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; Lainson, 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 meaning-less 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 predating 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?

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.

Feminism and narrative practice

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 'weakmindedness' 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.

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.

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.

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: Guildford.

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