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Below is a part of a paper and a version of the paper we published in *The Reflecting Team in Action*, Guilford Publications. Its title:

From "Spy-chiatric Gaze" to Communities of Concern: From Professional Monologue to Dialogue

Neutral dictionary definitions of the words of a language ensure their common features and guarantee that all speakers of a given language will understand one another, but the use of words in live speech communication is always individual and contextual. (Bakhtin, 1986, pp 88.)

Therapy, like politics, has always rested on the construction and maintenance of social reality. Until recently, therapists practiced in accordance with a set of enduring or given "truths." Unfortunately, these "truths" acted to conceal and support our monopolistic ambitions to control information on what constitutes right and wrong, normal and abnormal. The purpose of this chapter is to argue for "alternative knowledges" (Foucault, 1980) that derive from those populations most excluded from power (e.g., inmates, psychiatric residents etc). Our intent is to widen the frame of certain therapeutic traditions regarding the utilization of client knowledges and to increase the possibilities of utilizing these knowledges.

Our chapter proposes "*communities of concern*" as a means of re-visioning our relationships with people who seek our help. We substitute such "communities" for the exclusionary professional other and the degrading practices that seem associated. From our point of view, reflecting team practice (Andersen, 1987; Lax, 1991; Madigan, 1992a; White, 1995) exemplifies such communities of concern. Our hope in this chapter is to extend the reflecting team idea into areas of (co)research and political action.

Specifically, the chapter illustrates the practice of circulating client's local knowledges through the establishment of Leagues, letter-writing campaigns, and co-researching practices.

A Looking Glass History

Since the early 1700's, the deep problems of human concern have been assumed to be the monopoly of a range of health professionals. Therapeutic practice was managed through agreed upon structural, temporal, and ideological tenets. Therapeutic tenets dictated how therapy would be carried out, who would be involved, what information was relevant, how long therapy would take, what constituted a "cure," and so forth. Tenets of therapy were secured through hard fought struggles at academic, professional, and government levels. Tenets were mediated through policy guidelines that dictated appropriate practice procedure.

Since the 1700's, not much has changed. What gets to be said, and with what authority, is not viewed within the landscape of the excluded others' *story-telling rights* (Law & Madigan, 1994). How the problem is defined, who will be involved in the solution of the problem, and how much time is necessary to create change are considered the prerogative of the professional person.

Traditionally, the ideology of professional practice viewed clients/ patients as not having expertise in their own lives (Foucault, 1982). Often the existence of a problem is used as *prime facie* evidence to support such a claim. Health professionals viewed themselves as having "expert knowledge" and spoke openly of this knowledge with colleagues but not with clients. This expert knowledge marked the health professional off as the "observer" and distinguished her/him from the "other." In fact, the positivist methodologies that undergirded expert knowledge required separation of the observer from the "observed other," in what Joan Campbell refers to as "the watchers and the watched" (personal communication, Auckland, July, 1994).

Client observation has long been a practice of psychiatry, psychology, and family therapy. From behind one-way mirrors, the family therapy "eye" expanded to a four-by-six-foot gaze. This provided family therapists with a new eminence that they hoped would make them pre-eminent among their mental health colleagues as looking-glass heroes/heroines. Concealed and quite often anonymous, the behind-the-scenes team offered up ingenious hypotheses and interventions by telephone or in written summaries. Their comments were usually interpretive and strategic in origin as demonstrated by the work of the Mental Research Institute and Milan-style "teams."

The negative reactions of many families to these "gazing" practices often went unheeded because negative reactions were often interpreted as signs of perturbation, something that was unequivocally viewed as heralding change. However, both preceding and in the wake of reflecting team practices, questions were being asked as to whose benefit the therapeutic gazing ritual was structured for (Madigan, 1991b, 1995, in press), and, concern was expressed for "some of the clinical, political, and ethical dilemmas of different ways of reviewing and using one-way screens" (Young, 1989).

Postmodernism, feminism, and social constructionism called for a reconsideration of our structuralist and functionalist traditions (see White and Epston, 1990), as was the case in the social sciences at large. Alongside this discussion, the "other" began to talk back. Anna Yeatman (1994) suggests; many and maybe most commentators agree that [postmodernism] represents a crisis of authority for the western knowing subject, posed by the refusal to stay silenced on the part of those whom this subject had cast as other: natives, colonials, women and all who are placed in a client relationship to expert, professional authority. By insisting on their own voice and status as subjects, these erstwhile objects of modern western knowledge, have disrupted the epistemological order of domination inscribed within modern, western knowledge (p. 27)

The professional field of family therapy has begun to (re)view the tenets that long dictated the course of what we understood to be family therapy. Therapeutic ideas and therapy practice have begun the painful shift from being viewed as entitled truths to social constructions (Gergen & Shotter, 1989). Who constitutes the self, the status of therapeutic objectivity, structures, and discourse came under revision, and has been replaced by co-authoring (Epston & White, 1989), the decentering of the subject (Elliott, 1994; Madigan, 1991a; Sampson, 1989), the cultural effects on problem maintenance (White, 1995; Waldegrave, 1990), and therapist transparency (Epston & White, 1990).

It was through the introduction of reflecting teams that therapists began to oblige themselves to make their opinions visible and audible, and by the same token, accountable and contestable. Liberated from the distant security of the one-way screen, reflecting-team members joined with families they observed and sat in observation of their own comments. Having forsaken any allegiance to grand traditions of "truth," they felt entitled to offer up a "smorgasbord" of ideas and not correct interpretations. They suggested points of view, "not as rigid explanations but as tentative thoughts" (Lax, 1991). Clients were offered a chance to talk back, interrogate, question, and reflect back to therapists their thoughts about the therapist's thoughts. Within this recursive conversation, clients were intended a different status; one of inclusion and equity. It is here that the professional monologue that Foucault has referred to, was substituted for communities of dialogue; a process of talking with rather than talking to. Foucault (1984) writes:

In the serene world of mental illness, modern man [sic] no longer communicates with the madman [sic]: on the one hand, the man [sic] of reason delegates the physician to madness, thereby authorizing a relation through the abstract universality of disease; on the other hand, a man [sic] of madness communicates with society only by intermediary of an equally abstract reason which is order, physical or moral restraint, the anonymous pressure of the group, the requirements of conformity. As for a common language, there is no such thing any longer: the constitution of madness as mental illness, at the end of the

eighteenth century, affords the evidence of a broken dialogue, posits the separation of the already effected and thrusts into the oblivion all those stammered, imperfed words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is monologue of reason about madness, has been established on the basis of such silence. (pp. xii and xiii)

Through reflecting teams, clients participated as partners to the dialogue, co-constructing the very terms and language of the therapy, thereby receiving a chance to be directly involved in co-constructing the language of their own change. Epston and White (1990), found Myerhoff's (1982) "definitional ceremonies" as apt descriptions of these communities of concern in the manner in which they performed their knowledges and their re-descriptions of themselves as persons and families and therapists. They view the performance of reflecting teams as "celebrations of re-definition" which highlight and bring forth previously restrained solution knowledges.

The purpose for the establishment of ideas such as Leagues, letter-writing campaigns, and co-research projects involve the further circulation of "local knowledges" around problems to those not in attendance and can considerably widen the scale of operation. These communities of concern might be considered "*virtual communities*."

The voice of the client and their family is privileged in these communities of concern as the means to therapeutic ends. These communities may very well extend their activities from a concern to more organized co-research, or in the case of the Anti-anorexia/Anti-bulimia League to frank political activism on behalf of its membership and others.

Narrative Ideology and Practice

Leagues, letter-writing campaigns, and co-research are situated in a narrative ideology that acts "as if" it were true that the problem is the problem rather than the person is the problem (Epston & White, 1990; Madigan, 1992b; Roth & Epston, in press; White, 1995). These practices challenge both therapist and client to revise their relative positioning to, and beliefs about, knowing and not knowing about problems. Briefly, narrative ideas are situated in a therapeutic context that does the following:

1. Privileges the person's lived experience;
2. Encourages a perception that change is always possible and occurring through linking lived experience across the temporal dimension;
3. Encourages multiple perspectives and acts to deconstruct claims of expert knowledge;
4. Encourages the carnival of possible futures through the re-construction and re-remembering of alternative stories;
5. Invites a reflexive posture and demands that therapists be accountable for their therapeutic stance;
6. Acknowledges that stories are co-produced and endeavors to make the clients the privileged authors of their own experiences;
7. Believes that persons are multi-storied;

Leagues

During the early 1980s' my coauthor (DE) began to circulate his client's knowledges to others who were still trapped within the confines of particular problem lifestyles. He collected his client wisdom in what he called an 'archive'. The archive contained an assortment of audiotapes, letter writings, and artwork that represented a rich supply of solutions to an assortment of long-standing problems such as temper taming, night fears, school refusing, asthma, and, of course, anorexia and bulimia. He came to redefine his clients' knowledge as expert knowledge.

He was able to patch together a network of clients with the purpose of consultation, information, and mutual support. He called these client networks Leagues. As the Leagues grew, he realized that he had ready access to a wealth of consultants. His clients became his colleagues. The archive is now a vast offertory shared by David around the world.

Leagues are a gathering of persons who have a desire to protest the effects of a particular problem on people's lives. The membership constituency usually involves a majority of clients, mixed with an assortment of therapists, family members, friends, teachers, journalists, and community activists. They are structured in similar ways to many other grassroots political organizations, such as Youth against Violence Committee, or Doctors for Peace Group. A League's focus is directed toward combating a particular identified problem (e.g. fear and perfection training) and the structures that support the problem.

Leagues allow for the distribution of client knowledge from one client to another. In addition, they often voice strong opposition to those cultural and professional institutions that are problem supporting. A League's mandate acts to undo the knotted dichotomy of difference, distance, and status presently wedged between therapists and clients. Leagues can be seen as another step in stretching the ideas of transparency and reflecting teams into the community.

The Anti-anorexia/Anti-bulimia League

The Anti-anorexia/Anti-bulimia League encourages a different kind of self-directed 're-discovery' and encourages persons to retrieve, and reflect upon, what lies hidden in the wings of their imaginations. Members of the League realize their ideas represent the tip of an untapped therapeutic iceberg. To assist the readers of this chapter, David compiled a series of written questions about the League's history and membership involvement. Vancouver Anti-anorexia/bulimia League members - Jennifer and Lisa, volunteered to co-research and present the idea of their Anti- anorexia/bulimia League.

Lisa's co-research

David: How did you think professionals regarded the problem of anorexia and bulimia?

Lisa: I think that, generally, "professionals" regard the problem of those afflicted.

David: Who do you think they thought had the problem?

Lisa: It was the person, not the "eating disorder" that was the problem!

David: Where was the problem located?

Lisa: Before hearing about the League, I was strongly indoctrinated with the belief that anorexia was a deeply rooted and integral part of me, and that without it I would in fact lose parts of my own self anorexia/bulimia? anorexia/bulimia as a part of

David: How do you recall first becoming aware of the League in the context of your "treatment"?

Lisa: Oh God! When I first heard about the League I was involved in a transition group through a hospital youth clinic. Let's just say that, at that point, having been given a rather biased opinion of the League by the staff, I was not exactly in favor of its principles.

David: Did your impressions change over time?

Lisa: Yeah, my impressions have changed and continue to change over time. I think most often my impressions change according to how I feel about myself; when I am feeling strong my impressions of the League's activities in anti-anorexia are very strong and that everything is going to work out. When I am feeling fragile the voice of anorexia says "it sounds good in theory but in practice it is wrong". I think people supporting one another is a great idea, and living by the principles of the Anti-anorexia League is much easier doing it alongside other people than doing it on your own. Being part of the League, and seeing it begin to get together has been a great help to me and has the potential to help a lot of other people.

David: Did the league offer you anything different from the other forms of "treatment" you had undergone in the past or were undergoing?

Lisa: Definitely! The League offers a reality that is not offered in therapy. Most often in therapy you are viewed as the problem; that something has to be fixed, that there is a wrong in your past that you have to overcome this or that. The League has a different view of the problem; that it is something that has visited upon you, that you don't need it to live. In the past, and especially at the youth clinic groups, I would be asked to "check in with my problem," but there was no action taken or offered to relieve anorexia. The League is different; it says okay this is the way that it was, and this is what anorexia has taken away from you, and these are the pro-anorexic parts of our society. We don't dwell on the horror stories, we just go from here by taking action against anorexia. I think for me that the only way to get free is by taking action against the problem of anorexia and those things that support its life. I think action is the only way to combat eating disorders and the League does this in a variety of ways.

David: Did you sense that this was somehow different than a conventional, run-of-the-mill support group?

Lisa: The difference between the League and your run-of-the-mill support groups and 12-step programs is that in these other groups there tends to be a lot of comparison, and story telling, and it is like these worst of the worst stories keep people there; and keep people feeling hopeless and horrible. The person who lost the most weight is the one to be most pitied and most envied! The support groups often just fed into anorexia by supporting ideas of specialness and perfection. However, the anti-anorexia/anti-bulimia League is supportive of the non-anorexic, non-bulimic steps the person has taken. This is really important and very different. The League's way of thinking needs more attention by other "professionals" and support groups. Also, the League moves within the realm of political activism and does something about it, not only in ourselves but in the realm of the society; changing society. When our anti-anorexia media campaign really gets off the ground I think there will be potential for an anti-anorexic/anti-bulimic revolution; I really do!

David: When did you feel that you started to have a "voice" in matters of your life and death?

Lisa: Recently I have come in contact with my own voice and not the voice of anorexia. For so long I believed that anorexia's voice was just who I was, and anorexia just told me what to do; other people believed this as well and helped anorexia along. Now I am able to stop and say NO to the anorexia. I feel that I have the power and the real desire to say no; this voice is not who I am, I want to have a life and I am going to!

David: When did you feel you were being attended to and taken seriously?

Lisa: I think only when a person begins to take Anti-anorexic steps will they begin to be taken seriously. I mean a person in a support group can tell you that they are doing fine, but you can see they are not. It is only when they begin to fight back can they be taken seriously, because all of us who have suffered through anorexia and bulimia are experts at saying one anti-anorexic thing and doing another anorexic thing. When you really begin to take back your voice everything changes.

David: In your experience of human associations is there anything about the League that is unique in your experience?

Lisa: I think what is exciting about the League in Vancouver, and that which makes it different to a team or club or a family, is that there are so many aspects of support to the League. There is the community-building aspect of it, there is the goal that we are doing something for the community aspect of it, and there is the not blaming the person aspect of it. What I like most about the League though, is that it has the potential to not only help people break free of anorexia and bulimia, but to be able to change the society little bit, by little bit. The League helps women claim back their voice to say, "No this is not acceptable." The advertising, the standards we are made to live up to in the media, what the media considers "normal" is not acceptable by the League. Our society that supports anorexic activity commits violence against women and their bodies and we in the League will not accept this. When people begin noticing our League banners, newsletters, T-shirts and stickers, there will be change and we will make a difference.

Jennifer's co-research

David: How did you think professionals regarded the problem of anorexia/bulimia?

Jennifer: I believe professionals have viewed anorexia and bulimia as a disease.

David: Where was the problem located?

Jennifer: I believe that if a professional was to point his or her finger at a spot where anorexia and bulimia is located in me they would point to my brain; they would say that the problem is located in the way I think. I, of course, would respond that the problem can not be removed from the context of history, society, and politics.

David: How do you recall first becoming aware of the League in the context of your "treatment"?

Jennifer: My impression of the League began somewhat negatively. **David:** Did your impressions change over time?

Jennifer: Gradually, I began to look forward to League meetings where I felt I had a voice and I was listened to. I also began to feel an immense relief from "guilt" which I had been carrying around with me. I began to recognize bulimia was not only what the medical model suggested [eg. distorted body image, relentless drive toward thinness]. I became aware that bulimia and anorexia had convinced me that I could not fight back.

David: Did the league offer you anything different from the other forms of "treatment" you had undergone in the past or were undergoing?

Jennifer: The League differs from the normative support group in that it calls on the so-called patient to be the expert. Family members are taught ways to fight anorexia and bulimia from League members themselves. The individual is empowered and encouraged not to be passive, victim or patient. Furthermore through externalizing the problem the League calls on ALL members to consider their values and to critically examine the society in which they are embedded.

David: What would you say to a person who asked, " isn't this just another kind of Alcoholics Anonymous", " another kind of 12-step recovery movement"

Jennifer: An anti-anorexia anti-bulimia League is entirely different from a 12-step recovery program.

While I want to fully recognize and respect those individuals who have attained a sense of "well being" via the 12-step program it doesn't fit for me. To me the 12-step process is about "letting go"; giving up control and finding peace. Philosophically different, the Anti-anorexia/Anti-bulimia League empowers the individual through externalizing the problem. Anorexia and bulimia are proposed as a separate entity in themselves which the non-patient, non-victim is fighting back against. The League's perspective also demands responsibility not only from society, community, and the immediate context, but from the individuals own resources. The League acknowledges and respects the power of the individual. It fights back against the problem.

Leagues utilize an "anti-language" for explaining their philosophy and ideological position (e.g. the Anti-depression and Anti-anxiety Leagues). In doing so League members act to externalize previously internalized problem discourse. For example, the Anti-anorexia/bulimia League utilizes an anti-language to:

1. Establish a context in which women taken by anorexia/bulimia experience themselves as separate to the problem.
2. View the person's body and relationships to others not as the problem; the problem is the (counters the effect of labeling, pathologizing, and totalizing descriptions.)
3. Enable people to work together to defeat the effects of the problem.
4. Consider the cultural practices of objectification used to objectify anorexia/bulimia instead of objectifying the woman as being anorexic/bulimic.
5. Externalizing of and objectification of the problem which challenges the individualizing techniques of scientific classification and looks at the broader context for a more complete problem description.
6. Externalization is achieved by introducing questions that encourage the persons taken by anorexia/bulimia to map the influence of the problem's devastating effects in their lives and relationships.
7. Externalizing by deconstructing the pathologizing "thingification" and objectification of women through problem challenging accepted social norms.
8. Externalizing thereby allowing for the possibility of multiple descriptions and re-storying by bringing forth alternative versions of a persons past, present, and future.

Currently the Vancouver Anti-anorexia/bulimia League works in conjunction with the League in New Zealand in establishing Anti-anorexic/bulimic networks of activity, through consultations with clients, families, and therapists residing in Australia, America, and Canada. Prior to joining the League, members have usually taken part in a variety of anti-anorexic/bulimic therapeutic activities such as individual, group, and multiple family group therapy from a narrative perspective.

The purpose of the League is to traverse the questionable ideological and fiscal gaps that lay within the traditional treatment terrain of mental health. The League promotes the idea of independence and self-sufficiency. Its playing field is twofold: 1) preventive education through a call for professional and community responsibility and 2) as an alternative and unconventional support system for those women caught between hospitals and community psychiatry.

Through regular meetings, League members, families, lovers, and friends often take a direct action approach to the problems of anorexia and bulimia. For example, through the development of a media watch committee it can act to publicly denounce "pro-anorexic/bulimic" activities against women's bodies through letters written to a wide variety of magazines, newspapers, and company presidents. This enables the League to possibly return the gaze through anti-anorexic/bulimic surveillance directed toward professional, educational, and consumer systems.

The school action committee has developed an Anti-anorexic/bulimic program for primary and secondary school students, however, they are finding out that diets and concerns with body specification is now the talk of toddlers as young as four.

League T-shirts have the words YOU ARE MORE THAN A BODY emblazoned across the back of them with the League name and logo printed on the front. They were a hot selling item throughout this last year.

Radical in its philosophy, the Vancouver Anti-anorexia/bulimia League's mandate is to hold accountable those professional and consumer systems that knowingly render women with "eating disorders" dependent and marginalized. Dependency and marginalization can occur through practices of pathological classification; long term hospitalization; medication; funding shortages; and messages of hopelessness, dysfunction, and blame.

The League's battle is to win the war being waged on women's bodies on both the professional and consumer front. Through the process of reclaiming their lives from anorexia and bulimia, League members refuse to accept the popular misconception that they alone are responsible for their so called eating disorders. League members are beginning to make a crucial shift in their identities from group therapy patients to community activists and consultants. In helping at the level of community they are assisting other women and families in turn are helping themselves.

Given the choice of utilizing a League member or another therapist for an anti-anorexic reflecting team, I (SM) would prefer, whenever possible, to access a League member. Clients are always struck by the members compassionate and direct reflections. It is now common practice for us to pay ex-clients and League members to act as consultants to therapists in training, and as reflecting team members.

Below is an excerpt from a videotape made by a League member for the explicit purpose of circulating her ideas in the training of therapists on what they might need to know when working with the problem of anorexia and bulimia.

Stephen: What do therapists need to know when working with persons taken by anorexia and bulimia?

Mellissa: Well, I guess that it's important that therapists know that anorexia and bulimia have to be dealt with on a number of different levels that you can't just focus in on the individual. What's happening for them or what's happening in the family or what's happening in the environment or society is all important together. You have to deal with it on all levels or else you're just dealing with just part of what the problem is and I think it'll always come back if you don't.

Stephen: Is there anything that you have discovered that professionals might do that is unhelpful in going free of bulimia and anorexia?

Mellissa: Well, when they look at you as a bulimic person, you begin to look at yourself that way to. You begin to identify purely with your anorexia and your bulimia and you lose your self. You deny you have another aspect to yourself. You think about your eating disorder and everyone is saying well "you're bulimic" or "you're anorexic" and anything you do wrong is attributed to you being a Bulimic, or

Anorexic. This way really denies them a lot, denies them their personhood. You could say that because I struggled with bulimia and anorexia once, but that's just one aspect of my life. I feel it gets really hard because you're trying so hard in the struggle to hold on to yourself, to the inner person, the person that needs to come out, and then when everyone is focusing just on the bulimia and your anorexia, the behavior, then they push you and your self, down. Every time people and professionals do that you become smaller and smaller.

Stephen: What did you find helpful?

Mellissa: Well, I guess it had a lot to do with separating bulimia from myself. Being able to see it as one aspect of me and just that! And giving me my voice back, giving myself back my voice and pushing bulimia back, or trying to put bulimia back where it belongs; I don't know how to say that. Just trying to give it a sense of; I guess, separate yourself from it. You know, allow my voice to become louder and turning down the volume on the bulimic voice.

Stephen: Was there one tactic of bulimia that stands out for you as being particularly horrible?

Mellissa: Well yes, it was such a secretive thing. It told me that secrecy was the only way for me - and it to survive. And I guess it caused me to not only to have to keep it a secret to people on the outside, but it insisted I keep it a secret from everyone close around me and through this it imprisoned me. I couldn't reach out and I couldn't talk to people. And, as time goes on, you don't trust those people. Because it becomes your best friend. It's the only thing that made me feel better. Having a binge was to get rid of some of the rage by purging. It became everything. An all- purpose best friend, and coping mechanism, and it also kept me trapped and kept me doubting myself and the people around me.

Stephen: Is there anything that you have come up with to combat bulimia's compliance to secrecy?

Mellissa: When I feel that it's trying to put a strangle hold of secrecy around me I really actively think about it, and say okay what am I doing? Am I isolating myself? Is the bulimia causing me to withdraw? Then turning down the volume and going no I'm not going to let it have control and I actively really think of it as something separate. I call it for what it is and that's an abusive partner - it's just very abusive to me. By saying no to the abuse and reaching out for those people that are there, and have always really been there really helps diminish its grip. The bulimia has kept me in prison and isolated me, and denied me my own sense of self- worth and denied me the feeling that I am a good person and I am worth caring about and people do want to share and be a part of my life.

Stephen: I find your paralleling bulimia to that of an abusive relationship fascinating, could you tell me more about this idea of yours?

Mellissa: I was once writing a letter to my body and saying "I'm sorry for all the abuse" and da, da, da, da and I really began to identify just how abusive bulimia is! And how it acts exactly like an abusive partner. It attacks me at the moment I'm most vulnerable and it tries to keep me down. It tells me I'm no good. It tells me that no one else will like me and I can always depend on it and no one else will be as dependable. It tells me it's doing this because it really cares and it wants to do something really nice. You know it finds all sorts of really insidious ways of destroying every sense of self and self-worth that you have. It keeps you distracted, and then it slowly abuses you physically and mentally. It keeps saying that "I care about you" and "nobody loves you like I do." That's what kept it so firmly planted in my life. When anyone disappointed me, even a little bit, I said "well, its [bulimia] right." I am worthless, that's why this is happening, and I went to have a binge and yeah, it made me feel good for the short term and you know I tried to nurture myself by filling myself up and get rid of the rage by purging. It did help in the short term, the very short term, but it has disastrous consequences.

Stephen: How did you manage to get free of bulimia's abuse?

Mellissa: I think it was a number of things. First, the thing I really had to come to grips with was that it was an abusive relationship. Knowing about abusive relationships, I know it's not going to go away unless I get some help, right, (laughs). So, I really had to look at it, and whatever intellectual or emotional thing that kept me holding on to it had to go. I looked at it as separate from me, me in relation to an abusive partner and I realized nothing was ever going to get better. I knew I would never gain control of it, that it doesn't really love me. That it really hates me and it has it's own purpose and own agenda, and that was to destroy me. And, I had to really look at that and start letting go of all the lies that it had for keeping it in my life. And, just like when you leave an abusive partner you have to reach out. I found there where some very persistent and good people, League people, positive people that where really working hard at letting me know that they where there, and they would be there. They were a heck of a lot better then a bulimic partner. Slowly, by just beginning to trust and realize, yes, they were there and they know me pretty well now.

Stephen: How did you put an end to the abusive relationship?

Mellissa: I just kicked the bulimic bum out!

Is it any wonder that upon viewing the League's "What every therapist needs to know about anorexia and bulimia, but were afraid to ask" video's the room thunders with applause, interest, and tears? I (SM) asked psychiatrist Dr. Elliot Goldner, Director of St. Paul's Hospital Eating Disorder program in Vancouver, to offer his reflections after reading excerpts of the Leagues on-going co-research project.

Dr. Goldner writes: The writings of Lisa, Jennifer and Mellissa underscore a potent fact; people struggling against anorexia and bulimia possess a wisdom and expertise that must not be marginalized. Their research is pulled from the pores of experience and has not been limited to eight hours a day, academic blinders, and political or financial motivations. To ignore their insight would be folly. Yet, psychiatry and therapy practices have too often disregarded such careful and painstaking research, and have preferred promises of quick fixes, and electrifying solutions from technology and scientism. When I listen, instead, to the words of Lisa, Jennifer and Mellissa, these are some of the things I hear:

- 1. Collaboration is helpful in fighting anorexia and bulimia; leagues such as the anti-anorexia/anti-bulimia league can offer such collaboration*
- 2. Anti-anorexic/bulimic actions help to combat eating disorders for individuals and societies; in contrast, non-action (which characterizes some "therapy" or "support efforts") is not helpful*
- 3. Empowerment of those persons fighting anorexia and bulimia is helpful in combating eating disorders; such empowerment is supported by respect and by separation of the person and the problem*
- 4. Anorexia and bulimia can hold a person with the vice grip of an abusive partner; secrecy and shame can form the glue that adheres these problems*
- 5. Others (including those in "helping professions") may worsen the problem; this often occurs when people confer certain knowledges about a person and constrain that person's identity and selfhood.*

When presenting the League ideas in a public forum, we are continually reminded of their social impact on therapeutic possibilities. It is from within the wisdom of these co-research projects that therapists can be moved (shoved) toward a reflexive accountability. We would argue that the weight of therapeutic

accountability should privilege and be mediated through the knowledges of the once marginalized; not through a professionalized discourse.

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