Book Reviews

Biting the Hand that Starves You: Inspiring resistance to anorexia/bulimia

R.Maisel, D.Epston and A.Borden (2004)
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Reviewed by **Colleen Barrett**

Resolving the Riddle of Eating Disorders

Anorexia is generally seen as being at the more extreme end of the Eating Disorder spectrum, not least because of the fear it arouses in the people who witness its impact. There are other psychiatric disorders which are life threatening but none with quite the same level of dramatic visibility, this being enhanced by the seemingly simple solution often envisaged by the uninitiated observer; if the affected person would just start to eat normally there would be no such problem. That an individual would resort to all sorts of devious means to resist the food that would return her [needs to agree with "an individual"] to life and health is beyond the comprehension of such an observer. It is not surprising then that attitudes to sufferers of the disorder are often angry and hostile, this even at times including people who have some sort of role in treatment of the afflicted individual. It is an extremely difficult disorder to treat, from both sides of the treatment relationship. Perspectives and techniques which make this process more transparent and effective are therefore very welcome. *Biting the Hand That Starves You*, written by Narrative therapists Richard Maisel, David Epston and Ali Borden makes this sort of contribution.

While the title would seem to suggest a focus on anorexia, the authors refer throughout to anorexia/bulimia, or as they abbreviate it, a/b, indicating their belief that the different forms of eating disorder are largely interchangeable at the experiential level. It should be noted that they decline to give either term the status of a capital letter, this being an illustration of their determination to undermine the terrible status that a/b takes for itself.

Narrative therapy is defined on the website address provided in the book (p. xi) as follows:

> "The term narrative implies listening to and telling or retelling stories about people and the problems in their lives. In the face of serious and sometimes potentially deadly problems, the idea of hearing or telling stories may seem a trivial pursuit. It is hard to believe that conversations can shape new realities. But they do. The bridges of meaning we build with others help healing developments flourish instead of wither and be forgotten. Language can shape events into narratives of hope."

The importance of the conversations referred to is that they enable a therapist to make contact with the inner world of the eating disorder sufferer and the particular dynamic that is perpetuated by their "self talk". The idea of self talk has come to popular attention through the Assertiveness movement. Pamela Butler in *Self Assertion for Women* (1981) links low self esteem and a consequent lack of assertiveness to a self-demeaning inner dialogue. Matthew McKay and Patrick Fanning in *Self Esteem* (2000) talk about the internal role of Critic, which in its more extreme form they link to the development of Depression. This is a role which appears to be more commonly present in women. It is so habitually present for some people they are unaware of its presence in their thoughts, or its singular effects. Developing awareness of it by exploring with clients the specific thought processes, or the inner talk that goes with certain behavioural choices, can be a revelation for them and for therapists.

The concept of a self-persecutory element within the personality may have originated with object relations theorists. Harry Guntrip, in his book *Schizoid Phenomena, Object Relations and the Self* (1969), makes the claim that it is a primary drive in every human being to become a 'person'... to develop a personality in order to live. Guntrip claims that "[t]here are no fears worse or deeper than those which arise out of having to cope with life when one feels that one is just not a real person"(p.175). And that "[t]his feeling of weakness consists not in lack of energy or innate ability, but in this unremitting state of basic fear and distress and lack of self-confidence of which the individual feels ashamed" (p.183). "A self-frustrating situation of deep internal self-hate arises, along with a concentrated attempt to drive and force oneself to the conscious feelings and pattern of behaviour that is regarded as adult" (p.187). "The degree of self-hate and self-persecution going on in the unconscious determines the degree of the illness" (p. 190).

In a similar vein, the authors of *Biting the Hand* write of the seduction and capture of the person with a/b by the anorexic voice. The book uses transcripts and letters from work with clients in which the impact of this mind-talk and the anorexic persona from which it emerges are made very explicit. While the emphasis in the book is particularly on working with a/b it also includes comment about

the issues in the social environment that influence the particular form that the hidden negativity takes when it emerges as a/b. Like Susie Orbach in her classic work, *Fat is a feminist issue* (1977), the authors see eating disorders as a reflection of "cultural discourses that champion individual achievement and self control and gender specific stereotypes about being 'nice' and 'looking thin'". They consider that those who suffer from a/b have chosen to "refashion themselves" because they find themselves unable to live in or remake the world as they find it. (The authors quote Helen Gremillion's metaphor that "these young people are often the moral canaries in the mines of contemporary culture, detecting toxicity before those less sensitive to injustice do"). The form of their refashioning is determined by norms and expectations they encounter in that world. They believe that honouring their own needs will bring about rejection and disapproval; therefore they perform "acts of self erasure". A/b starts out by being a tool for such refashioning but ends up capturing the individual's life. When one talks of this happening to a life it goes beyond the physical. For someone who has been taken over by a/b there is no spontaneous individual life. The self, the essence of the person has been overcome, and what is left is the rigidity and life-suppressing tyranny of a/b.

When anorexia is manifested in a severe form, the personality or identity of the individual is usually totally overwhelmed, so that it is not possible to find a place in the mind from which the activities of anorexia can be identified or commented on. In Narrative therapy the first goal is to externalise the a/b, to unmask it by asking questions about its purposes and strategies. Such questions are directed from the therapist's own view of a/b as external to the person who is being affected by it and would take a form such as "Is that what anorexia tells you? How is anorexia tricking you into believing that? What would anorexia's purpose be in wanting you to believe that?" Until there is a distinction between the voice of a/b and the original self in the mind of the sufferer, there is no place from which a/b can be challenged. Once there is some clarity in the mind about the source of any particular thought there is the beginning of choice about the response that one makes to that thought, distancing from the negativity and self-destructiveness of a/b starts to be a possibility. As the authors say "The struggle commences when the person suspects for the first time that she may be in prison." A client I had been working with for some time suddenly had an image of herself inside a cage from which she could see others participating in and enjoying life, and was aware suddenly that she had not experienced such participation in her own life.

The authors provide a list of indicators to help those working with a/b clients to recognise when the client is responding from the a/b position. "We feel reasonably confident in concluding that the voice of a/b is operating when it: (1) denies the physical consequences of starvation or purging or attributes those consequences to something else; (2) claims the person is experiencing something such as happiness when there is ample evidence to the contrary; (3) speaks in a way that closes a person off to alternative viewpoints or perspectives; (4) argues that things are hopeless; (5) insists on the badness or unworthiness of the person; (6) emphasises that the only hope for a good future lies through thinness, self-discipline, bodily control, niceness or subservience, or perfection; and (7) minimises or dismisses the genuine love and caring of parents, friends, partners, and other concerned people." The focus and concerns of the voice will vary in emphasis from individual to individual, but there will always be some of these points that are recognisable, and which can provide a starting point for the externalising conversation.

Motivational Interviewing techniques (Prochaska & DiClimente, 1986) have been the only comparable technique for directly accessing anorexia's activities in the mind in an attempt to move the affected person towards a willingness to change. Motivational interviewing originated with addictions treatment (which has some common ground with eating disorders, not the least of which is the degree of associated compulsiveness) and involves finding and intensifying ambiguity in the mind of the client so that the subsequent conflict will bring about change. It does not have the same specificity of focus, however. Neither does it have the emphasis on externalising a/b which is such an important aspect of the narrative approach. Both these approaches have the advantage of offering methods that work directly on a client's denial of the peril they are in. Once this barrier has been breached other forms of therapy become more effective. If other therapies are used before motivational issues are dealt with there is some risk of increasing resistance to treatment because of the hidden and unchallenged activities of the anorexic persona. Trying to keep clients safe by requiring change in their eating patterns when they are still exclusively committed to the inner destructive voice carries the risk of increasing the defensive activities of a/b.

Turning one's back on a/b is not a straightforward process. In *Biting the Hand*, the authors describe Chloe's reaction:

> "I was thinking about this recently (anorexia's allegation that "it is the provider of vital protection against my lacking self") and I think it is one of the main reasons why I have remained under anorexia's grip for so long ....
>
> For me, anorexia is like a wall which I can hide behind. Anorexia may well be a prison wall but walls (even prison ones) serve their purpose."

With the possibility of letting go of anorexia, the fear and emptiness that contributed to the development of the eating disorder re-emerge. It requires an act of faith to move forward and to trust that something different is possible. At this point the book turns to the building of anti-a/b, a process that will initially sit alongside the activities of a/b and alternate with it in the mind. The process involves developing support for resistance to a/b, perhaps by meeting up with others further along the recovery path, developing a sense of moral outrage about the activities of a/b and its effect on your life, learning either to fight back against the a/b voice, or if that is not possible, to tune out or withdraw from the voice, and finally the construction of a new anti-a/b lifestyle. Chloe again describes this experience:

> "I have come to a simple way of explaining my Anti-Anorexic lifestyle.

> Are you ready?...Just being!! "Just being" means to me just feeling like I am feeling at that precise moment. If I am tired, then I will be tired. If I am feeling sick, then I will feel sick. If I am happy, then I will be happy!"

This is a very great change for someone who has internally subjected every element of her own experience to critical questioning and has seldom trusted herself enough to carry out a spontaneous act. It could be described as the beginning of a true life.

As in addictions, the path to a life without a/b will not be smooth. In stressed and difficult moments, a/b will still come up with its seductive promises, and sometimes a relapse into old patterns of behaviour may result. It is important that a relapse, or comeback as the authors call it, is seen as an almost inevitable part of the process of recovery, as part of learning how the disorder operates, and what state of being renders one vulnerable to the intrusion of a/b's negativity. In a section called The Rhythm of Recovery the authors describe the process of this struggle in dramatic terms:

> "The battle between a/b and anti-a/b is an epic one. The conflict between these two agonists mirrors those between the grand themes of Western civilisation: life versus death, good versus evil, freedom versus tyranny. The tension between these classic polarities will never be resolved through something as definitive and final as victory or "defeat"' just as the struggle between a/b and anti-a/b cannot be adequately rendered through terms such as cure and relapse. Comebacks can be viewed as a/b's desperate attempt to reverse a person's anti-a/b momentum. And although a woman's forward momentum may be temporarily halted while she turns around to defend herself against a/b's assault as best she can, such a reversal should not be viewed as a setback but rather as an inevitable part of the back-and-forth rhythm of "recovery"."

Working with families is an essential aspect of treatment as outlined in this book. An important factor in deciding the outcome of the struggle will be the quality of the support the person in recovery can call on. While acknowledging the pain and the powerlessness that parents endure when they have a child affected by a/b, the authors also have many ideas to help parents play this supportive role. Parents have a dilemma in terms of "how much power and authority (they) should wield to prevent their daughter from engaging in a/b-required acts (e.g., not eating or drinking, excessive exercise, vomiting or laxative use) and how much to accommodate her seemingly ever-increasing compulsions, fears, and demands." If the existence of a/b is in fact evidence of some sort of vulnerability in the development of the sense of self and the way this is impacted on by social attitudes, then controlling behaviour on the part of others could be seen as similar in kind to the role played by a/b and not contributing to a strengthening of the anti-a/b self, thereby perpetuating their daughter's difficulties and the a/b resistance. The authors propose that parents learn to communicate with their daughter in ways that will allow them to be her allies, and from which position, even if life-saving treatment is required parents will be able to approach this in a collaborative way. They will support their daughter in ways that empower both her and them. The authors express it as follows:

> "Parents can begin to feel overwhelmed, exhausted, and hopeless as their attempts to give their daughter love and support are repeatedly rebuffed. A/b often reinterprets a parent's love and support as something negative_ for example, as an attempt to weaken her resolve or fatten her up. a/b may also tell your daughter she is unworthy of love and care and would be better off dead. These distortions or dismissals of parental love and concern can make it difficult for parents to persist in their expressions of love, and to continue to believe in their daughter. Yet, by holding fast to whom you know your daughter to be and continuing to show love, affection, and faith in her, you can thwart a/b's attempts to portray her to herself in the most negative light. Instead, she may feel reassured that, at least in her parent's hearts, she is lovable and loved."

The authors also offer a caution:

> "However you should be careful to express your hope for and faith in your daughter in a manner that does not take her efforts to retrieve her life for granted. For example, if you respond to your daughter's anti-a/b steps with something akin to 'I knew you would come around' or 'we always believed you would do it', a/b can turn such encouragement into pressure and burdensome expectations. If the hope you have for your daughter is heard as an expectation or presumption, your daughter may feel guilty or believe herself to be a hopeless failure at those times when she is unable to sustain or extend her anti-a/b initiatives."

One of the most impressive aspects of *Biting the Hand* is its sensitivity and respect for the sufferers of a/b. The authors attention to all the minute detail of their subject's experience, and their subsequent recording of their stories, particularly the persecutory impact of the a/b voice, has made what I believe is a very special contribution to the treatment of eating disorders. It puts the punitive methods of the past (and perhaps sometimes the present?) into sharp relief, where such practices can be seen as having perpetuated and even mimicked the cruelty of a/b, even if the intentions behind them were well meant. Perhaps in the past the sense of frustration and fear that came from witnessing the decline of those affected by a/b prompted such responses. We are now in a better place, we have the means to understand the process that is being enacted and we can treat it not with the heavy hand of desperation and blame, but with courage and kindness and insight. The authors have given those of us who work in this field a more substantial platform to work from, and thereby a stronger basis for hope.

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Models of Madness: Psychological, social and biological approaches to schizophrenia

Read, J., Mosher, L. R., & Bentall, R. P. (2004).
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Reviewed by **Kevin R. Ronan**

In psychological practice, practitioners delineate *what* is said by clients from *how* it is said. For example, in the traditional diagnosis of schizophrenia, a demarcation is made between the content and process of thought and speech. Similarly, in the book "Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia" edited by John Read, Loren Mosher, and Richard Bentall, what is said versus how it is said is worth considering.

What is being said in a number of places in the book is sound, evidence-based, and challenges comfortable notions about the traditional diagnostic category of schizophrenia and its utility in helping those with significant problems in living. The content of the book includes useful information that challenges the reader to consider problems in aetiology, classification, assessment and prognosis, and treatment. To highlight a noteworthy example, Chapter 5 authored by the senior editor, John Read (titled "Does schizophrenia exist (sic: should there be a ? here): Reliability and validity") discusses the diagnostic heterogeneity problem that those of us who have worked in this area would immediately recognise. As Read points out, the fact of the matter is that schizophrenia lacks diagnostic and prognostic reliability. In fact, there is a great amount of variability in outcomes that has been demonstrated in a number of studies done over the past 30 or so years. In addition, a number of more specific demographic and psychosocial factors have been found to be more reliable predictors of longer-term outcomes than subtypes or the diagnosis itself. For example, having good pre-morbid adjustment (e.g., social skills) is one prominent predictor of outcomes.

Interestingly, as pointed out at the end of a section titled "Prognosis", research is cited that has unexpectedly, but consistently, found that outcomes for people diagnosed with schizophrenia have been worse in more developed countries (Sartorius, Gulbinat, Harrison, Laska, & Siegel et al, 1996):

> "An unexpected finding of the International Pilot Study of Schizophrenia, launched by the World Health Organization (WHO) in 1967, was that patients in countries outside Europe and the United States have a more favourable short- and medium-term course of the disease than those seen in developed countries." (p. 249)

This particular group of researchers affiliated with the WHO found a similar pattern of outcome findings related to geographic heterogeneity (i.e., outcomes in industrialised countries tend to be worse) in looking at 15- and 25-year outcomes (Harrison et al., 2001). More fundamentally, these researchers made some conclusions that go to the heart of the book's main thrust (Harrison et al., 2001):

> "15- and 25-yr ... trajectory ...assessments of course and outcome were completed. About 50% of surviving cases had favourable outcomes..." (p. 506). These authors go on to report that even in cases considered chronic that "16% of early unremitting cases achieved late-phase recovery" (p. 506).

Read himself goes on to quote these authors who rendered the following conclusion: "The ISoS (i.e., International Study of Schizophrenia) joins others in relieving patients, carers and clinicians of the chronicity paradigm which dominated thinking throughout much of the 20th century." (p. 513).

After describing such problems with prognosis and classification, the chapter begins to introduce alternatives in the last main section. It describes briefly the potential of evidence-based classification as a useful alternative to the current DSM subtypes. These include a two-factor model consisting of positive versus negative symptom clusters and further subdivisions (i.e., three through seven factor models have been identified).

Further, at the end of that particular subsection (titled "Reliable constructs"), Read also points out: "Constructs like hallucinations and delusions can themselves be broken down into clinically valuable and highly reliable dimensional variables such as duration, intensity, frequency, conviction, disruption and distress" (p. 52).

In the next section ("Dimensions"), Read goes on to elaborate briefly on the value of a dimensional approach and includes a limited review of supportive research. Nevertheless, while the section is quite brief, it does speak to (suggest? identify?) useful alternatives to the identified problems in classification and prognosis.

This and other chapters provide similarly useful content in helping to challenge the notion that the current understanding of schizophrenia [repetition of useful] actually helps those with significant problems in living, whether they are experiencing the positive/disorganised cluster(s) of symptoms (i.e., hallucinations,

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delusions, disorganised thought, affect, behaviour), the negative symptom cluster (e.g., withdrawal, apparent apathy), or a combination of features. In other words, the content in a number of portions of the book reflects well on the science (e.g., chapter on the cognitive psychology of hallucinations and delusions; chapter on intervention for first-episode psychosis; a number of other chapters) and, consequently, appears to be a harbinger for future research and practice trends. On the other hand, at the beginning and in some chapters in the book, some of the points made at times are presented not in a strictly sober, scholarly fashion but rather through the use of a different strategy. The overarching foundation for the tone of the book appears to be provided in the Preface and first chapter, respectively:

> "The purpose of all of these seemingly endless hours (of writing and editing a book) is to try and weaken the awful stranglehold that simplistic biological ideology has in the world of mental health, so that the thousands of people around the world trying to use their humanness to reach out, in the face of madness, to the humanness of others might be valued and nurtured in their work, rather than marginalized or scorned." (p. xviii)

and

> "For our part, we have gathered together the research evidence that can be presented, in that struggle, to those whose minds are not forever closed to the rather simple ideas that human misery is largely inflicted by other people and that the solutions are best based on human – rather than chemical or electrical – interventions." (p. 5)

The strategy itself appears to be at least partially documented in the following passage, after pointing out other similar efforts at a "wake up" call have been made over time:

> "Our own contribution is partly an updating of the evidence, partly a resurrection of forgotten or taboo research findings, and partly an introducing of newer approaches[1] ...It is also a straightforward, unashamed wake-up call. Everyone should act, in whatever way your circumstances allow, to end this madness." (p. 5)

A similar use of language underlies a number of chapters. Such a strategy may well be convincing to some readers. As a case in point, a recent review of the book by a psychiatrist notes:

> "This is mandatory reading for all psychiatrists. It shakes many of the shibboleths of psychiatry and does so with some sound science. Its purpose is to undermine the biogenetic paradigm of schizophrenia and this end is pursued relentlessly, beginning with a thorough critique of the original Kraepelinian formulation, moving through the twin studies and then the neuroanatomical and neurophysiological evidence." (Quadrio, 2005; p. 428)

On the other hand, the book's tone might not be as convincing to others, or perhaps even off-putting. Another review of this book (Merskey, 2005), after quoting a passage from the book, states:

> "As can be recognized from the tone of this quotation, the authors generally consider that psychiatry as practiced in the developed world is much in need of correction, or perhaps therapy if the practitioners were not so incorrigible ... (the book) deals with many issues and the points made here may seem small individually, although some are large in consequence. However, they tend to show the careless abandon with which this book makes some of its claims on items that the authors fancy will suit them." (p. 597)

Whether such a tone is convincing or off-putting may depend on the reader's predilections for reading scholarly or clinically focused material. The book's reception may well also depend on where the reader stands in terms of favouring the ideas and the research presented in the text or whether these ideas, and the manner in which they are at times presented, run counter to prevailing, and perhaps strongly held, convictions.

Given that I favour incorporating science into our practice and to many of the main tenets of this book, my own preference would have been to read a more widely authored, systematically presented, and sober dismantling of current models. In addition, given the array of topics presented, a summary chapter in particular might have served a useful wrap-up function. Nevertheless, a number of the fundamental points in this book – particularly those that are supported by sound science – do invite a wake up call to those who will take the time to read and consider them.

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Notes

[1] They cite here as examples, the role of child abuse and cognitive psychology and document how biological beliefs can increase stigma.

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