Reversing the panopticon: On narrative therapy and its place in the treatment of eating disorders

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Megan Buys

Dear Reader,

In deciding how to structure this piece, a piece that I am obviously passionate about, I realised I needed a way to convey this passion yet also remain on course with my argument and the ideas I want to share with you. At first, I decided to write you a letter, as you are reading now. My travels with writing therapeutic letters uncovered their intent: they help their authors to “re-remember” preferred aspects of self that may be, or once have been, entrenched in professional discourse (Madigan, 2011, p. 338). I would like to share with you a quote from Stephen Madigan (2011) that invited me to reflect further about re-remembering the (my, our) self: “What stood out . . . was the dramatic way problems, and the professional discourse supporting the problems, had convinced persons to remember to forget anything worthy, trustworthy or valued in themselves” (p. 339).

Meditating on Madigan’s notes on therapeutic letter campaigns, I shifted my initial idea towards something more introspective. In order to push for a re-remembering and “re-membering” (p. 339) of the importance of narrative therapy principles within the therapy room, I realised what I actually needed to do is write a letter to myself. Specifically, my younger self, who once unknowingly leaned on these principles of narrative therapy to pull herself out of a place that others—primarily, the predominant clinical psychology and health care system—kept her in. My younger self, without being fully aware of it, removed the decided-for anorexic and bulimic label out of her little body, placed it in front of her, and chose to have a discussion. She chose to write a new story. Now, in my letter to you, Reader, I give you a letter to myself: a story of reversing the panopticon that was once built around me. In doing so, I convey a very personal account of the breadth of importance that narrative principles have in, and out, of the therapy room. However, before I begin, I ask you to consider one thing: I am aware that this is an unconventional format. Though in saying this, I would argue that narrative therapy and the poststructural Foucauldian bed it lies upon, is anything but conventional.

Noticing the Invisible: An Introduction

Dear Megan,

It's so good to write to you again. I'm currently reflecting on our relationship over the past years, in a hope to re-document it as a written piece, rather than only fluid and formless stories in my head, or those we used to speak out aloud on our bushwalks. Someone I admire, David Epston (1994), once wrote, "Conversation is, by its very nature, ephemeral . . . But the words in a letter don't fade . . . they endure through time and space, bearing witness to the work of therapy and immortalizing it." (p. 31). Megan, I'd like, with your permission (yes—you have my permission), to recount our story together in a time-lined fashion that utilises both my voice (present you) and your voice (past me). I'd like to hear how you interpreted the events we lived through and how you felt at the time, because, after all, we are co-authors in this.

In their seminal work, Narrative Means to Therapeutic Ends, *White and Epston (1990) asked "How can we enable the writing of personal and collective stories that liberate and heal when the dominant stories are so problem-saturated?" (p. xi). Two decades later, in the prologue of* Narrative Practice: Continuing the Conversations, *Epston writes of his colleague, the late Michael White: "You 'played' with problems instead of being haunted by them; you knocked them off the security of their perches" (White, 2011, p. 35). This statement is the answer to the former question. Holding the importance of rewriting personal and dominant narratives in mind, narrative therapy recognises the fundamental significance of narrative in the understanding of power, and onward, towards the reclamation of power through story. Narrative therapy achieves this through its acknowledgement of the client's ability to author their personal narrative to be one that highlights empowerment rather than the continued entrapment of problem saturation, doing so through the separation of the person from the Problem (Guilfoyle, 2014; Payne, 2006).*

I explore this reclamation of power, inclusive of my own power, through Michel Foucault's (1975/2007) metaphor of the panopticon. Based on Bentham's design of a circular prison with a single, central watchtower, with prisoners unaware of whether they are being viewed in their cells, the panopticon is a mechanism of control achieved by the threat of permanent visibility to an "authority" that eventuates in self-subjugation, even if the authority ceases to exist (Foucault, 1975/2007). Epston and White (1992) utilise the Foucauldian metaphor of the panopticon at length in their discussions on narrative therapy, exposing the localised, everyday practices of power that can be described by illustrating what a panopticon is and how it effectively centralises and manifests invisible threat and control. Considering this idea, I propose narrative therapy to be a reversal of the panopticon's process: a tool used to separate oneself from one's perceived entrapment, and to discover a route of exit. Foremost, this paper encompasses my personal experience with narrative therapy as a tool in my own empowerment. Parallel to this journey, I propose that the politically and socially informed philosophical underpinnings of narrative therapy are necessary in the counselling profession. I highlight the radical contributions the practice modality has made to the field of counselling through the therapeutic relationship as one that, beyond all else, enables the client to reconnect with a greater sense of their own agency and by extension, power.

The Prisoner: My Personal Panopticon

I remember you describing a scene to me once. A moment that we later decided to describe as "The Stickiness". Before The Stickiness came and stuck to you—since we both agreed that you did not invent these problems, rather you were "recruited into actions and ways of thinking that create[d these] problems" (Combs & Freedman, 2012, p. 1034)—you never once believed you were anything other than a normal, fun, slim, pretty girl who loved her freckles and her hair when you cut it into a fringe at the age of 14. But then, in what seemed to be a matter of minutes, something different happened, something unusual, though from what we can see now, something not surprising. You had already felt the quicksand form underneath you for some time. The characters you idolised seemed to know things you wanted to know. Some girls in the older years at school spoke differently, looked different. So did the girls you spoke with online. The pictures you re-blogged on your online diary were already changing from colour to black and white. The drive to change, to be like one of these girls, was what The Stickiness was. You once wrote to me, "Like treacle, like tar, something took a hold over me that felt inescapable. From the moment I saw what I could be capable of doing, I knew I needed to get there". In that moment, something walked you to the bathroom, and without your fingers or the handle of a toothbrush (all techniques these online friends spoke about), just the constant upward heave of your diaphragm, you vomited up your entire dinner for the first time.

Foucault's (1975/2007) notion of the medical panopticon and the discursive power surrounding eating disorder "patients" is well accounted for by later scholars (Bell, 2006, 2009; Lester, 1997; Lock et al., 2005; Malson, 1998). However, few acknowledge the constructive and resistive nature of anorexic patients under classical medical care: systems that allow patients to continue their anorexic practices through the deceit of their medical carers (Boero & Pascoe, 2012; Boughtwood & Halse, 2010; Segal, 2013). The performative aspects of identifying as the "perfect patient" (p. 86) that Boughtwood and Halse (2010) uncover in their interviews with young female inpatients diagnosed with anorexia, I argue, is a tool for regaining personal power, yet the epitome of panopticonic influence. Narrative therapy's recognition of power, and the regaining of power through self-authoring and acknowledgement of one's own expertise (Weber et al., 2006), was the liberation from *my* personal experience with the above-mentioned context. Here, I wish to account for two significant nodal points in my life where I have felt the deeply helpful effects of narrative therapy, which birthed my interest and appreciation for the school: first, during my teenagehood experiences of disordered eating, and second, during my diaspora from my given diagnosis, informed by self-led education on narrative therapy. The former event provided a visceral experience of how a prisoner in a panopticon would establish their own subjugation, and the latter provided a language I could use to describe this experience, which allowed for a way out.

White and Epston (1990) argue that anorexia and bulimia reflect the pinnacle of the panopticon's purpose: the forging of "docile bodies" (p. 67) due to the incorporated threat of surveillance. I feel myself to be an example of this notion. The culture I was a part of,

one that consisted of a media environment saturated with the romanticisation and sexualisation of mental health disorders—appropriately expressed by Berridge (2013), Boero and Pascoe (2012), Burke (2009), Seko and Lewis (2018), and Shrestha (2018)—led me to construct my identity *and* body as a living portrait of the fragile, broken, mysterious girl, eventuating in the diagnosis of anorexia and bulimia nervosa. The real surveillance from psychologists, psychiatrists, dieticians, teachers, and my parents only heightened this construction because it allowed me to prove my subjugation to the invisible surveillance of the media context that I believed was monitoring me. It was only through stepping away from the dominant discourse of the mental health care system, through my personal research on narrative therapy, that I was able to sever myself from my attachment to the diagnosis and see my context as the Problem. Particularly, I learned to "privilege the voice" (White, 2011, p. 52) that no longer wanted to maintain the diagnosis of anorexia and script an alternative narrative that placed myself as the expert protagonist. Later, as a university student, I found the writings of Foucault allowed me to funnel my introspection into a clearer narrative that explored myself as a previous victim to the dominant narrative of this particular media culture, as well as the panopticonic mental health care provisions I was subjected to. From a personal standpoint, narrative therapy opposed this limiting, patronising, and victimising view of my mental "illness", and by siding with this opposition, I felt a sense of power return.

Exposing the Prison Cell: Understanding Narrative Therapy

There were many moments you've pointed out to me as being important for you in the timeline of this story we are telling. One, however, seemed always to come up. While our view of this moment brings strong feelings of sadness yoked with a flood of care, we also realised that these feelings were always there, even as the moment unfolded. Did you want to talk about this moment, Megan?

I remember the tiles of the bathroom feeling too cold. I couldn't seem to find warmth anywhere by this point, even if I curled myself up an inch away from the heater grates at night. The tiles feel too cold. But I couldn't seem to get up. This is it, isn't it? I remember thinking. This is really it. I'm in it. I did it. Just three more times and then I can get up. Just vomit into the drain three more times. Too cold. Just three. Too cold. I felt consciousness slowly slip away from me, as if my whole body was slipping into the drain. I wished it could. This was it, I thought. I did it. I didn't have to try anymore. I had officially reached full-blown eating disorder status, and I no longer had a choice in the matter.

The philosophical foundations of narrative therapy are mapped from poststructuralist philosophy and the linguistic turn of the early 20th century—the movement away from object-focused discussion to a focus on language as a representational system (Besley, 2002). In particular, narrative therapy's founders, White and Epson (1990), drew heavily on the work of poststructuralist philosopher Michel Foucault. Foucault's (1975/2007) ideas on truth, knowledge, and power capture the political essence of social constructivism through the way power is given to constructed ideas that are "accorded a truth status" (White & Epston, 1990, p. 72), which in turn give rise to societal norms. White and Epston

(1990) explored “truth claims” (p. 20) as existing on an individual level also. Here, narrative therapy proposes that the story we assign as truth is the story that holds power over our lives, one that injects a certain meaning to our experiences and behavioural patterns (Hahs & Colic, 2010). In addition, White and Epston (1990) draw from linguist Gregory Bateson who proposes that our understanding of an event can only exist through the context we assign it, as a map, rather than the territory. Since language ascribes context, it is through language that we give rise to dominant stories, and by extension, how we frame and assume our identity (Besley, 2002). Narrative therapy utilises these notions to allow the client to understand the dominant narrative of their lives and identity, alongside offering an alternative truth that places the individual as the protagonist, rather than a prisoner (White & Epston, 1990).

Narrative therapy was born not from psychological discourse, but rather exists as a “postpsychological” (McLeod, 2006, p. 201) alternative to the empiricist health care system that continues to dominate. This can be epitomised in narrative therapy’s separation of the Problem from the person through externalising conversations (Epston & White, 1992). In what Lock and colleagues (2005) describe as going “against the grain” (p. 315) of the dominant discourse of the Western psychotherapeutic field, narrative therapy disentangles the person from their diagnostic label, allowing the Problem to become tangible, bounded, and no longer all-pervasive (White, 2011). Narrative therapy’s non-pathologising approach offers the client a form of power that may have been lost or removed from them by their own prior narratives, their social context, or the dominant diagnostic-based system of clinical psychology and the Western medical model. Exemplifying the poststructuralist thought it frames itself from, narrative therapy offers a “constitutionalist” (Epston & White, 1992, p. 122) perspective to the field of counselling by existing as an alternative for clients who wish to move away from the predominant model described above. By extension, narrative therapy was developed with the understanding of the effects language and power have on the role of the therapist (White & Epston, 1990). Decentring the knowledge of the therapist and placing this expertise back with the client, allowing the client to author their own narrative, and dismantling the problem-saturated norm are all revolutionary contributions to the field of psychotherapy and mental health care. Epston and White (1992) argue for the unmasking of such subtle forms of power relations, for example, that of the expert clinician and ignorant patient. Through this unmasking—or “deconstruction” (Epston & White, 1992, p. 21)—it becomes possible for the client to re-examine and oppose these relations. Therefore, to reverse the panopticon, one must first expose the prison cell.

Holding the Keys: Narrative and the Client–Therapist Relationship

The goal had always been to be hospitalised, you told me. Although we both knew that we would never let this happen, there was still a feeling of failure present when you spoke to girls you knew who were. You had a friend you met online with whom you would text lists of what you each ate that day. You had pictures of girls with nasal feeding tubes and IV drips collaged in your online diary. You also had a team of medical professionals around you who kept you in check. Every new GP, dietician, psychiatrist, psychologist,

and eating disorder group coordinator you saw was just reinforcement. There was always a part of you who knew this wasn't right, and yet so many people, in different ways, told you it was. You were put on Zoloft, Seroquel, and the Pill from a psychiatrist who looked at your mother with an all-knowing smirk and said, "This is nothing, this will last 18 months". You sat in front of psychologists who printed you another worksheet on breathing and asked you to identify your unreasonable catastrophising, as if the sudden but so acutely planned slip of a knife to your skin wasn't a catastrophe. You stripped your clothes off in front of a dietician who, when you mentioned you had eaten a Mars Bar, said that wasn't "common anorexic behaviour". Next weighing session you lost 2 kg. No one ever asked what it was that you wanted, did they?

The client–therapist relationship in narrative therapy centres on the acknowledgement of the client's ability to author their own narrative (Lock et al., 2005; White, 2011; White & Epston, 1990). Primarily, it involves appreciating the client is the expert of their own context, and the therapist co-author rather than an authoritative figure or distant analyst. From here, the collaborative relationship between the client and therapist can be understood as the first invitation out of the client's perceived panopticon. By helping the client to identify and name the problem, the narrative therapist alleviates a level of prisonership, walking with them out of the incorporated subjugation that comes from identifying oneself *as* the Problem. Further, to be constantly associated with "normalis[ed] judgment" (White & Epston, 1990, p. 70) of one's diagnosis/label/Problem creates a toroidal, interpellation-like integration of the projected Problem. White and Epston (1990) describe narrative therapy's emphasis on externalising the problem as a "counter-practice" (p. 66) to the problem-saturated culture that dominates. The client–therapist relationship embodies this practice. Maintaining the position of a non-pathologising, curious, celebratory co-author is the foundation in assisting the client to inhabit their new, empowered narrative in protest of the victimising and subjugating narrative that may have existed before (Carr, 1998; Lock et al., 2005; Wade, 1997; White & Epston, 1990). Narrative therapy views people as "unique histories" (Polkinghorne, 2004, p. 53). Since the school's foundations lie in social justice and the Foucauldian notion of modern power —holding the assumptions that cultural narratives and social discourse most influence how a person shapes their identity, that narrative creates meaning, and that the individual is always separate from the Problem—narrative therapy as a philosophy and practice is inherently sensitive to client diversity (Combs & Freedman, 2012; Payne, 2006). On these assumptions rests the practice of reinstating personal agency and innate strengths that exist as "pre-existing abilities" (Wade, 1997, p. 24) within the client, rather than continuing to tread in a narrative that is no longer beneficial. By separating the person from the Problem, the ignition of personal agency may also include the removal of a diagnostic label from the client. Thus, the school directly deconstructs and subverts the dominant discourse that Doan (1997) labels the "Grand Narrative" (p. 191) of mental health care. The grand narrative Doan describes can be viewed as a panopticon in itself because of the interpellation-like nature of consistent, disadvantageous labelling. While the narrative therapist deeply acknowledges the existence of marginalising and maladaptive

discourses in society, they become a partner in resistance and protest against this panopticon (Wade, 1997) and shape an exit route through the creation of space for the client to celebrate their uniqueness and establish their preferred stories.

Walking Out: Critiques and Responses

But you did get up off the bathroom floor, Megan. You got up because you realised you did have a choice in the matter. You told me that you once wanted all the doctors and professionals you met to tell you that you were sick, in order to prove to yourself you were. And they did. But you don't think that's true anymore. You just never heard anyone say anything else about you. And when you hear something so much, so often, you begin to believe it, to embody it. Slowly, very slowly, you decided to hear something different. Maybe it was the fact that the online diary and "followers" you had were forcibly deleted. Maybe it was because the friends you had at school didn't want to be around you anymore. Maybe it was because the 10 sessions you had bulk-billed with a psychologist ran out, or that you stopped taking the medication the psychiatrist prescribed you as it took all your personality away, even the parts you loved. Maybe, in place of all these things, you had the time to walk through the bush down the road from your house and speak your story out to yourself to understand. You wrote it all out. You spread a piece of butcher's paper over your desk and mapped it out. You decided to build something different.

Contemporary philosopher Slavoj Žižek (2006) exclaims "we 'feel free' because we lack the very language to articulate our unfreedom" (p. 142). Herein lies the primary critique of narrative therapy, and of poststructural thought as a whole: that by acknowledging language as that which defines us, we must also acknowledge it is language that holds this definition hostage. By extension, postmodern therapies such as narrative therapy have been critiqued for being relativist to the point of reductionism (Held, 1995; Skovlund, 2011; Xu, 2010). While it can be argued that the systems of oppression present in our society are also products of language, by doubling back on Žižek's (2006) claim, these rhizomatic systems remain beyond the client's ability to single-handedly change: we continue to remain hostage. However, narrative therapy rests on the separation of the person from the Problem, as well as the deconstruction and externalisation of dominant oppressive discourse, a practice that seeks to provide empowerment for the client. Thus, a versed narrative therapist holds a broad view of the universal panopticon of power systems—those that may never be truly escapable—while also assisting the client to disentangle themselves from the grasp of their *own* prisonership and begin to walk out freely.

Looking Back: Concluding Remarks

Looking back, what we did together was offer a space for a new story to be written. Specifically, every chance we had, we created a "definitional ceremony" (White, 2007, p. 165) in order to re-remember, re-member, and re-build Megan in her preferred narrative, rather than defer to the multitude of definitions, diagnoses, and thin descriptions from the

normalising "gaze of society" (Harper & Spellman, 2013, p. 103). Megan was never the Problem. But neither were the eating disorders or self-harm. Those things were the walls of your—my—panopticon. Those things you could see and touch. You could smell the wetness of the bricks that were built around me, but who built them? Who formed those walls? Who was this invisible guard watching me? Whoever it was, they were the Problem. Once I realised this, I was able to walk out.

Narrative therapy's power lies in its ability to deconstruct the individual's panopticon. Yet, more globally, it also pursues the dismantling of the broader panopticon that includes the contemporaneous mental health care system and its place within the dominant, power-driven discourse of modern Western society. This seems an impossible problem, since we as therapists must place our stance firmly in both worlds, remaining a part of the panopticon (as mental health care providers) yet seeking to critique it. Narrative therapy offers us an answer. As Swan (1999) states, narrative therapy can "achieve the elusive end of politicising the personal" (p. 113). To elicit positive change in our clients, we must be aware not only of our clients' stories but also the subtle, more dynamic narratives that percolate within societies and cultures, narratives that may unknowingly have their grasp on our personhoods. In doing so, we give expression to our *own* power and foster our ability to regain a secure position on our *own* perch, rather than remain prisoners.

Yours in curiosity,
Megan

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