawn back into ideas of her needing to 'stand up for herself more', 'be less of a perfectionist and let some things go' or 'make some me-time'. The more obvious avenues we had available to us to escape her sense of frustration or failure simply took us right back into concepts of self-correction. One day, after a long, winding conversation that had us right back at 'needing to engage in more self-care' we stopped, stared at one another, and burst out laughing. Recognising the sheer banality of how easily we had become tied up in knots by ever-increasing and conflicting expectations saved us that day from the potential for despair.

What Laura told me was helpful about our conversations was that they helped her see what she was up against, and this made her more able to escape self-blame as she found new ways to navigate her circumstances as they became increasingly visible to her. Laura was an intelligent, capable woman. She had not been 'easily duped' or 'taken in' but was simply trying to live conscientiously according to a set of expectations, or code of conduct, she had not chosen, but the imperatives of which impinged on her life and her considerations until they barely gave her space to breathe.

This leads to my next assertion, that anorexia is not a mysterious illness with puzzling symptoms when you take the time to listen to context and meaning. Anorexia actually makes complete and utter sense under particular circumstances, which is what makes it so accessible and so appealing. The expectations Laura had been attempting to meet were neither imaginary, nor self-imposed, nor evidence of her 'weak-mindedness' or 'perfectionism', nor were they designed or imposed by overbearing family members. But recognising their role was key in understanding and in Laura untangling herself from her predicaments. I stress here that this was not a 'master-key' to unlock some universal mystery that is anorexia. As Paula Saukko (2008) points out, feminist understandings of anorexia have often homogenised experience just as biomedical (and now neuroscientific) models have, with equally unhelpful effects. I do not propose single-storied accounts of anorexia any more than I propose single-storied accounts of people's lives.

I will elaborate.

Anorexia as a means of living

The people I have spoken with in both counselling and research give diverse accounts of why they find anorexia welcome in their life: it numbs overwhelmingly difficult emotions; it provides a sense of order or control in their life; it is an identity they relate to or a companion that understands them; it brings with it a feeling of achievement, power, safety or purpose; it is a means of punishing themselves for failings or making up for inadequacy, exacting control over themselves and their body, being smaller and taking less space; it creates a feeling of being more or less feminine, and more. Others have assured me that there is nothing good about having anorexia in their life, and it is merely felt as an obligation, an oppressive force or something they somehow cannot shake off.

This complexity and diversity of experience can be better understood when we appreciate how one really doesn't have to go far to stumble across the multiple invitations and imperatives to self-regulation and self-surveillance that come from our cultural, political, religious and other contexts and belief systems, with which eating and exercise can easily become entangled (Brumberg, 2000; Crawford, 2006; Musolino, Warin, Wade, & Gilchrist, 2015; Rich & Evans, 2008).

We do know that bodies, within dominant Western culture at least, are under constant scrutiny, particularly

for women. So are eating practices. Both are domains women can operate in with social approval, (mostly) without treading on other people's toes. It is little wonder they may become a focus for regimes of self-improvement that never quite seem complete. Or means to live according to beliefs, values or commitments that reverberate through other realms of life, such as the careful use of time, or financial and other resources (Robinson, Kukucska, Guidetti, & Leavey, 2015). This is not just about media images and limited beauty ideals. If opportunities to live by cherished values do not seem available elsewhere, or strongly held commitments are readily extended into eating practices, if prescriptions for living are oppressive or hopes and expectations out of reach, if life experiences have proved to you that you are not safe or taught you that you are not worthy, if you have mastered the art of cognitive deference, anorexia in all its complexity can simultaneously offer multiple escapes from failure, opportunities for expression and resistances to unfavourable circumstances. Anorexia can become a means for living that provides immense relief despite, or because of, the agony it creates. Anorexia, if one were to personify it, does seem to 'understand' strong commitments; it offers possibilities for satisfying action within complicated, conflicting and unjust systems; it can provide a buffer from much that is painful and otherwise inescapable in life. Matters which may become increasingly compelling in instances where a person feels their experiences are misunderstood or refuted (as expressed by many of my counselling clients and research participants), and where their commitments and beliefs are devalued as much as they feel avowed to them. The practices and imperatives that become named anorexia (or not) may be experienced as profoundly relieving, or overwhelmingly oppressive, but they can offer hope of meeting the requirements of conflicting values and expectations while escaping much of what is undesired: albeit compromised, it can be a means of living that is otherwise elusive (see also Conti, 2016, 2018; Lavis, 2018).

Honouring complexity: Therapeutic approaches that attend to the politics of experience

If anorexia is not mysterious or puzzling but rather complex and multi-storied, then what is called for are therapeutic approaches that can attend to the politics of experience, and that can invite new understandings of

identity and possibilities in ways that are respectful of people and honouring of their lives and what is important to them.

What is also required is an escape from imposing linear metaphors of illness and recovery in relation to anorexia (Conti et al., 2016). Dominant models have long relied on externally derived criteria for wellness, related to weight restoration and absence of 'symptoms' (Bamford et al., 2015), resulting in an expectation that those living with anorexia perceive it as an illness to be 'got over' or to renounce as a sort of assailant on their life, or captor of their mind. But as both Janet Conti (2016, 2018) and Anna Lavis (2018) have shown, and I have argued above, for many people anorexia is a means by which to live rather than a problem to be vanquished, or even relinquished, without consideration of how life will continue without it. Several of the participants in my own research have spoken of anorexia being gradually supplanted in their lives by exposure to alternative ideas and philosophies. New priorities slowly took up increasing space in their lives as they understood themselves and their life circumstances differently. Conti (2016) and Dawson, Rhodes and Touyz (2014) showed similar findings. Participants in my research have spoken of recovery not as a state to be achieved, an absence of illness to be arrived at, or even a pre-anorexia identity to return to, but a process of transformational change with no definitive end point.

Responding to Touyz and Hay (2015) in their call for a 'new paradigm' in anorexia research and practice, Conti et al. (2016) have argued compellingly that it is crucial that our future practice and research escapes these linear metaphors, and instead engages with those used by the people with whom we speak, as they seek to create change that is meaningful to them:

Whether or not we are aware as a profession, we are powerful in selecting the stories and metaphors that become encoded in research and enacted in therapy sessions. The metaphors that we draw upon in our work are not merely descriptive, but also shape our understandings, the ways our clients engage with their life, and the processes of their identity formation. (Conti et al., 2016, p. 6)

Conti et al. drew extensively on narrative therapy writings in establishing their case. The practices and commitments of narrative therapy do not traffic in totalised understandings of people or problems, and Michael White (2011) urged against the imposition of metaphors, particularly those which incite self-

surveillance and contest. Through careful listening and attention to the expressions used by the people with whom we are speaking, the practices of narrative therapy support a context where it becomes

more possible for them to make decisions about what steps they might take to reclaim their lives, or to undermine the influence of anorexia nervosa or to protest its requirements, or however the task might be defined by these alternative metaphors. (White, 2011, p. 91)

From practice to research

As this article nears its close, I wish to describe how narrative therapy can make considerable contributions to shaping respectful and useful research.

In my current doctoral research, I have aimed for a narrative therapy lens to guide my decision-making at every step, in order to achieve research that sets itself apart from that which traffics in the reductive representations that I have found so hurtful in the past and presents conclusions which I firmly believe have impeded me and others from reclaiming our lives sooner. I by no means claim perfection in my methodological approach and am always ready to engage with critique, but I did set out with a clear intent to develop my research model around maintaining the dignity of participants, recognising their agency, and to understanding that they live life according to their commitments, just as I would my counselling clients. By drawing from narrative concepts and practices I have sought to:

- centre the voices of people with first-hand experience of living with anorexia
- create space for recognition of the ways in which people living with anorexia draw upon their own skills, knowledge and commitments to respond to their circumstances as 'counter-stories' to familiar representations of victimhood
- utilise research methods that illuminate both congruence and diversity, thereby escaping homogenisation of experience
- invite contributions from people who may have previously been excluded from research on anorexia
- recognise that knowledge derived from first-hand experience can make valuable contributions

to the lives of others and guide improved understandings and professional approaches.

I am not the first to appreciate the value of using narrative therapy questions in research on anorexia. Janet Conti (2016; Conti et al., 2016) has illustrated poignantly their value in her research interviews, which created space for participants to speak of anorexia on their own terms, assisting them in changing their relationship to it even in the process of research, which she largely differentiates from therapy. If we are to offer dignity, illuminate alternative stories of identity, resist de-contextualised understandings of problems and allow space to speak of the 'contexts of life that sponsor anorexia nervosa [and the] complicity of social institutions in this' (White, 2011, p. 89), then our research models need to align. Rather than research that focusses on investigating our brains, intimately privatising our pain, and obscuring contributing contexts and individualising suffering (Kitzinger & Perkins, 1993), our focus should be on remediating suffering by supporting people in recognising the unjust circumstances that contribute to their experience and privileging their stories of response so that we can collaboratively find the means by which to navigate, cope with and, preferably, change those circumstances, without inferring that they are somehow complicit or flawed.

Concluding comments

We need to do better in the realms of working with people's experiences of anorexia. We also need to do better when determining what we consider justifiable and ethical research, and in deciding what will become our mainstream therapies, by asking ourselves what these therapies attend to. I have argued that just and generative ways forward in relation to anorexia do not lie in exploring what happens in brains, but rather in co-researching 'the contexts of life that sponsor anorexia nervosa' (White, 2011, p. 89) and in working collaboratively with people to trace 'the social and relational history of what they give value to' (2011, p. 90) in order to support their reclamation of life in ways that are meaningful and sustaining. We also need to protect what is precious and unique in our therapeutic models and take exceptional care if we consider combining them with ontologically incongruent models, lest we lose sight of their essence and unwittingly replicate injustices by inviting yet further self-surveillance and disbelief or distrust in one's own thinking or experience. Narrative therapy is feminist-informed practice that

believes in people's capacity for local knowledge. This matters a great deal because, as Celia Kitzinger and Rachel Perkins (1993) have argued, 'therapy must also stand on some intrinsic good' (1993, p. 8). What I have always appreciated about narrative therapy is how it has embedded within it a commitment to standing on some intrinsic good, through its appreciation for context, its respectful stance that recognises how power and privilege operate, and its attention to social (in)justice.

It is no wonder that neurobiological understandings offer considerable appeal as a contrast to so much of what has been available in the past, and I am truly glad for any relief offered to individuals and their families and loved ones who have lived with the havoc anorexia can create. But until we address issues of power, privilege and patriarchy, deconstruct what is happening around us and to us, and recognise how we live our lives through these ideas – in both research and therapy – problems like anorexia will continue to dominate the lives of people who are trying to live conscientiously in a world that is set up to have them fail.

Stephen Touyz and Philippa Hay (2015) called for a 'new paradigm' in anorexia research and practice. I agree. We need to stop asking what is wrong with people (and/or their brains) and instead ask what happens to them, what their experience of life is and by what means they are responding in order to hold on to that which they treasure.

References

- Anorexia Nervosa Genetics Initiative. (2016). *The Anorexia Nervosa Genetics Initiative (ANGI)*. Retrieved from www.angi.nz/the-anorexia-nervosa-genetics-initiative-angi/
- Bamford, B., Barras, C., Sly, R., Stiles-Shields, C., Touyz, S., Grange, D., ... Lacey, H. (2015). Eating disorder symptoms and quality of life: Where should clinicians place their focus in severe and enduring anorexia nervosa? *International Journal of Eating Disorders*, 48(1), 133–138.
- Bastiani, A. M., Rao, R., Weltzin, T., & Kaye, W. H. (1995). Perfectionism in anorexia nervosa. *International Journal of Eating Disorders*, 17(2), 147–152.
- Beaudoin, M., & Duvall, J. (2017) Introduction: Merging soft and hard sciences. In M. Beaudoin & J. Duvall (Eds.), *Collaborative therapy and interpersonal neurobiology: Emerging practices* (pp.1–12). New York, NY: Routledge.
- Beaudoin, M., & Zimmerman, J. (2011). Narrative therapy and interpersonal neurobiology: Revisiting classic practices, developing new emphases. *Journal of Systemic Therapies*, 30, 1–13.
- Botha, D. (2010). Anorexia nervosa – the female phenomenon: Repositioning the males. *Counselling, Psychotherapy and Health*, 6(1), 1–20.
- Braun, C. M. J., & Chouinard, M. J. (1992). Is anorexia nervosa a neuropsychological disease? *Neuropsychology Review*, 3(2), 171–212.
- Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa*. New York, NY: Basic Books.
- Brumberg, J. J. (2000). *Fasting girls: The history of anorexia nervosa*. New York, NY: Vintage.
- Conti, J. (2013). *"It's part of what makes me": Women's constructions of their experiences of recovery from anorexia nervosa over 10 years* (Doctoral thesis). Macquarie University, Sydney, Australia.
- Conti, J. (2016). "I don't think anorexia is the way out": Reconstruction of meaning in women's narratives of anorexia nervosa over 10 years. *Journal of Constructivist Psychology*, 29(2), 165–183.
- Conti, J. (2018). Recovering identity from anorexia nervosa: Women's constructions of their experiences of recovery from anorexia nervosa over 10 years. *Journal of Constructivist Psychology*, 31(1), 72–94.
- Conti, J., Rhodes, P., & Adams, H. (2016). Listening in the dark: Why we need stories of people living with severe and enduring anorexia nervosa. *Journal of eating disorders*, 4(1), 33.

Acknowledgments

I hadn't intended to write this article, which began as a coffee shop conversation with Cheryl White and David Denborough when I was frustrated with neuroscientific claims about anorexia. Taking up Cheryl's suggestion that I write about my concerns, the paper started out small, and with David and Cheryl's combined encouragement it grew to incorporate multiple realms I found meaningful. I may never have had the courage to write so boldly without the backing of Cheryl's feminist lens and David's thoughtful questions and astute suggestions. I am immensely grateful to others who have read drafts and offered valuable feedback that stretched my thinking, and encouraged me to proceed: Claire Nettle, Kelsi Semeschuk, Angel Yuen, Jon Jureidini, Helen Gremillion, Ali Borden, Janet Conti and Aileen Cheshire have all been influential. I also acknowledge with thanks the Australian Government Research Training Grant that funded the PhD research referred to. Nor could I have written this article without the knowledge imparted by the people who have generously shared parts of their stories and journeys with me. I hope I have done them some justice.

- Craggs, T., & Reed, A. (2007). A service-user and therapist reflect on context, difference, and dialogue in a therapy for anorexia. *International Journal of Narrative Therapy and Community Work*, (3), 30.
- Crawford, R. (2006). Health as a meaningful social practice. *Health*, 10(4), 401–420.
- Dawson, L., Rhodes, P., & Touyz, S. (2014). “Doing the impossible”: The process of recovery from chronic anorexia nervosa. *Qualitative Health Research*, 24(4), 494–505.
- Epston, D., Morris, F., & Maisel, R. (1995). A narrative approach to so-called anorexia/bulimia. *Journal of Feminist Family Therapy*, 7(1–2), 69–96.
- Gremillion, H. (2003). *Feeding anorexia: Gender and power at a treatment center*. Durham, NC: Duke University Press.
- Grieves, L. (1997). From beginning to start: The Vancouver anti-anorexia/anti-bulimia league. *GECKO: Journal of Deconstruction and Narrative Therapy*, 1(2), 78–88.
- Hamsher, K. d. S., Halmi, K. A., & Benton, A. L. (1981). Prediction of outcome in anorexia nervosa from neuropsychological status. *Psychiatry Research*, 4(1), 79–88.
- Hepworth, J. (1999). *The social construction of anorexia nervosa*. London, England: Sage.
- Herzog, D. B., Dorer, D. J., Keel, P. K., Selwyn, S. E., Ekeblad, E. R., Flores, A. T., ... Keller, M. B. (1999). Recovery and relapse in anorexia and bulimia nervosa: A 7.5-year follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(7), 829–837.
- Kaye, W. H. (1996). Neuropeptide abnormalities in anorexia nervosa. *Psychiatry Research*, 62(1), 65–74.
- Kaye, W. H. (2008). Neurobiology of anorexia and bulimia nervosa. *Physiology and Behavior*, 94, 121–135.
- Kaye, W. H., Wierenga, C. E., Bailer, U. F., Simmons, A. N., & Bischoff-Grethe, A. (2013). Nothing tastes as good as skinny feels: the neurobiology of anorexia nervosa. *Trends in Neurosciences*, 36(2), 110–120.
- Kaye, W. H., Wierenga, C. E., Knatz, S., Liang, J., Boutelle, K., Hill, L., & Eisler, I. (2015). Temperament-based treatment for anorexia nervosa. *European Eating Disorders Review*, 23(1), 12–18.
- Kitzinger, C., & Perkins, R. (1993). *Changing our minds: Lesbian feminism and psychology*. New York: New York University Press.
- Klump, K. L., Bulik, C. M., Pollice, C., Halmi, K. A., Fichter, M. M., Berrettini, W. H., ... Woodside, D. B. (2000). Temperament and character in women with anorexia nervosa. *The Journal of nervous and mental disease*, 188(9), 559–567.
- Knatz, S., Wierenga, C. E., Murray, S. B., Hill, L., & Kaye, W. H. (2015). Neurobiologically informed treatment for adults with anorexia nervosa: A novel approach to a chronic disorder. *Dialogues in Clinical Neuroscience*, 17(2), 229.
- Kronbichler, R. (2004). Narrative therapy with boys struggling with anorexia. *International Journal of Narrative Therapy and Community Work*, (4), 55–70.
- Lainson, K. J. (2016). From “disorder” to political action: Conversations that invite collective considerations to individual experiences of women who express concerns about eating and their bodies. *International Journal of Narrative Therapy and Community Work*, (2), 1–16.
- Lavis, A. (2018). Not eating or tasting other ways to live: A qualitative analysis of ‘living through’ and desiring to maintain anorexia. *Transcultural Psychiatry*, 55(4), 454–474.
- Lebowitz, M. S., & Ahn, W.-k. (2014). Effects of biological explanations for mental disorders on clinicians’ empathy. *Proceedings of the National Academy of Sciences*, 111(50), 17786–17790.
- Madigan, S., & Epston, D. (1995). From “spy-chiatric gaze” to communities of concern: From professional monologue to dialogue. In S. Friedman (Ed.), *The reflecting team in action: Collaborative practice in family therapy* (pp. 257–276). New York, NY: Guilford.
- Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York, NY: Norton.
- Musolino, C., Warin, M., Wade, T., & Gilchrist, P. (2015). “Healthy anorexia”: The complexity of care in disordered eating. *Social Science and Medicine*, 139, 18–25.
- Nelson, H. L. (1996). Sophie doesn’t: Families and counterstories of self-trust. *Hypatia*, 11(1), 91–104.
- Oudijn, M. S., Storosum, J. G., Nelis, E., & Denys, D. (2013). Is deep brain stimulation a treatment option for anorexia nervosa? *BMC psychiatry*, 13(1), 277.
- Park, R. J., Godier, L. R., & Cowdrey, F. A. (2014). Hungry for reward: How can neuroscience inform the development of treatment for anorexia nervosa? *Behaviour research and therapy*, 62, 47–59.
- Rich, E., & Evans, J. (2008). Learning to be healthy, dying to be thin: The representation of weight via body perfection codes in schools. In S. Riley, M. Burns, H. Frith, S. Wiggins, & P. Markula, (Eds.), *Critical bodies: Representations, identities and practices of weight and body management* (pp. 60–76). Basingstoke, England: Palgrave MacMillan.
- Robinson, P., Kukucska, R., Guidetti, G., & Leavey, G. (2015). Severe and enduring anorexia nervosa (SEED-AN): A qualitative study of patients with 20+ years of anorexia nervosa. *European Eating Disorders Review*, 23(4), 318–326.
- Rose, N., & Abi-Rached, J. M. (2013). *Neuro: The new brain sciences and the management of the mind*. Princeton, NJ: Princeton University Press.
- Saukko, P. (2008). “I Feel ridiculous about having had it” – Critical readings of lived and mediated stories on eating disorders. In S. Riley, M. Burns, H. Frith, S. Wiggins, & P. Markula, (Eds.), *Critical bodies: Representations, identities and practices of weight and body management* (pp. 43–59). Basingstoke, England: Palgrave Macmillan.
- Steinglass, J. E., Eisen, J. L., Attia, E., Mayer, L., & Walsh, B. T. (2007). Is anorexia nervosa a delusional disorder? An assessment of eating beliefs in anorexia nervosa. *Journal of Psychiatric Practice*, 13(2), 65–71.
- Steinglass, J. E., Walsh, B. T., & Stern, Y. (2006). Set shifting deficit in anorexia nervosa. *Journal of the International Neuropsychological Society*, 12(3), 431–435.
- Strober, M. (2004). Managing the chronic, treatment-resistant patient with anorexia nervosa. *International Journal of Eating Disorders*, 36(3), 245–255.
- Thornton, L. M., Munn-Chernoff, M. A., Baker, J. H., Juréus, A., Parker, R., Henders, A. K., ... Yilmaz, Z. (2018). The anorexia nervosa genetics initiative (ANGI): Overview and methods. *Contemporary Clinical Trials*, 74, 61–69.
- Touyz, S., & Hay, P. (2015). Severe and enduring anorexia nervosa (SE-AN): In search of a new paradigm. *Journal of eating disorders*, 3(1), 26.

- Touyz, S., Le Grange, D., Lacey, H., Hay, P., Smith, R., Maguire, S., ... Crosby, R. D. (2013). Treating severe and enduring anorexia nervosa: A randomized controlled trial. *Psychological Medicine*, 43(12), 2501–2511.
- Treasure, J., & Russell, G. (2011). The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. *British Journal of Psychiatry*, 199(1), 5–7.
- UCSD (Producer). (2019, March 29). *Interview with Dr Walter Kaye* [Video file] Retrieved from www.vimeo.com/309544857/29f4f99a24
- Weber, M., Davis, K., & McPhie, L. (2006). Narrative therapy, eating disorders and groups: Enhancing outcomes in rural NSW. *Australian Social Work*, 59(4), 391–405.
- Weir, K. (2016). New insights on eating disorders. *APA Members Topics Publications*, 47(4), 36–40.
- White, M. (2007). *Maps of narrative practice*. New York, NY: Norton.
- White, M. (2011). *Narrative practice: Continuing the conversations*. New York, NY: Norton.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.
- Wierenga, C., Bischoff-Grethe, A., Romero, E., Peterson, D., Brown, T., & Kaye, W. H. (2018). Altered reinforcement learning from reward and punishment in women with anorexia nervosa [Poster abstract]. *Biological Psychiatry*, 83(9), s157.
- Wonderlich, S., Mitchell, J. E., Crosby, R. D., Myers, T. C., Kadlec, K., LaHaise, K., ... Dinkel, J. (2012). Minimizing and treating chronicity in the eating disorders: A clinical overview. *International Journal of Eating Disorders*, 45(4), 467–475.
- Yuen, A. (2019). *Pathways beyond despair: Re-authoring lives of young people through narrative therapy*. Adelaide, Australia: Dulwich Centre Publications.
- Zimmerman, J. (2018). *Neuro-narrative therapy: New possibilities for emotion-filled conversations*. New York, NY: Norton.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Intensifying the preferred self:

*Neurobiology, mindfulness and embodiment practices
that make a difference*

by Marie-Nathalie Beaudoin



Marie-Nathalie Beaudoin directs a narrative therapy, neurobiology and mindfulness training centre in San Jose, California, and offers therapeutic services to children, adults and families. She enjoys exploring new ways of enhancing therapeutic conversations, by combining her previous studies in human biology with narrative therapy. She has published several articles, books and DVDs. With a background in improvisational theatre, Marie-Nathalie is known internationally for her entertaining and thought-provoking presentations. In her free time, she enjoys hiking, dancing and paddle boarding with her husband and two teenagers.

*Marie-Nathalie Beaudoin can be reached at:
773 E. El Camino Real, #143, Sunnyvale, CA, 94086, USA,
phone: +1408-738-3343, email: mnbeaudoin@gmail.com,
website: www.mnbeaudoin.com*

Abstract

Neurobiology and mindfulness offer fascinating ideas for therapeutic conversations informed by narrative therapy. This article introduces two re-authoring practices that intensify the preferred self and enhance clients' abilities to live according to their values in spite of traumatic experiences. The application of these ideas is described with the story of a young mother who, for over a year, fought for the survival of her newborn baby crippled by a life-threatening disease and who, when the infant recovered, fell into the grips of a debilitating depression ('Critical Voice'). This depressive state lasted two years before narrative therapy was initiated. Given the neuroplasticity of our brains, how can we increase the likelihood that re-authoring conversations will be intense enough to neutralise the influence of fight or flight brain states, and gripping depressive neural networks, which have been strengthened for years? This article describes two neurobiology inspired ways to help our clients intensify the preferred self typically explored in narrative therapy: embodiment and positive affect development. Enriching narrative work with these practices increases the likelihood that we will succeed in a timely and enduring manner, in assisting people who have been suffering from long lasting, intense, viscerally embodied emotional problems and traumas.

Key words: *neurobiology; embodiment; positive psychology; trauma; emotions; narrative therapy; critical voices; depression; motherhood*

Kristin's story

The agonising journey had all started when Kristin, still exhausted from giving birth, was told by the attending doctor that her newborn baby had a brain tumour. She and her husband were in shock, astounded and horrified by the news. With little time to spare and grieve, they were mobilised to fight for their daughter's life. For a year, Kristin battled the disease, watching her baby undergo brain surgeries, driving her to chemotherapy, juggling work and nurturing, being up 18 hours a day. She was living full-time in 'fight mode', an intense state of limbic system activation. After one year, the good news was announced: her baby was recovering, against all odds, and was going to live!! There was a period of delight, elation and, in-describable joy ... and then the crash. Doctors at first called it a burn out, then depression. Kristin's dedication to her child, which had allowed her to be a supermom during the crisis, was turned against her by a cruel Critical Voice: 'What kind of mother doesn't have the energy to play with her precious baby?'; 'What kind of mother rests instead of interacting with her babbling daughter?' Over time, Kristin started feeling profoundly worthless, and like a complete failure, as a parent. The constant nagging Critical Voice commented on everything she 'should' be doing if she were a 'good mother', and made her feel disgusted with herself. She was aware the Critical Voice was like a relentless dictator that expected inhuman standards, but she couldn't silence it. She could only escape the torture and anguish by distracting herself and numbing her mind with YouTube videos and movies. The inner nagging was cruel, especially when Kristin allowed her baby to look at the videos too. 'Your daughter would be better off without you', progressively became the daily rhetoric in her mind. The only solution, according to the Critical Voice, was to remove herself as much as possible from her precious child's life, and let her husband be the primary caregiver. As painful as it was to stay away from her child and only see her for short moments (for example, on the drives to childcare or briefly before bed), she listened to the voice. But removing herself didn't attenuate the inner torture she was subjected to. It was a lose-lose situation: if she spent time with her child, she was constantly and ferociously criticised for every small thing she did and said; if she stayed away from her daughter, she was tormented by her lack of participation in her daughter's life and how much she burdened her husband. This situation was daunting for her husband who, although loving and supportive, struggled to sustain a full-time job and do all the care giving when he came home in the evening. After trialling various therapies, exercise

groups, community activities, parenting classes, and several antidepressant drugs, her husband finally found something for her that had not been tried before: Narrative therapy.

When Kristin first called, she wanted to know why one could 'try so hard to *not* be a certain way, and still be stuck in it'. She knew all too well that her state was 'unproductive and even irrational', but she just couldn't escape it. Her experience of herself was dominated by intense affective states such as despair, anguish, self-loathing and self-disgust, which felt completely out of her control. She felt she was 'only an insignificant drop in an ocean of people on Earth', and her only value as a human being was having a job that supported her family financially. That is what kept her going. Most of the time, when she was not at the office, she was in bed, resting. She allowed herself only very short moments with her daughter.

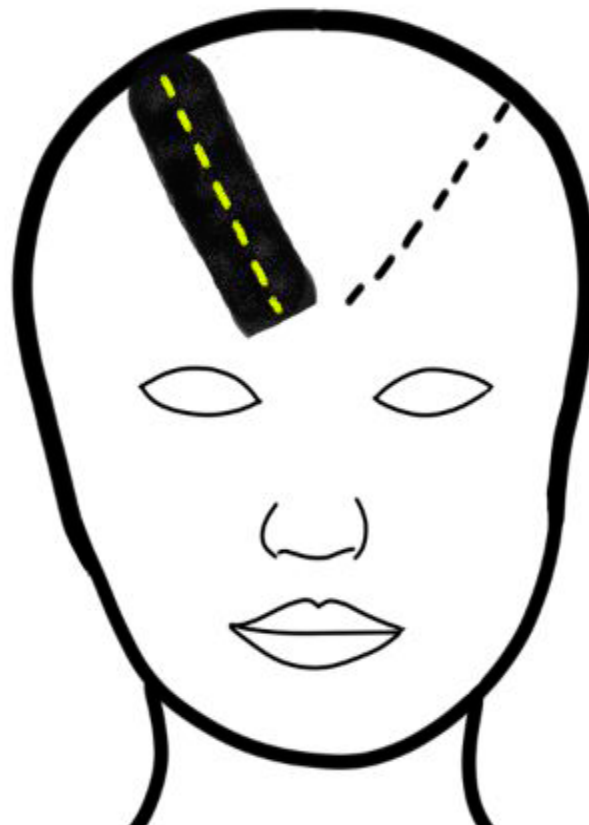
Narrative conversations quickly helped Kristin externalise the 'Critical Voice' and understand it as a harsh mental and emotional habit. She became clear that the Critical Voice was a distorting dark lens that was sapping much of her energy and robbing her daughter of a mother. She could see that the more it criticised her, the more anguished she became, and the less energy she had for her daughter (now a toddler). In fact, the Critical Voice turned her fierce dedication to her child against her, and while removing herself from parenting may have been an act of dedication, it accommodated the distortions of the Critical Voice rather than her daughter's needs. Talking back to the Critical Voice was impossible, as its associated affective intensity was overwhelming. Much of this intensity came from a combination of:

- repetitive and frequent neural activation of problematic affect making it more readily available as a default state
- powerful patriarchal discourses, which had circled her upbringing as a young woman and left her with an intense wish to be the 'perfect mother'.

Since Kristin perceived herself as having succeeded in meeting these mothering standards during her baby's recovery, the subsequent downfall was experienced as a loss of this 'successful selfless' identity. Deconstruction work helped Kristin realise that the 'selfless mother' standards, and most of the 'shoulds', originated from narrow cultural specifications that were unrealistic in the long run, had numerous negative effects in day-to-day life, and did not ultimately come from her own best judgment.

Critical Voice

- Criticizes everything
- Anguish, despair
- Self-judging, self-loathing
- “Shoulds”
- Unrealistic standards
- Disgusted by own action
- Surveils everything negatively
- Relentless
- Dictator-like
- Focus on duty, doing
- Robbing of life
- Harsh
- Self-absorbed
- Draining
- Unhappy
- Disconnected
- Isolated
- Unable to give
- Forced to remove self from parenting role
- Deprives daughter of a loving mother



Dedication

- Capable
- Self-forgiving
- Determined to care
- “It’s okay”
- Let it go
- Appreciation
- Observes positively
- Moments of peace
- Loving, Resilient
- Focus on meaning, being
- Present to life
- Absorbed by daughter, husband
- Energizing
- Hopeful
- Happy
- Connected
- Motherly
- Able to give
- Able to contribute in valuable ways

Figure 1. Opposing brain programs (computer graphics by Emilie B.R.)

Externalisation and deconstruction were enhanced in our first session by summarising her words in an illustration of two opposing ‘brain programs’ (Figure 1). This really resonated with Kristin, given her background as an engineer. The problem and preferred stories described in this figure were discussed as ‘programs’, ‘neural highways’, ‘brain states’, or ‘mental/emotional habits’, and this language provided alternative metaphors that were evocative for Kristin. She was also informed that if there can be neuroplasticity in one direction (the dysregulation of the limbic system associated with an intense and lengthy exposure to a life-and-death situation), her brain could also be neuroplastic in the other direction (reclaiming her life, and living her intentions, values and preferences more readily). She asked to take a photo of this figure with her iPhone, as this representation was a turning point in her understanding of herself. She finally comprehended why she had been stuck, despite numerous attempts at ‘not being this way’. While this type of drawing (Beaudoin, 2012) may not be as helpful in other communities, its language and metaphor have been evocative for the majority of people our agency serves, whose lives are immersed in the computer industry,

and surrounded by daily news featuring brain research. This language resonates with people as it makes visible their sense of ‘Me’ separate from the clutter of the problem, and reflects the felt ‘structure of their inner life’ (White, 2011, p. 134). At the onset of therapy, the problem neural network typically feels like a fast emotional highway with frequent powerful activation, and the preferred self network appears to be fainter; it is activated infrequently and is less connected with emotions, memories and actions. Discussing clients’ experiences as habits, neural pathways, brain states or programs provides opportunities to represent problems and preferred stories as separate from identities – these networks are discussed as the embodied effects of life experiences and enculturation, and can consequently be altered.

As Kristin’s awareness of the Critical Voice increased, she realised that ‘balancing self-care and child care’ was a more viable lifestyle, and that such balance might look different at different moments in time. After these first few sessions, Kristin attempted to reduce the volume of the nagging thoughts, and chose to ‘not go there’. Through regular re-authoring conversations,

she became increasingly able to avoid episodes of Critical Voice-induced anguish. She started having small moments of presence with her daughter. We discussed how she was a better parent when she did things out of care for her child, rather than in response to the Critical Voice's obligations. Progressively, Kristin attempted to insert herself more in her daughter's life. These attempts were sometimes successful, and sometimes not. She struggled with the fact that her child refused to be fed by her. The Critical Voice, always surveilling her every action, often made her feel clumsy and impatient with her daughter's refusal at meals, in spite of her better judgment. We agreed to put that activity on the backburner and to focus on first re-developing her relationship with her child. One day, it occurred to Kristin that buying complex new games provided a structured context where the novelty of teaching and playing kept her mind busy enough to keep the Critical Voice at bay. Within a few weeks, she found a 'Determination' to live again, and a desire to be with her child more often. She even started re-engaging with life by seeing friends she had been ignoring for a long time. Past experiences of 'Determination' and 'Dedication' were brought to the forefront of experience. The histories of Determination and Dedication were connected over time through multiple events. These events included supporting her brother when they were growing up, having a child in spite of her back problems, overcoming sickness during her pregnancy, and the determination and dedication she used to help her baby recover. This preferred story reminded Kristin of meaningful values of caring for others and contributing to a family, and how her parents had instilled these values in her. When Kristin blocked the Critical Voice, she could hear her own desire to spend time with her daughter, and notice that her daughter did enjoy her company.

Our therapeutic work became increasingly focused on scaffolding conversations that thickened Kristin's experience of her preferred story. This important concept has been extensively discussed by Michael White and David Epston, since the early years of narrative therapy (Epston & White, 1992; White, 1989, 1994, 1995, 2004, 2007, 2011) and further developed by many others (Denborough, 2014; Freedman & Combs, 1996; Friedman, 1995).

Kristin's husband was invited to attend as an audience to her preferred self, and to share unique outcomes he had witnessed. He recounted his surprise that the previous weekend, Kristin had chosen to go on a bike ride with him and their daughter, something they hadn't done together in years! Kristin had always been serious,

he said, but the depression had stolen much of their ability to talk lightly about events and be together as a family. He was pleased to see her smile again, and that some of the heaviness was fading away.

After several meetings highlighting unique outcomes and their meanings, and connecting to values and preferences, Kristin reclaimed more of her life and general ability to be with her daughter, who was increasingly accepting her mother's care. But could therapy really end and assume the preferred self would be intense enough to hold in a lasting way? Could several weeks of meaningful conversations overpower the affective trace that the debilitating anguish and Critical Voice had left in Kristin's neuroplastic brain? Was this renewed connection to experiences of Determination and Dedication *intense enough* to sustain Kristin through the usual parenting challenges to come, especially considering her devotion to her child?

From a physiological standpoint, a moderate future parenting mistake, as most mothers encounter in their journey, might re-activate the powerful neural network for anguish, depression, and the Critical Voice, which were strengthened for months. Intense emotions are among the most powerful encoders in the brain, ensuring lasting active memories of certain experiences (Damasio, 2000; Siegel, 2010). If the neural networks for 'despair' and 'anguish' were re-triggered, and competed with Kristin's preferred states of Determination and Dedication, the biological pull could be the strongest with the old intense problem networks.

Narrative therapy usually addresses this concern by thickening preferred stories of identity with documents (Epston & White, 1992), websites (Dickerson, 1998), reflecting teams (Friedman, 1995), outsider witness groups (White, 1995), re-memorial work (White, 2007), sports team metaphors (Denborough, 2014), and letters (Newman, 2008; White & Epston, 1990). Are there other ways to thicken preferred-self experiences, and in particular, ways to *intensify* their affective manifestations so that they are more likely to become a match for problems embedded in acute visceral reactions? In other words, how can we increase the neural likelihood that preferred experiences will be viscerally intense enough to override reactivated experiences of problems? This consideration becomes significant when working with issues of trauma.

Embodiment

Emotional and affective experiences exist in the body, and manifest themselves as biochemical and physiological reactions (Ekman, 2005). Every single emotion has a biological connection. Can you imagine being in love, or experiencing anger, without any manifestation in the body? Embodied sensations are a major component of our experiences of ourselves, and our lives. The body is the medium through which we experience everything. Therefore, engaging in therapeutic conversations without examining the links between experience and the body ignores a great deal of information: it would be like working with a black-and-white photo of experience, rather than its coloured version (Beaudoin, 2005, 2018). This becomes particularly important when re-authoring. Clients are typically articulate in their descriptions of embodied problem experiences, but are rarely able to provide as much detail about their preferred selves. Kristin, for example, could describe at length the heaviness in her limbs, the burning, sinking heart and the shallow breathing she experienced with anguish. When asked to describe her embodied experience in a preferred state she was, at first, completely blank. The following conversation was scaffolded to access this unnoticed aspect of her experience.

Marie-Nathalie: Can you give me an example of a moment when you might have felt Dedication this week?

Kristin: Yes, I've been in an 'on' mode this week! Ever since I realised that *I matter*, even if I'm not perfect, that I'm relevant to my daughter's life and can contribute to my family, I've had a lot of energy.

Marie-Nathalie: How does that energy affect you?

Kristin: I've been doing more around the house – I've even cleaned the fridge! And I've been playing more with my daughter.

Marie-Nathalie: Playing more with your daughter?

Kristin: Yes, I took her to the park and actually played instead of hiding behind my phone. I had the energy to do it and it felt good. I was really dedicated to being with her in that way.

Marie-Nathalie: So feeling like you matter and can contribute, gives you some energy, which allows you to go to the park and play more

with your daughter. When did you feel most connected to the experience of Dedication and Determination?

Kristin: Hum ... the whole time!

Marie-Nathalie: The whole time! If there was a moment when that was particularly intense inside of you or in your body, when might that have been?

Kristin: Maybe when I saw my daughter going down the slide and giggling. I loved catching her at the bottom. I felt so much love and dedication towards her.

Marie-Nathalie: What was it like to feel that Love and Dedication inside you when you were watching her and catching her at the bottom of the slide?

Kristin: It felt really good to be that way!

Marie-Nathalie: So it felt really good to be that way! If I had been sitting on a bench and watching you, what would I have noticed about you this week that would be different than how you might have looked a few weeks ago?

Kristin: Just that I was happier ...

Marie-Nathalie: Would your body have looked slightly different?

Kristin: Well, I would definitely be smiling more, laughing ... hum ... being more present to my daughter, fully dedicated to my time with her, determined to not waste a minute of this time.

Marie-Nathalie: So smiling more, laughing, being present, dedicated and determined to not waste a minute of this time. How would you describe how it felt to have a dedicated and determined human body when you were at the park?

Kristin: [thinking] I don't know ... It was really just like having more energy, like I said earlier.

Marie-Nathalie: It was like having more energy. Where in your body might this energy be coming from?

Kristin: Hum, let me think ... from my chest!

Marie-Nathalie: From your chest? Tell me more.

Kristin: Yes, it felt like a ... how can I describe this ... a rush of life in my chest.

Marie-Nathalie: A rush of life in your chest. Would your chest be like a headquarters for Dedication?

Kristin: Yeah, I like that! It's like a headquarters. It's vibrating with activity in there.

Marie-Nathalie: So Dedication's headquarters is in your chest and is vibrating with activity, giving you energy. Is this energy or activity radiating somewhere?

Kristin: Hum ... maybe it's radiating towards my arms and my throat.

Marie-Nathalie: Radiating towards your arms and throat. Which metaphor or image would illustrate that sensation?

Kristin: It's kind of like a ... hum ... maybe like a fire ... a fire that's spreading ... and tingling ... a gentle but powerful fire.

Marie-Nathalie: A gentle, tingling, powerful fire. How might you walk differently when that fire is activated?

Kristin: I'm not sure.

Marie-Nathalie: If you close your eyes and see yourself in the park, playing with your daughter in a dedicated way, how are you moving around and walking?

Kristin: I think I stand taller. There might be more strength or confidence to my step. Maybe I'm moving faster too.

Marie-Nathalie: So taller, faster, more strength, more confidence. Might you breathe a little differently?

Kristin: I do! That I had actually noticed. I seem to breathe more evenly and fully now, as if there's more space inside of me, now that the Critical Voice is not suffocating me.

Marie-Nathalie: So you breathe more evenly and fully without the Critical Voice suffocating you. How might you talk differently while playing with your daughter with Dedication as opposed to the Critical Voice?

Kristin: Well, I talk a lot more. I'm more playful, and I guess – I guess, I might make more eye contact with her! I just realised that! I actually look at her because I feel less ashamed and embarrassed by the Critical Voice.

Marie-Nathalie: What might she see in your face and eyes?

Kristin: Oh! I know she sees the love and dedication! She probably sees a more peaceful and joyful face.

Marie-Nathalie: So when you are connected to Dedication and Determination, you have an increased level of energy and playfulness. You smile and laugh more often. You feel taller, stronger, more confident. Your face is more peaceful, joyful. Your eyes express love, and you breathe fully and evenly. Dedication and Determination seem to have a headquarters in your chest, from which energy and vibrations radiate to your arms and throat like a gentle, tingly and powerful fire. Are you feeling these experiences right now?

Kristin: Yeah! Just talking about them seems to have brought them back!

Marie-Nathalie: Yes, if you remember how your body feels, it will make it easier to enter the experience of Dedication and Determination.

This conversation allowed Kristin to increase her embodied awareness of her preferred self. Articulating this crucial dimension added a wealth of detail, depth, complexity and fullness to Kristin's account, which significantly substantiated her preferred self. Many of the above questions were inspired by mindfulness meditation (Kabat-Zinn, 2003), which offers a powerful medium to increase clients' awareness of their embodied sensations, and opens the door to richer possibilities of description. The use of mindfulness practices to heighten awareness of embodiment is supported by research in neurobiology (Siegel, 2010) and writings in narrative therapy (Percy, 2008). Helping clients notice the physiological aspects of their preferred selves increases their likelihood of being able to enter those states at will, and affords them another way to activate those experiences (Beaudoin & Duvall, 2017; Beaudoin & Zimmerman, 2011; Zimmerman & Beaudoin, 2015). In other words, experience contains sensory features, which are felt as internal but are ascribed meaning externally through discursive and relational processes.

It is this meaning that then shapes the performance of certain dominant scripts and problem stories. Helping clients sort through their sensations, and inviting them to ponder upon 'how they feel inside', scaffolds the observation process using culturally available language. Furthermore, combining the brain's left hemisphere activity of languaging experience with the right hemisphere activity of feeling (left-to-right process), and helping clients make meaning of embodied sensations (top-down process) leads to a better integration of the story. This process then allows therapeutic conversations to include broader aspects of experiences in the deconstruction, meaning-making and re-authoring process.

Mobilising positive affect

Another way to increase the affective intensity of preferred experiences is to connect the preferred state to a 'positive emotion' (Beaudoin, 2015). Research shows that positive affect is associated with: a broader repertoire of considered actions, enhanced perspective, increased motivation, higher likelihood of finding meaning, and a greater ability to control unwanted embodied impulses. I have cringed at labelling and totalising an emotion as positive or negative as all aspects of experiences can be valuable in some contexts, and it's their effects that are helpful or non-helpful. I am now resigned however to using this terminology given the extensive research on the very distinct patterns of activation different affective states trigger in the brain (Fredrickson & Losada, 2005; LeDoux, 1996).

In therapeutic conversations, connecting to positive emotions and affective states involves asking clients to expand their preferred selves into unexamined territories. For example, I asked Kristen, 'If Determination and Dedication to care for your daughter were to be connected to a particularly intense positive emotion, which one might it be?' Kristen spontaneously answered 'Love' and 'Joy', and then she added 'Delight' and 'Elation'. Enriching re-authoring with positive emotions offers several advantages, which are only briefly summarised here (see Beaudoin, 2015; Beaudoin & Duvall 2017). First, positive emotion development opens the door to a whole new collection of memories, people and stories that may not have been included in the earlier re-authoring conversations (thickening effect). Second, it provides one or many other affective, preferred counter-states to the problem experience, which alone or in combination

can become more intense, physiologically, than the first readily described (affectively intensifying effect). Third, a positive emotion may provide a different entry into the experience of the preferred self than the one previously described (accessing effect).

For example, people who seek assistance with anxiety may develop a preferred self around being calm; others who consult because of anger issues may develop preferred selves around tolerance, patience or compassion; those who seek help with shyness may leave feeling more confident, connected to their values, and able to live in ways congruent with their intentions. Although this is not always the case, in all of these examples, people articulate preferred states that are in congruence with their values but in opposition to the presenting problems. This first level of re-authoring provides an important opportunity to neutralise the problem and reconnect with important values. Connecting with positive emotions and experiences can offer, with some clients, a second level of re-authoring that not only increases the intensity of the preferred self, as mentioned earlier, but also facilitates the client's ability to *thrive* with enhanced levels of wellbeing. It allows the client to move beyond their initial preferred self into a space of expansion, flourishing and blossoming.

After these positive emotions were named, we explored the history of Kristin's experiences of love, joy, delight and elation: how much she loved her brother, and how as a child she had enjoyed facilitating fun and playful magic shows for younger children at her elementary school. As a young adult, she had been delighted to organise surprise birthday parties for her husband whom she loved dearly. She shared the elation of successfully catching him off guard when he was in another state on a business trip and she secretly flew there! Our re-authoring work embarked on a whole new line of memories and events that had not come up before and could be connected to the earlier preferred story of Determination and Dedication. Through combining these different affective experiences of herself, if Kristin felt threatened by the Critical Voice, she could connect with her Determination and Dedication, and also her inner experiences of Love, Joy, Delight and Elation (brain states). She could position her body in accordance with previously articulated embodied observations of these states, and increase the intensity of her preferred selves more easily and at will. The Critical Voice and anguish became outmatched in physiological intensity. For Kristin, remembering to feel and express love in her eyes, and to re-activate the elation she felt when discovering her baby would live, gave much more power

to her preferred self. She started more consistently feeling like a mother who was not only dedicated but also loving, joyful and 'good enough'. Considering the love now readily expressed on most days, we concluded that for her daughter, she was not 'just a drop' but rather 'an ocean' on this Earth.

Once Kristin had elaborated and intensified her connection with an affective preferred self, and embodied her ability to deeply embrace Dedication, Love, Elation, Delight and Joy, I felt more confident in the option of ending our therapeutic journey. We re-created our drawing from the first session (Figure 1), this time with a strong program for her preferred selves, and a weaker dotted line for the Critical Voice. Once again, Kristin asked to take a photo, but this time with joy in her eyes. Although we cannot fully armour our clients in the face of life's ups and downs, we can at the very least provide the richest ways possible to equip their preferred selves with intense and powerful ammunition such as embodied experiences and positive emotions.

Conclusion

This article describes two neurobiology-inspired ways to help our clients intensify the preferred self typically explored in narrative therapy: embodiment and positive affect development. These practices add to established

ways of thickening the preferred self, such as documents (White & Epston, 1990), internet journals (Dickerson, 1998), reflecting teams (Friedman, 1995), outsider witness groups (White, 2007), and re-membering metaphors (Denborough, 2014).

Drawing ideas from other fields can enrich our work with new territories of inquiry and provide a broader therapeutic repertoire (Epston, 2016). Tapping into different traditions also provides additional linguistic concepts that may better fit with particular clients, such as Kristin, for whom the 'brain program' metaphor was resonant. Talking about a neuroplastic brain with various programs, and mindfully exploring sensations, adds an embodied dimension to our work and further enhances the externalising process, which is hope-promoting to many people. Narrative therapy has historically moved away from modernist disciplines and held different theoretical premises that honour a multiplicity of perspectives, identities and possibilities. Recent developments in neurobiology, neuroplasticity and mindfulness, which recognise that the brain is physiologically modified by experiences of relationships and contexts, open the door to a certain amount of collaboration between the two fields (Walker, 2016). Although much in these modernist fields remain based in expert knowledge, and is disconnected from personal experiences, an openness to a select few findings can allow us to better help people who entrust us with their stories of anguish and dedication.

References

- Beaudoin, M.-N. (2005). Agency and choice in the face of trauma: A narrative therapy map. *Journal of Systemic Therapies, 24*(4), 32–50.
- Beaudoin, M.-N. (2012). *The SKiLL-ionaire in every child: Boosting children's socio-emotional skills using the latest in brain research*. California, SF: Goshawk.
- Beaudoin, M.-N. (2015). Flourishing with positive emotions: Increasing clients' repertoire of problem counter-state. *Journal of Systemic Therapies, 34*(3), 1–13.
- Beaudoin, M.-N. (2018, June). Enriching narrative therapy with neurosciences: Spotlight on possibilities. Paper presented at Institut für Systemische Therapie, Vienna, Austria.
- Beaudoin, M.-N., & Duvall, J. (Eds.). (2017). *Collaborative therapy and neurobiology: Evolving practices in action*. New York, NY: Routledge.
- Beaudoin, M.-N., & Zimmerman, J. (2011). Narrative therapy and interpersonal neurobiology: Revisiting classic practices, developing new emphases. *Journal of Systemic Therapies, 30*(1), 1–13.
- Damasio, A. (2000). *The feeling of what happens: Body and emotions in the making of consciousness*. New York, NY: Mariner.
- Denborough, D. (2014). *Retelling the stories of our lives*. New York, NY: Norton.
- Dickerson, V. (1998). Silencing critical voices: An interview with Marie-Nathalie Beaudoin. *Gecko: A journal of deconstruction and narrative ideas in therapeutic practice, 2*, 29–45.
- Ekman, P. (2005). *Emotions revealed*. New York, NY: Holt.
- Epston, D. (2016). Re-imagining narrative therapy: A history for the future. *Journal of Systemic Therapies, 35*(1), 79–87.
- Epston, D., & White, M. (1992). Consulting your consultants: The documentation of alternative knowledges. In D. Epston & M. White (Eds.), *Experience, contradiction, narrative and imagination* (pp. 11–26). Adelaide, Australia: Dulwich Centre Publications.
- Fredrickson, B. L., & Losada, M. L. (2005). Positive affect and the complex dynamics of human flourishing. *American Psychologist, 60*, 678–686.
- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York, NY: Norton.
- Friedman, S. (1995). *The reflecting team in action: Collaborative practice in family therapy*. New York, NY: Guilford.

- Kabat-Zinn, J. (2003). *Coming to our senses: Healing ourselves and the world through mindfulness*. New York, NY: Norton.
- LeDoux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York, NY: Simon and Schuster.
- Newman, D. (2008). 'Rescuing the said from the saying of it': Living documentation in narrative therapy. *International Journal of Narrative Therapy and Community Work*, (3), 24–34.
- Percy, I. (2008). Awareness and authoring: The idea of self in mindfulness and narrative therapy. *European Journal of Psychotherapy and Counseling*, 10(4), 355–367.
- Siegel, D. (2010). *The mindful therapist: A clinical guide to mindfulness and neural integration*. New York, NY: Norton.
- Walker, M. (2016). *The social construction of mental illness and its implications for neuroplasticity*. Lanham, MD: Lexington.
- White, M. (1989). *Selected papers*. Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1994, March). *Therapeutic conversations as collaborative inquiry*. Workshop presented to Bay Area Family Therapy and Training Associates, San Francisco, CA.
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2004). Memory systems and the consequences of trauma. *International Journal of Narrative Therapy and Community Work*, (1), 67–76.
- White, M. (2007). *Maps of narrative practice*. New York, NY: Norton.
- White, M. (2011). *Narrative practice: Continuing the conversations*. New York, NY: Norton.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.
- Zimmerman, J., & Beaudoin, M.-N. (2015). Neurobiology for your narrative: How brain science can influence narrative work. *Journal of Systemic Therapies*, 34(2), 56–71.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

*All enquiries should be made to the copyright owner at:
Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000
Email: dcp@dulwichcentre.com.au*

Thank you! We really appreciate it.

You can find out more about us at:
www.dulwichcentre.com

You can find a range of on-line resources at:
www.narrativetherapyonline.com

You can find more of our publications at:
www.narrativetherapylibrary.com



Michael White's particularist ethics in a biological age*

by Philippa Byers



Philippa Byers has a PhD in philosophy and is currently working at the Plunkett Centre for Ethics (Australian Catholic University and St Vincent's Health, Australia) on a moral and applied philosophy project that addresses the vulnerabilities of people living with dementia. She has recently completed a social work qualification. Philippa can be contacted by email at: Philippa.Byers@acu.edu.au

Abstract

This paper offers a reading of Michael White's ethics of narrative therapy as a form of ethical particularism that seeks particularity rather than generalities or rules of thought, speech, behaviour or action. The paper draws on insights from British novelist and philosopher Iris Murdoch, and others, to characterise an approach to practice which does not privilege theory (which reaches in the direction of generality) but is a restrained form of moral attention and receptivity to discovery in the words, phrases, stories and story fragments that are offered in therapeutic conversations. The paper suggests that a hallmark of the ethics of practice that Michael White offered in his writing is that personal and philosophical questions and interpretations are left open for discovery. For this reason, the paper suggests caution about introducing terms and concepts from brain and neurological sciences, and the implicit philosophical assumptions that come with that introduction, into narrative therapy and practice.

Key words: *narrative therapy; neuroscience; ethics; moral philosophy; Michael White; Iris Murdoch*

* The term 'biological age' is a reference to the work of Nicolas Rose and Joelle Abi-Rashed (2012) and Nicolas Rose (2013), which will be discussed later in the paper.

Introduction

I didn't meet Michael White and am not a practising therapist, counsellor or community worker, but I have recently become a reader of White's written work. I was initially prompted by the intuition that reading about narrative therapy would help me reflect on differences between social work and other practices within the Australian mental health and human services sectors. But as I continued reading his work, I also discovered a distinctive philosophical voice.

Narrative therapy practitioners and other readers of Michael White will be familiar with his engagement with ideas from philosophy and elsewhere; for example, ideas about power and self-regulation from Michel Foucault, Jerome Bruner's work on the narrative constructions of meaning, and so on.¹ But speaking personally, when I read Michael White, I read an ethics which is sometimes referred to within moral philosophy as particularism or as an anti-theory approach to ethics, though I note that Michael White did not use these terms himself.² For me, what is distinctive in Michael White's written work is the 'quiet authority' of a particularist philosophical voice that is grounded in an orientation to practice, rather than to theory.³ As I read his work, I don't believe I'm reading a theorist, but rather a living account of what he himself said and did, and also refrained from, within his therapeutic practice, given a moral responsibility he suggested cannot be sidestepped once the 'real effects' of meaning-making within therapeutic conversations are taken seriously (1995, pp. 14–15). These effects are the constitutive results of meaning-making that occur in and shape the lives of individual people and their ways of living.

The first half of this paper describes Michael White's particularist ethics, and the second half reflects on the use of neuroscience findings within therapeutic settings. This reflection is prompted by recently articulated views that narrative therapy can be augmented, or better understood, or given stand-alone evidence of therapeutic efficacy, with the help of neuroscientific investigations of the natural processes and systems that underlie, or cause (in some sense of this word), or correlate with thoughts, feelings and emotions.⁴ I will propose that the use and appeal to neuroscience findings within narrative therapy is at odds with Michael White's particularist ethics of practice.

I begin by briefly describing ethical particularism, and link this to Michael White's emphasis on practice and skills more so than knowledge or theory despite his thirst for ideas. I draw on several ideas from British

novelist and philosopher Iris Murdoch to describe a 'receptivity to discovery' in Michael White's inclination to focus on the local and particular in lives, and to refrain from using language that is removed from the ordinary languages of conversation.⁵ I offer observations about the use and relevance of neuroscience findings in therapeutic and other contexts. And I conclude with a proposal for a cautious distrust of what one is *for* if one is *for* introducing neuroscience findings within or as part of narrative therapy, or as explanation for narrative therapy's therapeutic efficacy.

A particularist orientation

Ethical particularism is a 'broad church' that includes aspects of the moral philosophies of Simone Weil, Iris Murdoch, Knud Løgstrup and Australians Raimond Gaita and Christopher Cordner. It includes themes in Martin Buber's work on 'I–thou' relatedness and in Emmanuel Levinas's work on the unlimited ethical demand encountered (quite literally) in the face of another person as other than 'me'.⁶ A key implication of ethical particularism is that encounters of one person with another are regarded as incommensurable with one another.⁷ Or, to put this another way, each encounter is distinct and particular, as are the parties to it. From a particularist perspective, ethics takes place in our lives with one another, not in sub-personal motivational structures, nor in reasoned abstractions that are applied to life as rules for action. For this reason, there is an affinity between ethical particularism and literature, which is an affinity that is pertinent to Michael White's focus on the local and particular in lives, rather than the interior psychic structure and/or biological functioning of individual people.

One of the arts of fiction writing is to render individual characters or fictional persons – and the lives they lead and worlds they inhabit – as real to us.⁸ Fictional persons become real to us in the particularity that emerges as we read the stories of their lives. And the worlds that fictional persons inhabit become real to us, as inhabited worlds that we enter into in some sense through this encounter (via storytelling) with the particularity of fictional persons and their lives. We read for all kinds of reasons, but one of them is to find reality in our encounters with fictional persons, their ways of living and with fictional worlds; a reality that then speaks to us of human truth. One of the things that literature can *do*, so to speak, is to show the particularity of individuals and of ways of living that typically elude philosophical and other forms of analysis that seek to draw generalisable conclusions.

Ethical particularism has an 'in built' scepticism about routes to human truth that involve detours or departures from the 'stuff' of living encounters with embodied persons. Hence the affinity with literature, as literature takes us towards what is particular, rather than away from it in the direction of generalities, even though the persons, lives and worlds we are drawn to in literature are imaginary ones. I think Michael White had a similar scepticism about routes to human truth via generalisable conclusions, hence his orientation to the local and particular in lives and in ways of living as disclosed in narrative. He was not drawn to philosophical or scientific generalisations, nor to generalisations about therapeutic efficacy, nor to generalisations about what is 'good for' the people who sought his assistance.

At the risk of sounding glib, what Michael White bought to therapy was an art for developing practice pathways oriented towards the discovery and expression of particularity.⁹ In the course of developing these practice pathways he became a superb writer about practice, and the ethics of practice I'm referring to here as ethical particularism.

Practice as knowledgeable action

In the essay 'Deconstruction and therapy' (2016a), Michael White mentioned that he was not an academic. I suggest that this is because he didn't read for disinterested academic purposes, nor write for select academic audiences.¹⁰ He read with the clear purpose of finding ideas for developing therapeutic practices and skills, and wrote with the clear purpose of sharing ideas so that other therapists could develop their own practices and skills. Michael White's practices and skills involved collaboration with others in the therapeutic communities that he, Cheryl White, David Epston and others were building, and collaboration with the individuals, families and communities who sought his and their assistance.¹¹ His ideas about practice were ideas for therapeutic collaboration and interaction.

It also seems that Michael White didn't seek peer review or wait on approval to check that his interpretations of ideas, drawn from his reading of Clifford Geertz, Michel Foucault, Jerome Bruner and Barbara Meyerhoff (to name some key thinkers), met with the approval of select academic reviewers.¹² I don't know whether he did or didn't care about such approval, but I speculate that a reason for not seeking

or waiting on it was that the onrush of a life's work was too immediate and pressing. He read in the midst of developing collaborative therapeutic practices, and in the midst of honing the skills that would support them. He didn't read for the sake of developing a body of theory, but for working collaboratively with others in ways that *resisted* dominant cultural stories and messages and their associated social positionings and *avoided* the hierarchical social positioning of therapists as experts in the (interiorised) psychic formations of other people. I emphasise resistance and avoidance as these are actions in practice, as I'll briefly describe.

In the interview 'On ethics and the spiritualities of the surface' (2016b), Michael White distinguishes academic or expert knowledge from the 'knowledgeableness of the therapist' (2016b, p. 208). This, from his perspective as a narrative therapist, is knowledge acquired in 'therapeutic interaction ... [as] *action ... in the world of culture*' (2016b, p. 221, *emphasis added*). *What I'm drawing attention to in bringing these two phrases together is a distinction Michael White made between knowledge acquired at a distance from practice, on one hand, and knowledge acquired and exercised in practice, on the other hand.* The latter is a mode of action in two senses. First, a narrative therapist's speech and orientation towards others within therapeutic interactions is knowledgeable action, deliberately acquired and exercised to resist and avoid hierarchical social positioning, to the extent this is possible. And second, therapeutic interaction makes meaning, which is explicitly recognised as having effects, and thus acts on and influences ways of living.

Michael White was neither a theory-builder nor a gatekeeper. The community that he and others built has been a community of therapists and practitioners interested in developing ideas for practice as knowledgeable action in the way just described, rather than developing a body of expert knowledge that is either removed from practice or is taken to practice in ways that position therapists as experts who possess knowledge and an accompanying insight that a person seeking assistance lacks.

Receptivity to discovery

Michael White took care not to dictate a set of limits or criteria for determining what narrative therapy could and couldn't be, and thereby foreclose on narrative therapy's continuing development. When his own practice, teaching and writing came to an end in 2008, he left narrative therapy with an open rather than a closed future and didn't leave a set of prescriptions for

ethical practice. Although he didn't write about ethics in a prescriptive way by appeal to rules or duties, nor view ethics as a form of specialised knowledge, he was certainly not lacking in moral conviction or ethical commitment, or so I believe.

For example, Michael White described what I see as an ethical commitment to self-restraint within his practice, and this self-restraint arose in large part from his views about the potentially negative effects of dominant cultural stories and messages, and from the norms that each of us instantiate and communicate in our words, our ways of seeing and our ways of being with others. In the following passage, the latter is characterised as an unavoidable *being for* all kinds of things, which he suggested he deliberately distrusted, and placed a restraint upon, as an exercise in taking responsibility for their effects. He wrote:

because the impossibility of neutrality means that I cannot avoid being 'for' something, I take the responsibility to distrust what I am for – that is, my ways of life and my ways of thought – and I can do this in many ways. For example, I can distrust what I am for with regard to the appropriateness of this to the lives of others. I can distrust what I am for in the sense that what I am for has the potential to reproduce the very things I oppose in my relations with others. I can distrust what I am for to the extent that what I am for has a distinct location in the worlds of gender, class, race, culture, sexual preference, etc. And so on.
(M. White, 2016b, pp. 201–202)

This passage, and others like it, describe a politics of practice in the sense I've mentioned above with reference to the effects of dominant cultural stories and messages, and I don't dispute or seek to dilute this.

What I'm aiming to highlight is the particularist orientation included in the self-restraint Michael White described. A few words from David Epston are instructive as he described Michael White's investigations of ideas:

[I] suggest ... grand terms ... with some reserve, to indicate your vision, even if you restricted yourself to the local and particular about life.
(Epston, 2011, p. xxv)

In this passage, David Epston was writing in the 'I–you' form of a letter which invoked the specificity of their relationship.¹³ He also appealed to the metaphor of vision while noting Michael White's deliberately restricted focus on the local and particular in lives, and this points to a rich paradox: between the metaphor of vision, on

the one hand, with sight issuing from a singular point in potentially open-ended and unlimited ways, and, on the other hand, a deliberately restricted and focused attention to the local and particular in people's lives and ways of living. The paradox is that a deliberately restricted attention allows more to be 'seen', and, moreover, for it to be seen in potentially open-ended and unlimited ways, rather than limited or circumscribed ways.

By suggesting Michael White's ethics of practice is a form of ethical particularism, I'm suggesting that knowledgeable action in narrative therapy – in the practices and skills he developed with others and then wrote about with care – includes 'seeing' in potentially open-ended and unlimited ways, by restricting attention to the local and particular in the words and phrases that people use, and in openings to alternative and preferred stories and story fragments of their lives. This involves a receptivity to discovery which I'll briefly describe by drawing on several ideas from Iris Murdoch.

Murdoch gave an example, in a now well-known story, of a mother-in-law who viewed her daughter-in-law as 'unpolished', 'lacking in dignity and refinement', 'brusque' and 'tiresomely juvenile': 'my poor son has married a silly vulgar girl'. Murdoch described the mother-in-law as 'imprisoned' by a cliqued view of social status. However, as Murdoch went on to describe, the mother-in-law was also aware of her own class snobbery and her jealousy regarding her son, so she decided to 'look again' and in so doing her vision altered and the mother-in-law '*discovered*' that her daughter-in-law was 'spontaneous', 'gay', 'delightfully youthful', and so on (1997, pp. 312–313, emphasis added).

In the brief story, Murdoch describes an untruthful 'seeing' that changes to a more truthful one. The second 'seeing' is a response to the daughter-in-law as she shows herself in the absence of an untruthful and inattentive gaze, when the woman's 'vision alters' and she allows herself to see her daughter-in-law more truthfully. And what she sees is a discovery.

Iris Murdoch describes the condition for such a discovery as a 'just and loving gaze directed upon an individual *reality*' (1997, p. 327, emphasis added). This notion of love does not concern being in love with or emotionally committed to, and the notion of justice is not one of equality or rights. The 'just and loving' in this phrase concern truthfulness. And 'reality' here is not a pre-existing 'something' that could be known of via means other than this attentive, truthful gaze. Truthfulness in this sense is not premised on a metaphysical

understanding of truth. It is not premised on an understanding of truth as correspondence between what a person judges to be true and a pre-existing and objectively determinable reality. It is a moral truthfulness 'seen' by attending to the particularity of another person. This can be contrasted with seeing another person at a remove, via snobbery or other forms of social positioning. It can also be contrasted with seeing another person as an instance of a type, as one among others who fall under a general category, and for whom a generalisable conclusion applies.

A gaze that is 'morally truthful' in Iris Murdoch's sense is not a moralistic gaze, nor one that only takes in moral qualities that are the standard fare of moral language, nor one that casts a rose-tinted glow over others. It is simply a gaze that is receptive to the 'individual reality' of another person. As Melbourne philosopher Christopher Corder (2016) has described, Iris Murdoch's 'gaze' is a form of attention, which is not the unearthing of facts, but a *discovery* in the sense of an impression upon the one who is attentive. Corder has noted that there are a range of interpretations of Iris Murdoch's phrase 'a just and loving gaze directed upon an individual reality' and her view of moral attention. He is particularly illuminating when describing what the latter is not:

[it is] not a 'particularizing conceptual refinement' ... nor is it simply ... 'seeking and getting more accurate information about ...' 'getting the facts right about...' 'acquiring knowledge about...' [who or whatever is an] ... object of attention. (Corder, 2016, pp. 203–204)

He continues:

Murdochian attention is not seeing something *about* another – seeing her more truly because one has come to register more truths about her. It is, instead, an orientation to her. (Corder, 2016, p. 208, emphasis added)

Murdochian attention, according to Corder, 'is not actually acquiring more information or setting oneself to acquire it' (2016, p. 216). Rather, it is '*attention* as a kind of *receptiveness*, and as accompanying, being present at or to, *waiting-on*, serving, answering to' (2016, p. 208, emphasis added). Christopher Corder is describing a 'receptivity to discovery' that is not fully conjured with visual metaphors. David Epston's observation addressed to Michael White that 'you restricted yourself to the local and particular about life' (2011, p. xxv) invokes it, as does Michael White's account of his deliberate distrust of

what he is *for*. In this vein, I note that the notion of 'gift' was significant for Michael White, as the receipt of a gift connotes both receptivity and the discovery of something unexpected.

At the risk of offering a truncated and thereby trivialising summary, Michael White's particularist ethics of practice is a receptivity to discovery in the words, phrases, story openings, stories and story fragments of the people he met with, which involved restricting his attention to the local and particular within conversational languages and the neologisms that enter into them. These discoveries are not discoveries about objectively verifiable truths or facts. Nor are these discoveries justified or made more 'real' by appeal to sources of truth or fact other than the words and phrases that are offered.

I suggest that Michael White believed the discoveries that emerge in the words, phrases and openings to alternative and preferred stories and story fragments are discoveries that elude the grasp of 'conceptual refinements', elude the empirically-derived findings of psychological sciences, and elude the dominant stories that shape expectations about how people ought to live and how they ought to feel about their lives and ipso facto themselves. And here we come to a question raised by recent suggestions that findings from brain research and neurological investigations (neuroscience, for short) can enter into and inform the practices and ideas of narrative therapists. Would Michael White have thought that the discoveries that emerge in the words, phrases and openings to alternative and preferred stories are ones that also elude conclusions about thought, affect, emotion and experience that are derived from neuroscience? Although I can't know this with certainty, I nonetheless suspect he would.

Michael White's particularism and neuroscience

Science is a discipline that seeks to generalise from specific observations and investigations to larger groups, and the replicability of findings is a hallmark of the application of scientific methods and procedures. Science is explanatory, not descriptive. It seeks to explain how it is that phenomena occurring now will occur again, and again, and so on. And, insofar as science is successful in this, its explanations are truthful (though fallible). In contrast, literature is descriptive, and the mark of truthfulness in literature is not replicability but particularity or specificity. Literature can reveal

particularity in character, lives and worlds, as described above. It can also identify something general or generally known in new or in previously unheard ways.¹⁴ Although Michael White was concerned with the reality of people's lives, not with fictional and imagined ones, he was concerned with how particularity is revealed in these two senses. He was concerned with the particularity that is revealed in descriptions of specific lives and ways of living, not in explanatory investigations that are 'true' insofar as they are replicable.

Generalisations in specific domains can be valuable, and this includes generalisations that are emerging from neuroscience. Neuroscience findings are generalisations about how our brains and neurological systems function. This is not a criticism and does not mean the generalisations are simply crude or of no value. But here I propose a philosophical position that I think Michael White took seriously: particularity in lives and in ways of living elude *all* kinds of generalisations, as there is always 'yet more' which is not predictable, and not a repetition of what has come before it.

In non-research contexts – that is, in life – there are cases in which 'the exception proves the rule', as the saying goes. We observe patterns all the time and base our expectations on them, and noticing irregularities here and there does not lead us to give up our expectations. But I believe that Michael White had a gift for developing practice pathways that elicit exceptions to rules and generalisations. These are exceptions that neither prove, nor disprove rules and generalisations. Discoveries of particularity in lives and in ways of living elude the rules of dominant stories, of psychological types, of moralised generalisations and so forth. They don't disprove them, they just elude them.

My sense of Michael White's ethics of practice, as a form of ethical particularism, is that he sought particularities that elude generalisations and regularities. I suspect he would not have been inclined to introduce generalisations and regularities as a means to interpret the particularities that emerge in therapeutic conversations. If correct, this suggests (to me) that he would not have been drawn to including generalisations from neuroscience within his narrative practice. This is not to say he would have thought that such generalisations were untrue, but rather that he sought something very different.

From the perspective of ethical particularism, ethical life consists in our meeting with one another as individuals, not in rules or abstractions or in intra-psychic formations. I will draw a parallel here and make a proposal. From

Michael White's perspective, ordinary languages within conversation were adequate to the task of expressing particularity in lives and in ways of living – the particularities that elude generalisations as just described. He did not turn to sub-personal or supra-personal structures (be they biological, intra-psychic, cultural or neurological) to justify or support this position. This would be 'seeking or getting more information about' why a person's words are either adequate to the task of speaking to the particularity of their lives and ways of living, or, alternatively, why they are inadequate to the task. Turning to sub-personal or supra-personal structures would be seeking information about why the people he met with said what they said from sources other than their saying it. He developed practices in order to refrain from this very thing, hence his restricted focus on the local and particular in lives, and his restriction to the ordinary languages of conversation. I suggest that for Michael White, turning from conversational words to neuroscience, and then back again, would be a detour from the local and particular in lives as revealed in the words and phrases that people use when they speak of their lives.

I've described 'receptivity to discovery' with reference to Iris Murdoch (and Christopher Cordner's elaboration of her ideas), and thus have drawn on moral philosophers. In so doing, I haven't sought to elevate narrative therapy as a moral therapy via appeal to moral philosophy, nor suggested that narrative therapists have moral insight that others lack. If I did so, I'd be suggesting that narrative therapists have moral expertise. In suggesting this, I'd be suggesting the kind of thing that I believe Michael White strongly opposed: I'd be positioning narrative therapists as experts in the complex warp and weft of the ethical lives of others. In describing Michael White's particularist ethics of practice – as receptivity to discovery – I've not described a theory, but rather a practice orientation. And, as I've hoped to explain, this orientation includes restraint. In Michael White's case this was a restricted focus on the local and particular in lives, and a restriction to the ordinary languages of conversation. I believe he thought that for the purposes of therapy, such languages were more than enough, and would agree that

every language existing today is fantastically expressive. It would be a miracle, except that it is utterly commonplace, a fact shared not only by all languages but by all the humans who use them. (Lane, 2018)

I believe that Michael White held the modest view that people mean what they say and that what people say

contains the seeds of difference, which I've referred to in this paper as particularity. I've taken the latter point, about difference or particularity, as one of the insights he drew from postmodern and poststructuralist sources.

There is a directness in narrative practice, which comes from avoiding positions that substitute the authority of speakers with other forms of authority, including scientific authority. This can make narrative therapy seem like an incredulous approach to therapy on first acquaintance.¹⁵ I believe that Michael White assumed that people know what they are talking about when they speak of their own lives and experiences, and this incredulity is the unavoidable price of eschewing authoritative positions with respect to meanings that are given. Another price is to exercise caution about drawing conclusions that concern individual lives on the basis of empirically-derived generalisations and neuroscience findings.

Reflections on neuroscience findings in therapeutic contexts

I've recently completed a social work qualification, prompted by a desire to work differently in the future. In my two student placements, I noticed that social workers and others sometimes show schematic representations of the human brain as they work with individuals within mental health settings. A common purpose is to point out that areas in the brain 'flare-up' during panic attacks. I suspect that this is used as a means to assist with explaining the aversiveness of such experiences. There are popular YouTube clips in which neuro-psychologist Dan Siegel demonstrates a model of the brain with his hand, using a flaring four-finger motion to represent the reactions that occur in the brain during 'fight or flight' responses (see for example Siegel, 2012). I've noticed this hand model and gesture re-enacted to communicate the message that rapidly occurring neural processes are involved in certain highly 'charged' experiences. Or, to put this another way, when a person feels something strongly, there is associated brain activity that (in some way) accounts for expressible reactions and feelings and other deeply-felt phenomena, such as a racing heart or a sweat that comes on suddenly.

During the two placements, I noticed that providing introductory-level information about neuroscience is now an accepted therapeutic intervention referred to as psycho-education; although those who educate others about neuroscience are typically not trained in it

themselves. I also noticed some potentially unreflective ways in which brains, selves and persons are referred to within psycho-education sessions, in comments such as 'your brain is making mistakes', 'your brain is doing X', 'your brain responds by X'ing'.

I have subsequently wondered about the extent of reflection by social workers and others on the double reference involved in such phrases. For example, in phrases that refer to a 'you' that is 'your' brain and refer to another 'you' who is impacted by what the brain is either doing or what is occurring in it.¹⁶ In addition to the double reference, I've wondered about the extent of reflection on the ambiguity between what is said to occur in the brain, and hence is a physiological event, and what the brain does. Here I'm pointing to ambiguity between what is an *act* (with the corresponding question of *who* acts? is it 'me' or 'my' brain?) and what is merely an *event* (with the corresponding question, am 'I' doing something or is this just an event in 'my' brain?).

I've wondered about the possible therapeutic implications of this kind of double reference and ambiguity. For example, how this double reference differs from other forms of double reference: how the double reference in the phrases above differs from the more subtle double reference when a person says of her friend, 'she's grieving, and she told me her heart really aches'. This expression invokes a grieving self and an observing self: 'I'm upset, and I notice a pain right here in my chest.'

Reflecting on these differences raises questions. For example, do certain forms of speech and certain sources of scientific information implicitly reify some 'selves' or 'agents' more so than others? If so, does implicit reification suggest an objectivity that less reified selves or agents lack? And if this is the case, what are we to conclude about such objectivity? Does talking about the brain and neurological actions/reactions/events within psycho-educational conversations implicitly deprioritise questions about the meaningfulness of experiences? In what way is the mind-body dualism that is implicit in many forms of speech affirmed in phrases, such as those above, which include reference to the brain? Is this dualism unavoidable? If so, what are its effects in terms of how personal agency is conceived?

These questions are both personal and philosophical, and they are questions that brain science does not answer, and, as science, does not need to answer. But they are entirely pertinent to the issue of how forms of speech and the authority that is often implied in them have impacts within therapy and then beyond it.

A personal reflection

I've had cause to reflect on brain research through a more personal connection.¹⁷ In 2015 my father was diagnosed with Alzheimer's dementia, which is a neuro-degenerative condition. He is currently doing well and is content with his day-to-day life, despite knowing he has dementia and being aware of his forgetfulness. The effects on his autobiographical memory are striking. He wonders about his work life and regularly turns to me and says, 'I used to do stuff, didn't I?' To which I reply, 'you certainly did'. The next part of this regular exchange is his comment, 'oh well, it's lucky I don't have to sit any more organic chemistry exams'. He still remembers, or says he remembers, the ordeal of a final chemistry exam when he was 21, although he cannot directly recall much of what has happened since then. Despite this, a range of skills acquired along the way is still available to him. He remembers the bass part to Handel's Messiah and can sight-read the score well enough to start singing his part at the right time, and on the right note. He sang a cut-down version of the Messiah perfectly well in a community choir last Christmas, according to my brother who sang alongside him. He used to speak French as a second language and a large vocabulary remains. His mental arithmetic skills are sharper than mine. However, he doesn't know the day of the week, and checks that I am in fact his daughter. Once this is established, he asks who my mother was. As I mention her name, he tilts his head skyward and blows her a kiss, despite their having parted ways in the mid-1970s with a good deal of pain and acrimony.

I've read about the progressive impact of Alzheimer's and can name some parts of the brain that are involved in my father's autobiographical memory deficits and his skills retention. On a micro-level, I know a little bit about the beta-amyloid plaques and neurofibrillary tangles that are interfering with his neuronal functioning. It probably won't assist my father, but I think that brain research on neuro-degenerative conditions is very important. I also think basic brain research with no immediate practical application is important.

But the outcomes of brain research are of no assistance in my concern that my father be recognised and responded to as a full member of the community he lives in; that he not be spoken down to, patronised, ill-treated or turned away from on account of the deficits I've described. This is not simply because I love him; it's a moral concern about his standing with others. This is not a concern about his brain, but a concern for the whole person he is and for the life he still leads despite cognitive impairment. On several occasions, I've noticed

staff in the residential care facility where he lives speak to him, or of him, in ways they wouldn't if he possessed his former charisma and presence. But he has changed and so has the way he is occasionally spoken to or about.

I know that little training is offered to staff on the neuroscience of Alzheimer's and other dementias. Some neuroscience education might foster more insight, for example that people with dementia have not willed it on themselves, that they were not always forgetful, that restlessness and agitation in the late afternoon is not a moral failing and so forth. But what happens on occasion, due to overwork or straightforward moral inattention, is that my father, in common with others who live with neuro-degenerative conditions, is not seen by a 'gaze directed upon an individual reality'. These days, there are occasions when he is less real to others than I would like. This is not to do with knowledge, but with the attentiveness of others to him.

In care contexts, where people like my father are dependent on others, failures to see the reality of those who are dependent has direct moral implications. In therapeutic contexts, such failures have similar moral implications as they can underlie abuse and other failures of respect. But the receptivity to discovery I've sought to describe in Michael White's particularist ethics of practice is not simply a corrective or check against moral failure. This is included of course, as narrative therapy seeks to be a 'respectful, non-blaming approach' (Morgan, 2000, p. 2) to therapy. But Michael White's receptivity to discovery is more subtle than simply maintaining forms of distance and developing attitudes that are a corrective or put a break on failures of respect. It includes a subtlety that instantiates and communicates a respect for particularity. It includes a subtlety that keeps open the questions I raised above, about the nature of any possible subject of self-reference and the nature of personal agency. It includes a subtlety that does not foreclose on or answer these questions in advance. It is a subtlety that leaves open the question of what findings and models from science, and resulting ideas and metaphors, are of interest to people and how they themselves may choose to make sense of them.

Writing off neuroscience?

Michael White didn't write about narrative therapy as a closed, copyrighted or theoretically-bounded system. The narrative community he was part of developing hasn't become a closed society that affords itself the

prerogative of closing its doors to new ideas, new members or new ways of practising. Since the time that Michael White's work came to an end and he left the gate open for others to take narrative therapy forward, an aspect of the culture(s) in which the therapy world is embedded is shifting.¹⁸ This raises questions about how open to cultural shifts and changes narrative therapy either is or should be.

In brief, and here I am drawing on accounts by Nikolas Rose (2013) and Rose and Joelle Abi-Rashed (2012), we are in the midst of a (possible) passing of one age of the sciences of the human psyche to another age. We are passing from what Nicholas Rose have referred to as the dominance of the 'psy sciences' to a new dominance of biological or life sciences. This substitutes the brain for the mind as the 'seat' of the human soul, and this substitution is already having effects; a few of which I noticed on my student placements as mentioned above.

Nicolas Rose and Joelle Abi-Rached outline the history of critique and at times antagonism on the part of the human sciences to what are sometimes reductionist and functionalist conclusions of biological or life sciences. However, they suggest that there are now possibilities for a more fruitful relationship between these disciplines, one that would allow for new ways of considering the relationships between nature and culture; that is, for considering the relationship between our natural being and our collective lives as meaning-makers. These authors are right to suggest that there has been antagonism towards science and give some acute descriptions of the reasons why the antagonism has, at times, been justified.

I'm not arguing for further antagonism or wanting to rehearse existing antagonism towards science and then direct this towards neuroscience. But I do suggest that emerging models and metaphors will have effects, just as previous ones have. They will reinforce, unpack and/or create new assumptions about the split between meaning and matter, and assumptions about the split between living and non-living matter and 'where' or how meaning sits between them. I suggest that the proposal I've offered in this paper, that the particularities that Michael White sought are those that elude generalisations of all kinds, is by no means off the table with the introduction of neuroscience findings as a possible adjunct to narrative therapy. I'm not writing off neuroscience, nor lamenting the shift Nicolas Rose and Joelle Abi-Rached have identified. Nor am I suggesting that narrative therapists should be against neuroscience, as a science. But I am proposing (after Michael White) that those who are enthusiastically *for neuroscience*

within narrative therapy consider observing his deliberate distrust as an exercise in responsibility for the effects of their being for it. I am proposing a cautious distrust of any attempt to answer philosophical and personal questions on behalf of others by appeal to neuroscience. The genius of Michael White was to leave personal and philosophical questions open for discovery, and not use therapy or any of the sciences to answer them in advance for others.

Notes

- ¹ Here are several key references for each thinker: Foucault (1973, 1979); (Bruner 1986, 1990).
- ² Writing about Michael White's ethics of practice is not to engage in hagiography. I'm not discussing or seeking to elevate Michael White's own moral qualities, nor seeking to suggest that narrative therapists are more or less ethical than anyone else. However, I do think that the careful practice of narrative therapy does involve a distinctive ethical orientation to those who seek assistance. For the purposes of this paper, I use the terms 'ethical' and 'moral' interchangeably with no intended difference of sense.
- ³ I've borrowed the phrase 'quiet authority' from narrative therapist David Newman. In conversation about practice he has used the phrase to describe the authority that accompanies the words of young people when speaking of their own experience (he also uses this term in Byers and Newman, 2019).
- ⁴ The works I have in mind are Zimmerman (2018), Hutto and Gallagher (2017) and a collection on neurobiology and therapy edited by Marie-Nathalie Beaudoin and Jim Duvall (2017).
- ⁵ I'm using the expression 'ordinary languages of conversation' in the plural to suggest that there is no privileged conversational, spoken language, e.g. English rather than Greek, and to acknowledge that ordinary, spoken languages shift and alter over time, and hence no living language is an unchanging entity.
- ⁶ Here is a key reference for each thinker: Simone Weil (2002); Iris Murdoch (1992); Knud Løgstrup (1997); Raimond Gaita (1999); Christopher Cordner (2002); Buber (1970); Levinas (1969).
- ⁷ Please note that in this context, I do not intend the terms 'individual' and 'particular' to invoke individualistic conceptions of selfhood, nor to connote isolation of persons from one another.
- ⁸ Drawing on Australian literature, there is an orientation to place, landscape and the formation of imagination developed in Gerald Murnane's (1982, 2009) work that is distinctively particularist. A different kind of example is Raimond Gaita's account of the never-to-be-repeated ethical lives of his father and his father's friend Hora in *Romulus, my father* (1998).
- ⁹ He did more than this, and I'm not suggesting his approach to therapy can be summarised in one phrase.
- ¹⁰ See Cheryl White's account of Michael White's 'independent scholarly approach' (2011, p. 162).
- ¹¹ See Cheryl White's (2009) account of the early, ongoing and anticipated collaboration between Michael White and David Epston.

- ¹² Here is key reference for thinkers not previously cited: Geertz (1973); Meyerhoff (1992).
- ¹³ Given the context of the passage, the 'I-you' appositely invokes Michael White's work with people experiencing grief, see 'Saying hullo again: The incorporation of the lost relationship' (2016c).
- ¹⁴ For example, Bob Dylan was awarded a Nobel Prize for literature for speaking to a generation of experiences that were known to them in a voice that had not been heard before, and for using a folk tradition to speak in new ways.
- ¹⁵ That is, 'are you really saying that people know what they mean, even though they don't know what their brains are doing or making them do?' To which the answer is 'yes'.
- ¹⁶ David Newman and I have described the simultaneous personal and impersonal quality of such phrases (2019). The present discussion makes a different, though related point.
- ¹⁷ I'm currently working on a dementia research project, but the thoughts shared here are more personal than professional.
- ¹⁸ I can only comment on the anglophone cultures that I am familiar with.

References

- Beaudoin, M., & Duvall, J. (Eds.). (2017). *Collaborative therapy and interpersonal neurobiology: Emerging practices*. New York, NY: Routledge.
- Bruner, J. (1985) *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.
- Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.
- Buber, M. (1970). *I and thou* (W. Kaufman, Trans.). New York, NY: Simon & Schuster.
- Byers, P., & Newman, D. (2019). A first person principle: Philosophical reflections on narrative practice within a mainstream psychiatric service for young people. *International Journal of Narrative Therapy & Community Work*, (1), 19–28.
- Cordner, C. (2002). *Ethical Encounter: The depth of moral meaning*. Basingstoke, England: Palgrave.
- Cordner, C. (2016). Lessons of Murdochian attention. *Sophia*, 55, 197–213.
- Epston, D. (2011). Introduction. In D. Denborough (Ed.), *Narrative practice: Continuing the conversations* (pp. xxi-xxxviii). New York, NY: Norton.
- Foucault, M. (1973). *The Birth of the clinic: An archaeology of medical perception*. (A. Sheridan Smith, Trans.). London, England: Tavistock.
- Foucault, M. (1979). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). London, England: Penguin.
- Gaita, R. (1999). *Romulus, my father*. Melbourne, Australia: Text.
- Gaita, R. (1999). *A Common Humanity: Thinking about love, truth and justice*. Melbourne, Australia: Text Publishing.
- Geertz, C. (1973) *The Interpretation of cultures: Selected essays*. New York, NY: Basic.
- Hutto, D., & Gallagher, S. (2017). Re-authoring narrative therapy: Improving our self-management tools. *Philosophy, Psychiatry, and Psychology*, 24(2), 157–167.
- Levinas, E. (1969). *Totality and infinity* (A. Lingis, Trans.). Pittsburgh, PA: Duquesne University Press.
- Løgstrup, K. (1997). *The ethical demand*. Notre Dame, IN: University of Notre Dame Press.
- Lane, G. (2018, December 6). Who decides what words mean. *Aeon*. Retrieved from <https://aeon.co/essays/why-language-might-be-the-optimal-self-regulating-system>
- Myerhoff, B. (1992). *Remembered lives: The work of ritual, storytelling, and growing older*. Ann Arbor: University of Michigan Press.
- Murnane, G. (1982). *The plains*. Melbourne, Australia: Text.
- Murnane, G. (2009). *Barley patch*. Sydney, Australia: Giromondo.
- Morgan, A. (2000). *What is narrative therapy? An easy to read introduction*. Adelaide, Australia: Dulwich Centre Publications.
- Murdoch, M. (1992). *Metaphysics as a guide to morals*. London, England: Penguin.
- Murdoch, M. (1997). The idea of perfection. In P. Conradi (Ed.), *Existentialists and mystics: Writings on philosophy and literature* (pp. 299–336). London, England: Chatto & Windus.
- Rose, N., & Abi-Rached, J. (2012). *Neuro: The new brain sciences and the management of the mind*. Princeton, NJ: Princeton University Press.
- Rose, N. (2013). The human sciences in a biological age. *Theory, Culture and Society*, 309(1), 2–34.
- Siegel, D. (2012, February 28). Dan Siegel – 'Flipping your lid': A scientific explanation [video file]. Retrieved from www.youtube.com/watch?reload=9&v=G0T_2NNoC68
- Weil, S. (2002). *The Need for Roots: Prelude to a declaration of duties toward mankind* (A. Wills, Trans.). London, England: Routledge.
- White, C. (2009). Where did it all begin? Reflecting on the collaborative work of Michael White and David Epston, *Context*, (October), 59–60.
- White, C. (2011). Epilogue: Continuing the conversations. In D. Denborough (Ed.), *Narrative practice: Continuing the conversations* (pp. 157–179). New York, NY: Norton.
- White, M. (1995). The narrative perspective in therapy. In *Re-Authoring Lives: Interviews and Essays* (pp. 1–40). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2016a). Deconstruction and therapy. In M. White (Ed.), *Narrative therapy classics* (11–54). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2016b). On ethics and the spiritualities of the surface. In M. White (Ed.), *Narrative therapy classics* (pp. 195–226). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (2016c). Saying hullo again: The incorporation of the lost relationship in the resolution of grief. In M. White (Ed.), *Narrative therapy classics* (pp. 95–107). Adelaide, Australia: Dulwich Centre Publications.
- Zimmerman, J. (2018). *Neuro-narrative therapy*. New York, NY: Norton.



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

All enquiries should be made to the copyright owner at:

Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000

Email: dcp@dulwichcentre.com.au

Thank you! We really appreciate it.

You can find out more about us at:

www.dulwichcentre.com

You can find a range of on-line resources at:

www.narrativetherapyonline.com

You can find more of our publications at:

www.narrativetherapylibrary.com



Narrative responses to physical pains

An interview with Sister Seraphine Kaitesirwa



Sister Seraphine Kaitesirwa is a narrative practitioner in Kigali, Rwanda, where she works at a clinic for children and young people.

Sister Seraphine can be contacted c/o: seraphinewase@yahoo.com

Abstract

Sister Seraphine Kaitesirwa is a narrative practitioner in Kigali, Rwanda, where she works at a clinic for children and young people, some of whom experience concerns that show up as physical pains in their bodies. Sometimes, these pains have become named somatoform disorder. The pains can have serious effects for the lives of the children and young people, and their families, causing significant distress. Drawing on narrative principles, and with her appreciation for embodied experience, Sr Seraphine has developed a series of externalising questions and practices that invite the children and young people into a new sort of relationship with the pain, with remarkable effects. On a recent visit to Kigali, David Denborough caught up with Sr Seraphine, eager to hear more about her practice. The two were joined by Yishai Shalif and Cheryl White.

Key words: *physical pain, narrative therapy, externalising, somatic experience, Rwanda*

David: I'm interested to hear how you respond when people speak to you about physical experiences, somatic experience. Perhaps you could tell me a story about your practice?

Sr Seraphine: Usually they are referred by the doctor. They may have gone through many different tests, all of which were negative. They may have been told they are exaggerating. So, first of all I acknowledge their pain.

David: You told a very powerful story today about a man and his tears. It illustrated how you profoundly acknowledge the pain or suffering people bring through their bodies. Could you say a little more about that acknowledgement? How you really give people chance to share their experience with you.

Sr Seraphine: I acknowledge the pain because that is their experience. It depends on the age of the person, but if they are a child or adolescent I will say, 'Can you locate the pain in a drawing?' Sometimes they draw a picture of their body, or sometimes I provide a sketch of the human body. I ask them to locate the pain. Even before they draw I may have asked, 'What shape is your pain? What does the pain look like? If it had a colour what would that be?' Then they can choose to draw with different colours. I might also ask, 'If this pain could have a voice, what would it say?' and they may express that in different voices. I might develop this further to ask, 'If this pain had eyes and ears, what would it not like to hear or see?' Then they might speak of those things. We may go on to explore when the pain is more or less, and what they do to make the pain less. These are the things within their power, and within their means. These are the exceptions. This is how I find out about their strengths, and what supports the pain to become less. After working together, maybe three times, they come and tell me the pain is less. Recently I met with a girl who was using crutches due to her pain. I did this with her, and today she is walking.

David: So, this can be quite profound and disabling pain that they have been experiencing. Does this happen in different parts of the body? Perhaps more commonly in some places than in others?

Sr Seraphine: Yes, it is usually their head or sometimes their legs. The pain may just be on one side. And some young women have back pain.

David: When you ask whether the pain has eyes or ears, what sort of things do people say?

Sr Seraphine: One young lady told me the pain comes when her stepsister says bad things about their mother. She told me, 'My stepsister says she loves me, but she cannot when she treats our mother badly.' She gets a pain in the back of her head whenever her stepsister speaks ill of their mother.

David: And when you asked, 'What does the pain not like to hear?' is that when she told you that? Is that what the pain didn't like to hear?

Sr Seraphine: Yes, as the story unfolded she was crying.

David: What do you think it is about this process that assists people? Why do you think having these conversations together makes a difference?

Sr Seraphine: I believe that sometimes there are issues in people's lives that they have not been able to voice. There are hidden concerns that they are going through alone. But in an environment that takes these matters seriously, they can voice what they don't like and talk about what they are going through. We have created a space for it, in what I've noticed as a culture of silence. So, if someone using crutches is unhappy about something, such as someone talking ill about their mother, it is very hard to say, 'Please stop, you are hurting me.' She will keep it to herself, and I believe this is what causes many body pains. When a child is able to say, 'I'm not happy about what's going on at home,' then I invite parents to listen, so they know what's happening for the young person, and what's going on in their life.

David: And then there's a chance for them to take some action and to do different things at home. Have you talked with a person about their bodily experiences with another person in the room, as an outsider witness?

Sr Seraphine: I haven't had that opportunity. I only invite other people in *after* the voice behind the pain has already been explored, to listen to what is showing up as bodily pains.

Sr Seraphine: I was thinking about the culture of silence. When someone is suffering silently and alone, keeping their concern inside, it tends to expose itself in some way. I've seen it with children, as their way of saying, 'I'm not happy with something. Something's wrong.' It's a kind of signal that they're not happy. The concern or worry expresses itself as pain that cannot be seen by tests. They say they have a headache, but the headache is a way to voice something else that is not going right.

Yishai: I'm curious to know how the idea to personify the pain first came to you.

Sr Seraphine: The drawings worked so well with children, asking where the pain was in the body. So, I thought, 'Maybe we could also ask about what feeling goes with this pain,' but staying with the idea of using pictures, that's when I thought, 'What if the pain had a voice? What would it say?'

Cheryl: Am I right in thinking that in Rwanda sometimes people go to the doctor with a pain, but they know themselves that it's from the genocide or from trauma? That pain is sometimes a metaphor, or a way of talking about something difficult. Does this occur in Rwanda in a way that might be a bit different to some other cultures?

Sr Seraphine: Yes. But also, sometimes it's children whose parents are both alive. There are examples where children have shown body pains but are not happy with the quarrels their parents are having at home. Or maybe their father is not present. Being taken to the hospital means both parents come to check on them. That way the child can create a scenario, using their body, to have both parents come to check on them.

David: Are there times when it's quite difficult for the child or young person to give voice to the pain? When I was a kid, there were times I had stomach ache when there was no physical reason for it, but I don't know if I would have been able to name what that represented. How would you explore that?

Sr Seraphine: Yes, sometimes children can draw the pain but not give any voice to it. Drawing is powerful in itself, and any child can let you know, 'This is where I feel the pain.' Then you can ask, 'If you had anything to tell this pain, what would you tell it?'

David: Okay, you in this situation you can invite them to talk to the pain rather than the other way around?

Sr Seraphine: Yes, you can also talk to the pain.

David: Am I right that you grew up in Uganda?

Sr Seraphine: Yes, I'm Rwandan but grew up in Uganda.

David: Did you notice any differences in relation to body experiences in Uganda than in Rwanda? I'm really interested in cross-cultural differences ...

Sr Seraphine: In Uganda I worked in schools and bodily pains were typical among adolescents, the same as here in Rwanda. The children there had similar complaints about headaches, as a way of saying there was something going on.

David: What about issues that are really difficult to speak about? Like child sexual abuse or other forms of abuse that are very hard or not safe to speak about. How can those be responded to?

Sr Seraphine: It's difficult for a child to share any family secrets, like telling me that mum and dad always fight. It's like taking family secrets outside, and to a child that's not easy. Perhaps they're not happy about dad coming home drunk. There are many issues it would be hard for a child or a woman to speak of.

David: I remember on one of our early visits to Rwanda, when working with counsellors from Ibuka (the national genocide survivors association), that one colleague said: 'It is a trait for many Rwandans not to talk openly about our problems.' They also described the ways in which, despite this, some survivors were turning to friends to share memories that otherwise would not go away, and that sharing them with others meant they were no longer alone with them.¹ If it's a cultural trait in Rwanda, to *not* talk openly about problems, it seems the work you're doing is particularly significant ...

Sr Seraphine: Yes, here in Rwanda, it's very hard to say, 'I'm not happy with the working conditions,' or, 'I'm not happy with what you did.'

David: If someone is unable to speak openly about what is wrong, but can speak of how their body is struggling, the work you do brings people together to talk. That seems really significant to me. Thank you so much Sister.

Reference

Denborough, D., Freedman, J., & White, C. (2008). *Strengthening resistance: The use of narrative practices in working with genocide survivors*. Adelaide, Australia: Dulwich Centre Foundation.

Note

¹ See: 'Living in the shadow of genocide: How we respond to hard times – Stories of sustenance from the workers of Ibuka' in Denborough, Freedman, White (2008, pp. 21-24)



Dear Reader

This paper was originally published by Dulwich Centre Publications, a small independent publishing house based in Adelaide Australia.

You can do us a big favour by respecting the copyright of this article and any article or publication of ours.

The article you have read is copyright © Dulwich Centre Publications Except as permitted under the Australian Copyright Act 1968, no part of this article may be reproduced, stored in a retrieval system, communicated, or transmitted in any form or by any means without prior permission.

*All enquiries should be made to the copyright owner at:
Dulwich Centre Publications, Hutt St PO Box 7192, Adelaide, SA, Australia, 5000
Email: dcp@dulwichcentre.com.au*

Thank you! We really appreciate it.

You can find out more about us at:
www.dulwichcentre.com

You can find a range of on-line resources at:
www.narrativetherapyonline.com

You can find more of our publications at:
www.narrativetherapylibrary.com