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Meeting together; eating together

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In this paper I offer a brief account of a long journey; a personal journey, in one sense - an individual's experience of a group - but perhaps also a story about a group experience.

It is a story about how I used to eat alone - how I found my way to the table - and what it feels like to be eating together.

For twelve years now I have been working as a psychotherapist in an NHS eating disorders service. This story is about food and the refusal and spoiling of food - and about eating as a group behaviour. It treats of non-gregation and of congregation[2] and of how difficult and frightening these experiences can be.

This story is in and of the psychosocial. Bion wrote about narcissism and social-ism and of the interplay between these two sets of valencies, the one ego-centric, the other socio-centric, that he

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[2] Earl Hopper has developed the concept of incohesive states of massification and aggregation (Hopper, 2003) and these fearful defensive states of being in group structures are manifest in the ward environment and the field of eating disorders, as others have elsewhere noted (Wood, 2012; Scanlon and Adlam, 2012). In offering the playful juxtaposition of non-gregation and congregation, I must acknowledge my debt to Hopper's thinking.

suggested were 'equal in amount and opposite in sign' (Bion, 1992, p. 122). This story touches upon the *socio-narcissism*, perhaps, of monads, of monodisciplinary silos, of Enclosures, of Diogenes in his barrel (Scanlon and Adlam, 2011); it points towards the *psycho-social-ism*, let us say, of groups, multidisciplinary teams and communities of learning and the public/private spaces of the *agora* (Adlam and Scanlon, 2013).

Lastly, this is a story of the creative possibilities inherent in Rivière's suggestion, referred to by Sasha Roseneil[3], in her introductory talk at the launch event upon which this short paper is also a commentary, that '[T]hese other persons are in fact therefore parts of ourselves ... [W]e are members one of another' (Rivière, [1952] 1955, p. 359).

In July 2002 I successfully applied for a part-time post as a Group Psychotherapist on an inpatient eating disorders ward. It was confusing, however, upon arrival, to discover that my services were not required for the actual delivery of group psychotherapy. I was invited, first of all, to treat a few patients in individual psychotherapy; secondly, to observe existing twice-weekly small therapy groups through a one-way mirror and then afterwards to help the co-facilitators of these groups to make some sense of their experiences.

I am not at all sure that I was much help, to being with, to these new colleagues of mine, and to their patients; but in order to try at least to make some sense of my own experience, I arrived at

[3] See her full talk entitled 'The Psychosocial Challenges of Establishing the Field of Psychosocial Studies' included in this edition.

the tentative realisation that, although the ward ran an intensive group programme - and had recruited a group psychotherapist, feeling in some sense that such an item was missing from its inventory - nonetheless, it did not seem to know how to make use of one. I am reminded of Bion's wry comments on his recruitment by the Tavistock Clinic 'to take therapeutic groups' employing his 'own technique' (Bion, 1961, p. 29): the eating disorders service seemed to have taken the diametrically opposite position ... However, some while later, having eventually managed to discard the 'observation' model of supervision and to insert myself as co-facilitator into one or two of these groups, I began slowly to understand nonetheless that I very much shared the ward's dilemma: I did not really know what I was for, either.

I made myself useful at the edge of the ward (running 'transition groups' for individuals moving towards and into the outpatient phase of their treatment); I made myself a nuisance, I rather think, on the ward itself, restlessly liminal, unsure whether to join in or to stay out in the cold (though I don't exclude the possibility that, at times, nuisances may have their uses (O'Loughlin, 2011)). I was part-time in more senses than one. I subscribed, fearfully as I would now see it, to the dubious maxim that a psychotherapist should not eat with the patients, in order to protect the free operation of the transference. I ate alone.

The ward is now a different kind of treatment centre. Economic and political shifts in the structure of funding of NHS services - 'local services for local people'; 'world class commissioning' and its covert flip-side, creeping privatisation of the public health service; the

ideological 'slipknot' of 'austerity' - have changed the face of inpatient treatment for eating disorders. My workplace is more of an acute ward, making extensive use of the Mental Health Act and of interventions such as naso-gastric feeding. At the same time, the medical model of full recovery from the eating disorder, for those with motivation to change, has been set aside in favour of the recovery approach, working collaboratively with sufferers to support them to identify their own treatment goals, once they are out of immediate physical danger.[4]

Some of these shifts in the matrix have intersected with threads in my own personal story. For example, when my other NHS workplace, the Henderson Hospital Democratic Therapeutic Community, was closed down in 2008 (see eg Wrench, 2012), my working hours on the eating disorders ward increased and I found myself inching slowly towards the centre of the milieu and away from my monadic, monastic life at its periphery. During this time, the closure of the Henderson Hospital and other similar therapeutic communities for the treatment of severe personality disorder seems also to have coincided with, and perhaps be causatively linked to, a change in the severity of presentation to inpatient eating disorders services: as though both staff and residents (or potential residents) of therapeutic communities have moved across into other types of inpatient therapeutic milieu, in search of containment.

I have also gradually mutated into a different kind of psychotherapist. It seems to me now that, if I feel I am not being useful, I had better find a way to make myself useful, rather than grumble that the workplace is at fault for not making use of me. It is a long time, for example, since I last

[4] Or perhaps we should simply note how the recovery approach has been successfully colonised and incorporated by the medical establishment (Turner et al, 2011; Scanlon and Adlam, 2010).

interpreted in the transference: things are perhaps none the worse for this sea change (Bruch, 2001; Skårderud, 2009). I like also to consider that my patients gradually started to teach me something important as the years went by: something about the merits of sitting *with* them and listening closely *to* them as a more effective and appropriate alternative strategy to interpreting *at* them (Adlam, 2014; 2015 in press).

There is, therefore, no lost Golden Age here: nonetheless, if I am certain of the need not to wax nostalgic, I am equally certain of the opposite perils of Whig History (in which history consists in a gradual progression towards the alternative but equally illusory golden age of the presumed enlightenment of contemporary times). Anecdotally there is broad consensus that the severity and complexity of clinical presentation has escalated. The formal evidence base for the inpatient treatment of anorexia nervosa does not extend much further than the important but inherently circular recognition that food is the only type of medicine known to ameliorate the physical sequelae of starvation.

Moreover, the diagnostic categories for eating disorders, even following recent completed or ongoing reviews (APA, 2013; WHO, 2014), although they contain many positive developments[5], still scarcely do justice to the suffering of patients who have stopped being able to dream except somatically through their bodies and yet are suffused and flooded with desire; nor do our current treatment strategies appear significantly to alleviate the predicament of a necessarily 'anti-social'

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[5] Such as, for example, the concerted effort across both systems to reduce the number of people diagnosed with Eating Disorder Not Otherwise Specified (EDNOS - previously as many as three quarters or more of all eating disorder diagnoses (see e.g. Machado et al, 2007): one thinks of the emergence of the eventually unhyphenated (Roseneil, 2014; Hoggett, 2008) Association for Psychosocial Studies as an attempt to contain (Enclose? colon-ise?), within a distinct system, those elusive waifs and strays, psycho-social studies 'Not Otherwise Specified'.

out-group bent upon the dogged pursuit of undreamed transformatory strategies for self-realisation. The refusal and spoiling of food confounds something at the very epicentre of how we in the in-group organise ourselves; the anti-social out-group are therefore 'always in danger of meeting primitive human behaviour disguised as treatment' (Main, [1957] 2009, p. 65).

> No man is an island entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as any manner of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind. *Meditation XVII: Devotions upon Emergent Occasions* (John Donne, [1624] 1999, p. 103)

And yet ... the ward's programme now includes daily morning community meetings in which all members of the community are invited to con-gregate and the working life of the ward is collaboratively reviewed and constantly renegotiated. Research design and implementation on the ward is co-constructed here and out of these meetings has now emerged a 'therapeutic eating charter', a kind of Magna Carta or Bill of Rights agreed between patients and staff to govern all encounters and exchanges within the dining room. The Charter perhaps serves as a reminder that none of us find it easy to con-gregate; that nobody's relationship to food is entirely straightforward; that a common humanity links the would-be-feeders and the won't-be-fed: we are all 'involved in mankind'.

A profoundly psychosocial ailment - food refusal and spoiling - is perhaps helpfully beginning to be considered psychosocially. A series of boundary events and border skirmishes in the liminal spaces between in-group and out-group are being negotiated - sometimes tentatively, sometimes bad-temperedly, almost never disrespectfully - in the bio-psycho-social *agora* of the therapeutic milieu. And at some point in this process, I started to come regularly to the table, to eat with and alongside the patients (and alongside my nursing colleagues, who, it is necessary to emphasise, have of course been doing this all along). The alternative agonies of non-gregation are still present - and not only for the patients - but fewer individuals within the milieu are eating alone.

Rivière suggests that there are 'moods and there are moments when we can be and are deeply conscious of the extent to which our lives and our being are interwoven with those of others' (Rivière, [1952] 1955, p. 359). Might these psychosocial encounters act as indicators of or preliminaries to psychosocietal change? We heard Valerie Walkerdine[6] discuss Guattari's model of revolutionary change and his imagery of 'territories of existence' and the movements of tectonic plates beneath the surfaces of the continents (Guattari, 1989, p. 25; echoes here, refracted down through the centuries, of Donne's 'piece of the continent, a part of the main'). Perhaps it is not inconceivable that something important may be stirring in the deep ocean trenches of the eating disorders ward.

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[6] See her full talk entitled ‘Felix Guattari and the Psychosocial Imagination’ included in this edition.

Roseneil argues that ‘the psychosocial imagination ... is not, and cannot be, the property or product of any single mind ... It is, and can only be, that which is more than the singular, beyond not just the individual but also the dyad’ (p. 132, this issue). I bring my remarks to a close and my story to an end (or at any rate a pause) with the sense that my previous paragraph might have stood just as well, if the last three words had been replaced with Association for Psychosocial Studies ...

- For Martin -

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