Fiction-reading for good or ill: eating disorders, interpretation and the case for creative bibliotherapy research

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ABSTRACT

Compared with self-help bibliotherapy, little is known about the efficacy of creative bibliotherapy or the mechanisms of its possible efficacy for eating disorders or any other mental health condition. It is clear, however, that fiction is widely used informally as a therapeutic or antitherapeutic tool and that it has considerable potential in both directions, with a possibly significant distinction between the effects of reading fiction about eating disorders (which may—contrary to theoretical predictions—be broadly negative in effect) or one's preferred genre of other fiction (which may be broadly positive). Research on creative bibliotherapy, especially systematic experimental research, is lacking and requires a medical humanities approach, drawing on knowledge and methods from psychology and cognitive literary studies as well as clinical disciplines to expand our understanding of how the dynamic processes of interpretation mediate between textual structures and characteristics of mental health and illness.

I find reading completely invaluable as a therapeutic experience and means of exploring my feelings and potential (Anonymous survey respondent with a history of anorexia and EDNOS [eating disorder not otherwise specified]).

For a few days after being exposed to eating disorder ideas or stories I will restrict food or increase exercise. Just being reminded of them as a coping mechanism makes me want to engage in them again. (Anonymous survey respondent in recovery from anorexia and bulimia).

NARRATIVE, INTERPRETATION, MENTAL HEALTH AND EATING DISORDERS: THE CONNECTIONS

Many of the gaps in our understanding of health and illness may turn out to be attributable to our ignorance of the role of cultural factors, long treated in medicine as an optional extra to be contemplated only once the biophysical essentials are properly worked out. However, clinicians, researchers and public health bodies (the WHO Health 2020 policy framework, for instance[1]) have begun to recognise that a multidisciplinary approach which takes cultural factors seriously is needed to tackle major healthcare challenges of the kind presented by mental illness, meaning that the medical humanities ought to be more than a discretionary and often marginalised optional addition to a medical degree.[2] And although meaningful interdisciplinarity is easy to advocate and hard to

practise, this article will make the case for one place to start, demonstrating what we stand to gain from a thoroughgoing medical humanities exchange between psychiatry, psychology and cognitive literary studies focused on the preventative, therapeutic and antitherapeutic potential of one aspect of everyday cultural engagement: fiction-reading. Despite the apparent specificity of eating disorders and the obvious vastness of interpretation, I will show that understanding interpretation better can help us understand eating disorders, as well as vice versa. An overview of existing evidence, including a major survey recently carried out in partnership with the charity Beat, will set out our current state of knowledge (and ignorance) and the kind of work that needs to be done next.

The most general grounds for bringing mental health and fiction-reading into dialogue with one another are evolutionary. Storytelling is a universal human activity and an activity apparently unique to humans, and arguments are often made for its evolutionary adaptiveness.[3][4] One of the reasons humans have told and listened to stories for so much of their evolutionary history may be that stories have helped us survive as a species, and one of the ways they may have done so is by increasing our cognitive fitness,[5][6] perhaps by allowing us to safely test out courses of action that would carry real-life risks or by improving social cognition. As with any evolutionary argument, hypotheses are far more easily made than tested, but there is one quality that speaks directly to the cognitive significance of storytelling: the parallelism between the structures of narrative and of experience itself. Experience is intimately bound up with the narrative spin we put on it: whether it's framing this dinner as either a dreary networking event or a chance to stock up on some postgym protein, or telling the story of one's life as a journey towards acceptance or a battle against the odds. The narrativisation of experience (whether or not in words, whether or not in words explicitly spoken or written to oneself or others) is typically automatic and immediate,[7][8] and the narratives we read thus occupy an important place within the broader narrativisation to which human experience is constantly subject.

Consequently, narratives can be thought of as 'the phenomenal form in which patients experience ill health' (p. 49)[9]—or at least as one such form. And any narrative, whether cognitively self-generated or chanced on in a work of fiction, is at the same time a form and an object of interpretation. (I will return

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at the end to the question about the fictionality or otherwise of textual narratives.) Thus, taking a medical history is an interpretive act for both parties: narratives are created that interpret the experience of illness and then are in turn interpreted by the medic and the patient. Ill health is a context where the narratives we tell about ourselves, and which others tell about us—from the medical history to the diagnosis, to the retrospective reflection on illness as one of life's chapters—become particularly fraught with interpretive possibility.[9] The case for a 'health humanities' that attends to individuals' interpretive experiences of reality has been strongly made,[10] and whatever specific shapes it ends up taking, productive exchange between clinicians and literary scholars will be crucial to working out how to turn the narratives we constantly create, encounter and recreate to therapeutic advantage.

These considerations already give us a broad remit for asking what relevance engagement with written fictional narratives may have to mental illness. Attempting to sketch out the relevance of fiction-reading to mental illness as a generic whole is probably not the best way to begin, however: such endeavours run a constant risk of overgeneralisation and imprecision. A case study approach is more promising, and given the close links between eating disorders and other common conditions such as depression and anxiety disorders, and between written texts and other art forms, the broader principles (though also the limits of transferability) should readily emerge.

To begin with, though, why investigate written texts (novels, stories and poetry) rather than, say, film, theatre or other ways of engaging with narrative? There are good reasons to expect these other art forms also to exert cognitive–emotional–behavioural effects that might be therapeutically relevant.[11 12] Written narrative, however, makes an appealing starting point for investigation because it is the purest instantiation of the capacity of language to generate unlimited meanings from the combination and recombination of a relatively small number of arbitrary symbols. Once we move to empirical investigation, this complexity-from-simplicity makes it possible to attribute cause and effect and control for relevant variables on the textual side far more easily than can be done for the infinite variations on embodied human interaction, lighting, audio quality and so on that make up any theatrical or film production.

When it comes to recipients' responses, too (as opposed to how to acquire knowledge about them), the qualities of written language versus a filmic or theatrical form are also relevant: as a broad generalisation, we might say that the inherent constraints of the medium (a limited number of characters, diacritics and so on, typically printed or displayed on a two-dimensional surface) leaves more to the cognitive activity of the reader than in any other form of narrative art. This more actively participatory role means we can expect greater variation in individuals' responses to a given narrative, such that we might observe more salient interpretive differences between, for example, those with and without personal experience of an eating disorder. Arguably, if we are seeking the blankest canvas for the manifestation of interpretive activity, creative writing should be our focus: there, after all, rich narrative material revealing interpretive processing may be generated from the sparsest of prompts. However, the clinical practice of expressive writing or poetry therapy often takes the reading of poetry or narrative as its starting point,[13] meaning that the reading component requires systematic investigation as the foundation for investigating of the writing. Furthermore, fiction-reading is a far more common everyday activity than creative writing, which gives its study an ecological validity for a far wider population, especially when it comes to

questions about inadvertent (or deliberate) harm through text-cued interpretation.

Finally, within the broad set of processes that can be classified as interpretive, there are several at play in the convergence of fiction-reading and mental health that warrant close attention. The first is mental imagery. When vision is merely providing the initial access (via processing of the words on the page or screen) to the perceptual experience of interest (the imaginative response to what is described), imagery can take different forms from the visual perception of real-world objects or events and from pictorial representations of them. In the eating disorder context, these differences may be significant insofar as a linguistic prompt to imagine something food-related or body-related contains more perceptual freedom than the explicit showing of a body on stage or screen. Language can leave more unspecified, and the imagination may do too,[14 15] or else may fill in the textual gaps in therapeutically relevant ways. Second, metaphorical associations are readily and explicitly conveyed in language in ways that may support or otherwise intervene in the associative networks that grow up in an eating disorder, for example, in the form of moralising connections between eating and cleanliness.[16] Third, shifts of narrative perspective can be enacted in verbal narrative with a degree of subtlety and precision likely to exert significant influences on the recipient's cognitive–perceptual alignment with one or more (or no) characters, and so affect his or her cognitive–emotional appraisal of all other elements,[15] thus providing a metalayer of interpretive guidance to affect readers' responses along the other two dimensions.

How, then, having sketched out the relevance of specifically written narrative to mental health, can we configure the case for thinking that fiction-reading as an interpretive act might be therapeutically valuable in the context of disordered eating in particular? Like all mental illnesses, eating disorders are in part illnesses of interpretation—of meaning-creation gone wrong. The distortions involved may range from low-level perceptual and motor discrimination[17] to high-level conceptual configurations,[18] and interpretive prompts like works of fiction may intervene at multiple levels. Eating disorders thus offer a lens through which to study the ways in which interpretive activity can change under conditions of psychopathology, while interpretation can be seen as one of the fundamental dimensions on which the condition of disordered eating—like all other mental health conditions—is manifested.

Considered as manifestations of interpretive disturbance, eating disorders inhabit both ends of the spectrum that extends from a heightened tendency to perceive interpretive salience in the environment (as found in, for example, schizophrenia[19]) to a reduced perception of such interpretive salience (in, for example, Parkinson's disease[20]). In eating disorders, hypersemic and hyposemic states compete. Food-related and body-related stimuli have high attentional capture and can be objects of both preoccupation and avoidance.[21 22] Ruminative brooding and belief in the benefits of rumination often coexist with experiential avoidance and an absence of more constructive reflection: control over the abstract idea of hunger, for example, replaces acknowledgement of the embodied experience of hunger.[23] Such changes in interpretive activity have been found to help predict the onset and duration of related clinical diagnoses,[23] making clear the importance of studying the underlying cognitive processing. The same conclusion has been reached in eating disorder research on context-dependent fluctuations in body image. Deficits in interpretive processing of physical, emotional and social cues, for instance, can result in rapidly fluctuating misperceptions of body size and shape that help entrench the disorder.[24]

One contributor to the profound interpretive changes that contribute to eating disorders is the sociocultural dimension. Eating disorders are complex biopsychological phenomena, but they are also culturally inflected in a direct and significant sense: right now, in most (post-)industrialised societies, some variation on slimness is what people are typically trained to aspire to, and both the aspiration and the supporting behaviours are culturally reinforced at every turn. Psychological research (both correlational and experimental) on the effects of mass media makes clear that media depictions of the typical 'thin-ideal' body are linked to women's body dissatisfaction, internalisation of the thin ideal, and eating behaviours and beliefs,[25] with conventional and social media images playing different roles.[26] Not only images, but language too, can serve as a means of both expressing and encouraging psychopathology, notably on proanorexia websites.[27 28] Cultural and aesthetic representations of food, eating, exercise and other bodies, and the value judgements that attach to them, are by no means the only eating disorder risk factor.[29 30] However, they can spur interpretive processes that act as potent drivers of an emergent psychopathology, and later on, they can create powerful obstacles to recovery. Yet these representations, along with cultural and aesthetic expressions that extend far beyond the realm of food and bodies, also have the potential to offer strong alternatives to narrowly defined notions of beauty, purity, control and self-worth. Moreover, the more restrictive the mass media's systems of value become, the more important a role there is for cultural artefacts that encourage exploration of alternative ways of thinking and being, for example, through the processes of cognitive defamiliarisation long theorised to be prompted by 'foregrounded' features that deviate from the norms of everyday language use.[31 32]

Finally, eating disorders also epitomise another often-overlooked characteristic of 'mental' illness: the profoundly embodied nature of all 'psychological' conditions. Eating disorders help reveal the meaninglessness of any hard-and-fast distinction between mental and physical ill health: having an eating disorder is as much about physical malnourishment and disturbed eating and/or exercise habits as it is about imbalanced mood, cognitive anxiety, low self-esteem or a desire for control, since all enter into complex feedback loops with each other from the very beginning.[33 34] Calibrating the physical and psychological facets of recovery is challenging, because cognitive problems arising from malnutrition can (especially in anorexia) easily hamper recovery and can therefore also problematically encourage clinicians to make refeeding the sole focus of treatment. However, these profound mind–body interactions also have the advantage that in recovery from an eating disorder, deliberate, often very simple, self-directed changes—eating more, exercising less and so on—can have rapid and significant effects on the eating disorder system.[35] This in turn means that anything which affects attitudes and mental states, and thereby intentions and motivations, has a real chance of making an immediate difference. One potential strand of fiction-reading's therapeutic efficacy may be as a catalyst of changes to attitudes and motivations, potentially through changes to interpretive tendencies that link the immediate embodied context (eg, the need to eat the next meal as planned) to the wider existential context (what eating this meal will mean for my life).

Research in all these areas offers a strong mandate for an interpretation-focused approach to the study and treatment of eating disorders as complex systems in which disturbances to the structures of interpretation play an important role. In what follows, I outline what is known and not known about how disordered eating and interpretation of texts (including fictional texts) interact, and how we might start to reduce the size of the 'not known' category. Some of the evidence presented comes from an online survey conducted in collaboration with the UK eating disorders charity Beat, and while the empirical details are reported elsewhere,[36] their wider theoretical import is explored here. This article may give the impression of raising far more questions than it answers, or generating problems with no solutions. I make no apologies for this, since it is with carefully articulated questions that every meaningful research programme must begin. This article aspires to the modest first step of assessing the state of our knowledge and articulating what a sensible second step might look like.

EXISTING EMPIRICAL EVIDENCE FOR SELF-HELP AND CREATIVE BIBLIOTHERAPY
Bibliotherapies in practice
In opposition to the mass media's apparently primarily negative effects stand the practices known as self-help bibliotherapy (the use of self-help books for therapeutic purposes) and creative bibliotherapy (using prose fiction, poetry or occasionally film). (The related fields of 'poetry therapy'[37] and 'narrative-based medicine'[38] focus on writing, rather than reading, poetry or narrative. The evidence base for their efficacy for eating disorders is also fairly small but growing.[13]) Recommending that a patient read a particular text, or recommending that (s)he read more (or less) in general, or express his or her feelings in writing, have long been informal medical practices,[39] but in recent years, bibliotherapeutic approaches have begun to be formalised. In the UK, for example, national-level schemes like 'Mood-Boosting Books' or the 'Reading Well Books on Prescription' programme allow for self-help books from themed lists to be recommended by GPs and made readily available at public libraries. Uptake has been strong, and a large majority of users report finding the books helpful for understanding their condition, improving their confidence in managing their symptoms and/or reducing their symptoms.[40] In collaboration with the Centre for Research into Reading, Literature and Society at the University of Liverpool, the Reader Organisation charity's 'Get into Reading' scheme, which offers fiction reading groups for vulnerable populations, has generated observational research on the value of creative bibliotherapy for women prisoners[41] and people suffering from depression.[42]

For eating disorders in particular, National Health Service care trusts in the UK now recommend (self-help) bibliotherapy for use either as a stand-alone treatment or in conjunction with other psychological or pharmacological interventions, and some provide lists of book recommendations with short reviews.[43] The current National Institute for Clinical Excellence guidelines on eating disorders include observations on the prevalence of 'the reading of books or other self-help materials with or without professional guidance' (p. 150)[44] and recommend 'self-help' (independent or clinician guided) for bulimia. Some of the public health resources[43] include first-person illness-and-recovery memoirs alongside self-help books, and a small body of published work reports on successful clinical uses of drama[11] or a mixture of creative writing and poetry-reading[13 45 46] as part of treatment.

Systematic research on efficacy
Systematic experimental research on the efficacy of self-help bibliotherapy has been conducted for a range of mental health conditions, including eating disorders, and has yielded promising results. A randomised controlled trial by Ruwaard and

colleagues[47] found that unsupported bibliotherapy (reading a self-help book about bulimia and binge eating) may have only small immediate effects on the symptoms of bulimia but may increase the likelihood of recovery in the longer term by promoting positive attitudes towards treatment. Unsupported self-help bibliotherapy has been associated with small to moderate effects on bulimia and binge eating in a range of other studies (see the meta-analysis in ref 48). A 2006 review[49] found no significant differences between pure or guided self-help and other psychological therapies on variables of bingeing and purging, other eating disorder symptoms, interpersonal functioning, depression or treatment dropout—a significant finding given the perennial lack of funding and length of waiting lists for more conventional treatments.[50] A meta-analysis of guided self-help versus wait-list control for binge eating[51] found an effect on global eating disorder psychopathology and binge abstinence.

The most commonly used texts in these studies are self-help books based on the principles of cognitive–behavioural therapy (CBT). The evidence on genres other than self-help is much more limited for all mental health conditions. Creative bibliotherapeutic practice is common in both the public and the private sector, from local libraries to the School of Life (a private company 'devoted to developing emotional intelligence through the help of culture', who charge £100 for a session resulting in a 'prescription' to 're-enchant the world' for you). Yet solid evidence is scarce. The evaluative and research elements of the policy and clinical interventions for other genres summarised in the previous section are solely observational, with benefits claimed on the basis of participants' self-report and researcher/facilitator observation, and no control conditions or randomisation. A systematic review of evidence for the efficacy of creative bibliotherapy was published by Paul Montgomery and Kathryn Maunders in 2015,[52] focusing on the strengthening of prosocial behaviours in children and finding a small to moderate positive effect. However, a more recent review for post-traumatic stress disorder,[53] although it found promising trends in a number of qualitative or low-quality quantitative studies, failed to locate any high-quality controlled trials at all. As psychiatrist Jonathan Detrixhe puts it, 'Unfortunately, thus far, the mere belief in fiction's important place in the therapy room is held in higher esteem than the need to rigorously research the phenomenon' (pp. 60–61).[39] This hierarchy needs challenging through attention to interpretive activity as it changes in mental illness and in response to specific textual prompts.

Theories and evidence of mechanisms
Self-help bibliotherapy
A dominant feature of the current state of clinical bibliotherapy research and practice across all mental health conditions is an underdeveloped understanding of the mechanisms by which text-cued interpretation may have positive (or negative) consequences. Research on self-help bibliotherapy generally assumes the transparency of the written medium: that is, if self-help bibliotherapy works, it works because the therapeutic model on which it is based (almost exclusively CBT) works. Self-help bibliotherapy is typically conceived of as a form of CBT, not as a form of bibliotherapy, and so mechanisms responsible for change are assumed to operate similarly in self-help and CBT.[54]

This is not to say that no attention is paid to what distinguishes individual reading from face-to-face therapy. Some researchers speculate on the benefits that bibliotherapy might have over standard therapy: reducing the delay and cost and avoiding the embarrassment and fear of stigma often associated with engaging in formal therapy; fostering a feeling of 'universality' (the sense that one is not alone); increasing self-efficacy or empowering patients to work in their own time and at their own pace (especially where depression, anxiety or starvation-related attentional deficits might interfere with focus during a session with a therapist); and encouraging the consolidation and continuation of learning beyond discrete sessions.[49 55 56] Suggested drawbacks include the danger of feeling daunted by dense pages of text, or feeling a more personal sense of failure if recovery is not achieved;[55] the minimal regulation of the self-help market and the conflict between capitalist and therapeutic agendas; and the idea that uncritically following a set of mass-produced guidelines should not necessarily be considered *self*-help (though there is evidence that readers of self-help are anything but uncritical).[56] Broadly speaking, though, these pros and cons are less about the specifics of the reading process than about working alone without a dedicated professional. That is, interpretation as a textually cued activity is not investigated in its own right.

Indeed, it is a striking characteristic of all the published studies I have reviewed that beyond naming the text used and offering an occasional comment on the main areas covered (ref 57 offers the most careful descriptions), no reflections are ever made on the structure or style of the text concerned. What might we gain from attending to these aspects? Let's take the most commonly used text in the existing literature, Christopher Fairburn's (1995) *Overcoming Binge Eating*. The book begins with first-person testimony from a hypothetical sufferer: 'It starts off with my thinking about the food that I deny myself when I am dieting. This soon changes into a strong desire to eat. […] Afterward I feel so guilty and angry with myself' (p. 3).[58] Vignettes of this kind, usually a few sentences long, are sprinkled throughout the text, often at the start of a new section, to create immediacy and concreteness. An illustrative food diary and a supermarket receipt for a purchase of binge food are also provided (p. 13, 15).[58] No explicit comment is made as to the factuality or fictionality of these glimpses into a life with binge-eating disorder: to most readers, the first-person mini-narratives probably imply constructed exemplarity, while the typographical variation in the 'handwritten' food diary and the printed-and-scanned shop receipt pushes us further towards crediting them with individual reality. Investigating readers' interpretive responses to these sections alone, or to the book without them, or to these sections presented explicitly as factual or fictional, would advance our understanding of the cognitive–emotional processes at play in textually mediated CBT. One possibility is that the importance of the constructed first person grows as face-to-face contact with a therapist diminishes: that is, that 'pure' self-help depends on it more than the guided version does. The reader may use such elements to construct the sense of being understood, and of not being alone, that would typically be created by a therapist's explicit references to (or implicit knowledge of) other patients who have gone through similar experiences. Whether readers' perceptions of fictionality or factuality also contribute to this function is another open question to which I return in the final section.

Pending a better understanding of the effects of textual construction, clues as to the mechanisms of bibliotherapy may be found in evidence for the dimensions and predictors of self-help efficacy. Perkins and colleagues' review[49] found no overall difference from waiting list on bingeing and vomiting but reduced general psychiatric symptoms and reduced problems with interpersonal functioning, suggesting a therapeutic mechanism that targets psychological aspects of eating disorders more effectively than behavioural ones.

The timescale of effects may also offer clues as to mechanisms, with an early study finding that contact with a current or former sufferer alongside the self-help materials helped improvement in bulimic symptoms continue after the end of the treatment programme as compared with no contact[59]; in another study, the guided self-help group 'caught up' with the standard CBT group's improvements in depression and knowledge by follow-up (6 months to 2 years later).[60] Without knowing how the two groups continued to change beyond formal follow-up (did the self-help group go on to 'outstrip' the other after 'catching up'?), this suggests that bibliotherapy may help embed beneficially self-per-petuating cognitive habits more slowly but equally or perhaps more effectively than standard therapy. This raises the possibility that sustained and independent textual engagement may be uniquely conducive to profound restructuring of clinically relevant interpretive habits.

Finally, some studies suggest participant predictors of greater efficacy including lower baseline knowledge about eating disorders, more problems with intimacy, and higher compulsivity,[61] or fluctuating bodyweight and willingness to monitor and communicate about bingeing, but not current age, duration of illness or binge frequency.[59] A study of internet-based guided self-help found that lower scores in the personality traits of dutifulness and assertiveness and higher scores for self-affirmation best predicted drop-out.[62] However, more work is needed to establish whom bibliotherapy might best target,[63] especially as self-help interventions move from the traditional book to online or combined formats, some with multimedia, discussion forum and mobile components.[64–66] Insights of these kinds have yet to be developed into a coherent theory of textually mediated therapeutic change and may or may not translate beyond CBT-based self-help texts to texts written with other aims and audiences in mind. However, the interpretive dynamics at play clearly need investigating from both the textual and the readerly perspective.

Creative bibliotherapy

What about modelling the mechanisms of change for creative bibliotherapy specifically? Here we have no eating disorder work to turn to, so theory developed in other contexts must be our starting point. The field of creative bibliotherapy theory is dominated by the tripartite paradigm of *identification* (with the fictional character), *insight* (into the reality of the illness) and *problem-solving*, with little empirical justification. The classical model of creative bibliotherapy, developed for use with children who have suffered abuse, posits initial 'identification and projection' followed by 'abreaction and catharsis' and finally 'insight and integration' (ref 67 based on refs 68 and 69 70). That is, first, the reader recognises similarities between the problems confronting the character and herself and applies her interpretation of the story to her own life. Then she experiences 'an emotional release that may be expressed verbally or nonverbally' (p. 196).[67] Then she gains insight into the problem confronting her and begins to recognise solutions to it in what she reads. This depends on as close as possible a 'matching' between the situations of the fiction and the reader's life, as well as detailed and realistic progressions towards happy endings; plot summaries of some possible books are provided to facilitate this.

A later update (in the context of adolescents coping with family difficulties) elaborates on the goals of creative bibliotherapy: to provide new information about problems, to offer new insight into problems, to stimulate discussion of problems, to communicate new values and attitudes, to create awareness that others have dealt with similar problems and to provide solutions to problems.[71] An alternative account (developed as an adjunct to counselling for stepchildren and remarried adults) also acknowledges the more fluid experiential possibilities of fiction-reading. Fiction may 'provid[e] readers with models to help them handle situations', or convey new facts or alternative ways of approaching problems. However, it can also allow readers to 'escape into new roles and identities and sample life-styles vicariously', and help them overcome fear, guilt or shame by imparting a sense that their problems are normal and so can be talked about freely, so also helping them to build up trust with a therapist (p. 327).[72] This last point relates to the fact that all three accounts presented here treat fiction-reading as only one part of a therapeutic process that also involves professionally guided discussion or other activities to help the reader draw out what was gleaned from the reading and apply it to his or her own life.

The models presented here cover a relatively narrow sphere of psychiatric relevance (typically young people with social difficulties or a history of abuse), and few attempts have been made to put the theories to any substantive empirical test. Caroline Shrodes[68] used written reports by students as case studies to illustrate her general theory of identification, transference, catharsis, insight and relation of self to others. Marilyn Coleman and Lawrence Ganong[72] present some small-scale self-report data (groups of clients completed rating scales for understanding, identification and perceived realism of the texts), but this seems to be as far as the testing goes. Zipora Shechtman's three-stage model, developed in work with aggressive adolescent boys, is better evidenced. It draws on the stages posited in integrative counselling—exploring the problem, gaining insight and committing to change—and it has some empirical support in improving empathy, commitment to change, insight and therapist satisfaction.[12] However, the model lacks theoretical precision as regards the materials used: no more is said about text choice than that it should be 'a story, poem, or film relating to aggressive behavior and its consequences' (p. 646),[12] as though a single thematic commonality allowed the three art forms to be considered equivalent. (See also ref 73 (p. 26).) The supposed role of the text in the therapeutic process is also underspecified. Emotional response seems to play an important part: the reader identifies the emotions involved in the textual situation before discussing the reasons for the character's behaviour and possible alternatives. The attempt to understand the character is thought to 'provide a model for empathic interaction' that has the potential to 'soften up' 'tough kids' in a way that interacting with other real people face to face would not. The general idea is that engagement with literature helps 'reduc[e] the level of defensiveness' by offering a more indirect route into the therapeutic process (p. 645).[12] However, more detail is needed in both the hypotheses and their corroboration, and of course their adaptation for the field of eating disorders treatment may involve significant differences on demographic and textual dimensions, bearing in mind the characteristics of cultural inflection, embodiment and hypersemic/hyposemic instability discussed earlier.

Across the field, assumptions are frequently made (and not tested) about what texts to use in creative bibliotherapy: recommendations include that texts should, for example, be modern or of universal appeal, realistic, non-offensive to religious beliefs or values, of literary merit, and consistent with prevailing research or clinical opinion, as well as offering effective and problem-specific solutions and happy endings.[72] Belief in the healing power of a particular kind of reading is buttressed by powerful cultural-aesthetic value judgements: we must avoid 'off-color

language', 'events intended to shock', 'silly, inane, or bizarre characters' or any other 'gimmicks' that might 'attract and tantalize the reader in a "common sort of way"' (pp. 328–329).[72] These simplistic notions of what literature can be and do, and of what qualities are conducive to rewarding interactions with it, ignore the complexity of both literary and human phenomena. They demand implausible combinations of literary quality with (say) constructive happy endings, while also militating against openness to the possible benefits of genres beyond the high-literature canon, like the stories whose history of folk transmission has long required the brevity, perspicuity, relevance and truthfulness that might also be valuable therapeutic qualities.[74]

Presumably one reason for circumscribing the range of relevant texts so tightly is to guard against the potential for doing harm rather than good. Some mention is made of this possibility, in warnings about both the text and the reader side of the interaction. Shechtman summarises the general idea in asserting that 'High-quality literature is essential, as a poorly written novel with stereotyped characters and simplistic answers to complex questions is probably worse than no reading at all' (p. 22).[73] Others suggest that texts should be chosen so as to avoid leaving readers 'despairing and depressed' by those that present crises without optimism or bad coping strategies without good (p. 328).[72] Meanwhile, readers should be encouraged away from 'unrealistic expectations about solving a problem through a book', and we must bear in mind that readers may 'project into, misinterpret, noncomply, or avoid responsibility for a problem through the bibliotherapeutic process' (p. 427).[71] Acknowledging that 'what clients do to reading' is just as important as 'what books do to clients' (p. 427)[71] is obviously crucial but demanding that 'crises should be presented in an optimistic, surmountable fashion' (p. 328)[72] is restrictive enough to demand further investigation. It is perfectly possible that emotionally difficult experiences of reading books without happy endings may function as a kind of literary exposure therapy. Such experience may help make long-term healing possible through the short-term discomfort of confronting unpleasant realities and one's own ingrained responses to them, and then gradually changing those patterns of interpretive response through sustained engagement with characters who may or may not have all the answers.

Along these lines, Paul Montgomery and Kathryn Maunders[52] sketch out a model that is broadly compatible with the *identification–insight–problem-solving* paradigm but is more open to complexity in both the text's stance on the problem and the reader's engagement with the text. The starting point is the hypothesis that the bibliotherapeutic process may bear close parallels to engagement with CBT: both involve the potential for identifying unhelpful cognitions, challenging their meanings and eliciting more realistic assumptions and beliefs. Reading may make these things possible by providing opportunities for *recognition* (of oneself or one's traits/situation in those of a textual character), *reframing* (of one's own experiences in relation to the textual ones), *empathy* or *identification* (with a character) and *emotional memories* (elicited by points of convergence or contrast between textual events and events in one's own life). All the concepts invoked here remain as yet highly underspecified (the brief glosses are my inferences), and they raise further questions: what exactly is involved in recognition or reframing, what are the conditions for empathy or identification (if the latter even exists in the strong sense often assumed), why are only emotional memories relevant and so on. However, they provide a point of departure for subsequent work (by Calla Glavin and Montgomery[53]) that proposes (specifically in the context of post-traumatic stress disorder) a possible link between exposure therapy and the transportation theory of narrative engagement.

On this model, if a reader is transported into a narrative world, he or she becomes correspondingly distanced from the real world in which the trauma exists, and this may create the potential for more critical engagement with real-world avoided stimuli and associated responses. This hypothesis suggests that reading experiences may be uncomfortable in the short term yet in the longer term beneficial, as well as running counter to the 'matching' view by flagging the potential importance of a gap between real and textual worlds. This latter notion is supported by cognitive-literary research investigating the poignancy and bivalency in reading experiences after experiences of loss,[75 76] as well as the unsettling yet ultimately elevating phenomenon of aesthetically prompted 'sublime disquietude',[77] and the alternation between confrontation with and distraction from loss that a text may helpfully stimulate.[78]

Careful research will be needed to develop these distinct research findings and proposals into a robust model of the mechanisms of text-cued psychological change. However, the new data presented in the final part of this discussion offer support for the importance of some ambivalence or difficulty in the reading experience by suggesting that while improvement in mood may be a crucial aspect of how readers perceive reading to be psychologically helpful, reading about characters who suffer and then recover from the illness the reader has is not what tends to elicit such mood improvements—quite the contrary.

The contrast between long-standing theories and newer hypotheses and data will only be resolved by empirical investigation. On the exposure therapy model, for example, affect shift might be predicted to be greater when reading is followed by a structured questionnaire to make the 'difficult' nature of the reading salient, for instance by drawing out textual elements that demand interpretive processing which in real-world contexts would be avoided. For the hypothesis that transportation may allow for improved processing of situations that induce real-world fears, transportation measures[79] could be administered alongside a prereading and postreading behavioural avoidance measure.[80] Experiments of this kind can and should be performed to allow us to start selecting among hypotheses and refining them.

The same applies to other aspects of the existing theory. Within the traditional character–reader matching paradigm, statements about the supposed benefits of bringing books into the therapy room are often characterised by unwitting paradox: maximising the similarity between the reader and the fictional character clearly promotes identification, for instance, but it is unclear how insight is meant to emerge if reader and character so closely resemble each other. How exactly does 'identification' (feeling the same as a character) flow into self-recognition? If it were possible for a character to be an exact 'mirror image' of the reader, would the reader gain anything (s)he could not gain from self-examination? And once we acknowledge that the reflection cannot ever be complete, we acknowledge too that any useful effects that arise arise because of the gap between character and reader. We also cannot assume that the smaller the gap, the greater the effect—because what does *small* mean? There is no single dimension on which similarity between a textual and a flesh-and-blood person can be measured in the interests of a neat 'match'.

Of course, these logical problems with the basic thesis do not rule out the possibility that therapeutic effects are indeed achieved thanks to a process involving some degree and

dimension of similarity between reader and character, but any investigation of such effects must acknowledge that such similarities are only ever partial (not least because characters exist in language and readers in flesh and blood). There is a large literature, arising out of both psychology and cognitive literary studies, on the importance of 'identification', finding correlations with changes in cognition, attitudes, intentions and actual behaviour. Identification also connects closely with personal and interpersonal identity formation, through processes such as behavioural mirroring[81 82] and joint attention,[83 84] with clear implications for therapeutic applications. However, a closer look makes clear that identification is a multidimensional rather than a unitary phenomenon: it is operationalised in one study,[85] for example, through the combination of perceived similarity plus liking, wishful identification and parasocial interaction or feeling that one 'knows' a character or person. Its relation to textual structures such as narrative perspective is also complex.[86] In sum, identification is complicated[87] and cannot be equated with (perceived) similarity (which is itself not trivial either). Both are almost certainly relevant to bibliotherapeutic efficacy, but—as the new evidence I will present in a moment categorically confirms—we need to do better than aiming for maximal matching of confused-to-happy characters with confused-to-happy readers.

Moving on to the 'insight' plank of the traditional models, there are also reasons to question the general assumption that insight—rather than some other kind of change—should always be the primary goal. A prevalent characteristic of chronic eating disorders is a wide and lasting gap between a high level of insight into how the illness is affecting one's life and oneself and the simultaneous inability to act on that insight,[35] so increasing insight may be less important than changing other cognitive or behavioural tendencies. Detrixhe[39] suggests some alternatives: that fiction might serve as a prop in therapeutic alliance-building, as a stimulant to fantasy, or as an engine of emotions, helping people make the transition from intrapersonal to interpersonal emotion. Billington's work on group reading supports the notion of interpersonality as a key driver of reading-mediated benefits,[88] and although this is likely heightened by the group setting, it may operate saliently between reader and author, narrator and/or characters, too, as suggested by Keith Oatley and colleagues' work on literary reading as a complex social simulation which produces highly variable fluctuations that can be the precursors to personality changes.[89] Billington and Robinson[88] also propose that the benefit of (group) reading lies primarily in the encouragement to (re)discover other ways of thinking and feeling—to practise continuous mental and emotional flexibility. Such flexibility may be about increasing insight, but it may also be something rather different: the shaping of old insights into new contexts where their meanings undergo change, for example. Along with the reasons to attribute relatively advanced self-directed insight to chronic eating disorder sufferers, these proposals merit investigation as alternatives to the insight hypothesis.

In sum, we know little about how fiction might achieve therapeutic effects, nor what factors determine how likely it is to do so, for any mental health condition, including eating disorders. Like interpretation itself,[90] bibliotherapy with fiction or poetry is often practised and rarely researched. Assumptions about the inevitably edifying nature of art are frequent, and realistic acknowledgements of the complexity of both literature and human beings are oddly rare. So we have a long way to go, but there are good reasons to predict that fiction may have an important therapeutic role to play in the prevention and treatment of mental illnesses such as eating disorders.

NEW SELF-REPORT EVIDENCE AND FUTURE DIRECTIONS

Exploratory research has begun to establish an evidence base linking eating disorders and fiction-reading. A recent online survey attracted 885 respondents, with an average age of 28 (range 18–75, SD 10.26), and of whom 847 were female and 773 reported personal experience of one or more eating disorders (most commonly anorexia), whether past or ongoing. The data, presented in full elsewhere,[36] suggest that engagement with fiction can play a major role in maintaining, exacerbating, triggering relapse into, or conversely aiding recovery from an eating disorder.

Key findings include the observation that respondents perceive their preferred type of non-eating disorder fiction to have therapeutic potential combined with a lower antitherapeutic potential than that associated with other text types (eg, fiction or memoir/autobiography about eating disorders and also self-help books). When characterising the helpfulness of reading across all genres, respondents reported positive changes in perspective on illness and recovery as a particularly prominent factor. This finding provides some support for the insight-based model of therapeutic change and also suggests a little more differentiation when it comes to the concept of insight, with five dimensions mentioned with similar frequency: 'informing you about the facts of eating disorders', 'letting you see your eating disorder through someone else's eyes', 'putting your eating disorder into perspective as something that other people have too', 'giving you an idea of what recovery might feel like' and 'motivating you by giving you a sense of what life could like after recovery'. It is also important to note that since overall helpfulness ratings were higher for self-help than for either fiction or memoir about eating disorders, we cannot necessarily conclude that this kind of insight is likely to be reliably generated by reading narratively structured texts about eating disorders.

More detailed analysis of responses on various dimensions key to disordered eating suggested that for the majority of respondents, their preferred genre of fiction has positive effects on mood, while effects on self-esteem were less pervasive but similarly positive. Meanwhile, effects on feelings about one's body and diet and exercise habits were more neutral. Conversely, fiction about eating disorders (defined as 'fiction that includes one or more characters who have named eating disorders, and/ or strongly exhibit the symptoms of an eating disorder, and/ or exhibit any eating-disorder symptoms that are central to the story') was reported to have far more consistently negative effects on mood, self-esteem and body-directed feelings, for respondents with and without a personal history of disordered eating. (The healthy control group was, however, small (n=112) compared with the group reporting personal experience of an eating disorder.) Those with a past or present eating disorder reported more strongly negative effects than others on feelings about their body and diet and exercise habits.

The salience of the negative response to eating disorder fiction goes against a major plank of creative bibliotherapy theory: that therapeutic effects are dependent on similarity between the reader's and the fictional character's situations. These preliminary results suggest the opposite: that reading about someone else who has an eating disorder is more likely to be experienced as harmful than as helpful with respect to mood, self-esteem, body-related feelings and diet and exercise, whereas reading about scenarios that have nothing to do with eating disorders

has potential to be therapeutically beneficial for mood and self-esteem. There are many respects in which a relationship of resemblance may be construed between reader and character, including basic demographic variables, physicality, personality, social and professional context and so on. However, these findings imply that if similarity is taken to pertain specifically to the pathological condition in question, its effects may be equivocal at best, and seriously harmful at worst.

More generally, the data suggest that it may be premature to ascribe all therapeutic cognitive progress to a route through perception of similarity with a fictional other, generation of insight into one's own condition and problem-solving action. The frequency with which non-canonical, non-realist literature (eg, fantasy, science fiction, children's or young adult literature like *Harry Potter*) was described as eliciting important effects suggests that assumptions about the need for simplistic forms of textual realism and optimism should be reconsidered. At least for the case of disordered eating, these early observational findings suggest that if insight is generated, the kind which leads to positive, recovery-oriented action is more likely to be obstructed than encouraged by reader-character or real-world–fictional-world similarity when it comes to the illness in question.

This kind of challenge to the received wisdom about aesthetic engagement and mental health makes clear that further exploration of the dynamics and the results of interpretive activity is warranted. Further investigation is called for not least because fiction-reading can so clearly be harmful as well as helpful. A sizeable subset of the survey respondents' free responses (answers given in response to invitations to provide more detail about their multiple-choice responses) offer detailed reports of the ways in which fiction about eating disorders comes to play a salient antitherapeutic role, with 18 respondents spontaneously reporting that they deliberately seek out such fiction knowing that it will trigger an exacerbation of their disorder, whether by encouraging a competitive attitude towards the character's illness (wanting to be thinner or more unwell, or to eat less), by serving as an instruction manual for learning new disordered behaviours or by otherwise entrenching them more fully in the mindset and habits of the disorder. The quantitative data outlined earlier support this observation by suggesting that the exacerbation of an existing eating disorder may occur via changes to disordered behaviours and body-directed feelings in particular.

The qualitative responses also indicate the significance of dynamic feedback loops in which fiction-reading provides an additional input into an already destabilised system. The role of fiction-reading can be either therapeutic (typically by introducing stability-enhancing negative feedback into the system) or the opposite (typically by exacerbating self-reinforcing positive feedback). Nineteen types of positive feedback loop involving fiction-reading were identified in 97 responses (11 instances involving some kind of therapeutically beneficial effect, the rest only antitherapeutic effects). Four types of negative feedback loop were identified in 19 responses (all but four instances therapeutically helpful). (For more detail, see ref 81). Without direct prompting, a significant subset of respondents thus indicated that the dynamics of 'spiralling' into illness or stalling in recovery, or conversely finding a stable footing and helpful momentum in ongoing recovery, may involve fiction-reading as a significant contributor.

Interpretation is a critical channel via which such feedback is instantiated. The strength of the interpretive dynamics is especially clear in cases where fiction-reading exerts destabilising effects on the mind–body system. In these cases, there are clear indications that the filtering of textual salience can become highly disrupted, with salience being unduly attributed or denied to elements of the textual content or structure. Among the most poignant responses were those that conveyed (directly or indirectly) the extreme selectivity and persistence of textual processing that can be associated with an eating disorder. This ranged from an exclusive focus on food in texts concerned primarily with other things (eg, *The Hobbit*) to the envy of a protagonist's death from an eating disorder that lasts for days after reading about it.

The dynamics of these interactions can be illuminated from the perspective of dynamical systems theory and within the framework of cognitive literary studies, asking how the degree and nature of a reader's immersion or transportation into the world of the text may affect the overall impact of a textual encounter (see analysis of the survey data from this angle in ref 91). Refining Glavin and Montgomery's suggestion that transportation may help in achieving critical distance from entrenched patterns of stimulus and response,[53] it may be fruitful to conceive of reading as a liminal experience incorporating substantive emotional and conceptual engagement with the characters and situations of the text and, at the same time (and perhaps in changing degrees), a meaningful connectedness to one's own real-world experiences and constraints. It may be a characteristic of fiction-reading in general that the direct response to a fictional character or their situation is in constant interaction with reflection on this response,[92] and in a pathological context this interplay may take significant forms: envy of the extent of the character's disorder, for example, in tension or alternation with the meta-awareness that such envy is a sign that one's recovery is not complete, or the self-protective reminder that the fiction is only a fiction, or the analytical identification of textual features that help drive the envy—or indeed the comfort to be drawn from aesthetic appreciation itself.[93] The tensions or vacillations between the response and the reflection on it may be mediated by narrative perspective, metaphor, textual imagery, cognitive realism and other characteristics that draw more or less attention to themselves as facets of the textual construction (Ch. 4).[15]

Testimony to direct, pragmatic, often bodily effects of fiction-reading was widespread in the free-response data. Reading a book may be a distraction from the suffering of real life or from the difficulties of eating, needing to eat or having eaten, although it is often prevented from serving this function by other factors that impede reading: for example, anxiety about the necessity to stop exercise to read or the difficulty of sustaining concentration adequate for reading. Fiction-reading also directly affects embodied sensation and action: some of the causal chains reported in the antitherapeutic direction involved reading making readers feel fatter or heavier, subsequently eating less, exercising more, body-checking more, and/or making themselves vomit—and so further exacerbating the cognitive restrictions of the illness, in turn making future physical vulnerability greater and so on. More positively, reading-mediated cause and effect were described as involving, for instance, learning how to listen to or 'be in, and stay in' one's body again, and encountering new and less constrictive possibilities for engaging with the body and food, such as how to experience one's body as sexual. This is direct opposition to the hyposemic (avoidant) and hypersemic (obsessive) tendencies that are powerful characteristics of the embodied interpretive disturbances of eating disorders.

Linking back to research outlined earlier on interpersonal benefits of reading, another recurring theme was the value of the fictional world as a social world: reading is often perceived as a way to create meaningful connections with other people, to encounter new role models, and simply to feel less alone,

with the text or its characters serving some of the functions of real-world friendship for some readers. As explored earlier in the context of the transportation hypothesis, the significance of these interactions is not dependent on any kind of wholly transported illusion that the text is other than a text: characters can be understood to be characters in books and nonetheless perform some of the important roles that physically real people do (see more detail on this testimony in ref 91). And harking back to our questions about identification, reading can also induce profound feelings of loss of self, with the habitual embodied self ceding to a feeling of identity with the book or the fictional world. This may result in the reader identifying with another (textual) person or in temporary freedom from the bodily dissatisfaction which impedes recognition of things in life that matter more. Finally, reading is reported as stimulating the ability to imagine that life could be other than it is—perhaps the single most fundamental prerequisite for changing one's interpretive paradigm and so initiating recovery from 'mental' illness.

CONCLUSION

The ways in which fiction-reading can be helpful and harmful in the context of mental illness clearly extend in many directions throughout the web of mind–body interactions that interpretation encompasses. The effects of fiction-reading are not limited to generating illness-directed insight based on recognition of illness-related similarity with textual others; indeed, reading about people with similar conditions to one's own may do more harm than good, by promoting competitively pathological thoughts, feelings and behaviours, and indeed readers may seek it out for precisely this purpose. Reading fiction can shift interpretive weightings in ways that mould readers' immediate emotional and bodily responses and have the potential to alter their attitudes, behaviours and values even long after they stop reading, often in profoundly multivalent ways.

Exploring the broad question of how it is that we engage with people and scenarios we know only through verbal description will teach us a lot about how apparently rarefied 'aesthetic' or 'cultural' phenomena have direct and everyday effects on everything we are and do, and this wide area of inquiry encompasses numerous more specific questions, many of them raised directly or indirectly by the overview offered here. These questions can be separated into three rough categories: text, reader and context.

In the first, we might include the effects of genre on narrative processing (eg, refs 94 and 95), as well as the roles of the linguistic and literary features discussed here, including metaphor, narrative perspective and textual imagery as prompts to imagining and appraisal. Another key question in this category concerns the role of fictionality versus narrative structure or other markers of 'literariness': what does the 'creativity' in 'creative bibliotherapy' most meaningfully denote? Although the survey was structured around the fiction/non-fiction distinction, the data suggest that eating disorder fiction and eating disorder memoir may elicit comparable though not identical responses— and some free responses made clear that the fictionality criterion was not being consistently applied by all readers. This is in line with previous findings that framing a narrative as fictional or factual has no effect on transportation[96] and that external realism and narrative coherence may be more relevant to transportation and identification.[97] The hypothesis that textual interpretation aligns with automatic processes of experiential narrativisation would suggest that narrative structure is central to the power of reading to lastingly affect real-world interpretive

habits (and the fiction–memoir parallels support this notion). However, 'non-narrative' genres like lyric poetry may achieve salient effects through higher degrees of foregrounded language, for example. And the question remains open of what difference, if any, the framing of a narrative as either fictional (as in a novel or short story) or factual (as in memoir or biography) makes to specific aspects of these dynamics.

The second category includes the impact of the reader's age and their sex or gender (including in relation to the protagonist), literacy, reading experience/expertise and familiarity with a specific genre. Personality variables like openness to experience may also be relevant,[98] as well as clinical variables such as a specific eating disorder diagnosis (or other mental illness, with or without comorbidities), severity of illness and the status of past or present treatment or other recovery attempts, if any.

Third, relevant aspects of the wider context might include temporal factors (from time of day to illness duration, and frequency and duration of reading episodes), and environmental factors (the physical location and medium of reading, the presence or absence of other people), as well as the inclusion or not of structured support for processing what is read, whether with a therapist or a reading group or via retrospective questionnaires or automated prompts during the reading process. Research on all of these factors, and more, exists in other fields: from the psychology of language processing to social anthropology of reading, and especially in relevant areas of cognitive literary studies and clinical psychology. However, the dots need more systematically joining up, in a concerted and balanced form of medical humanities research.

In short, the capacities of fiction seem to include a power to enhance our vulnerability to mental illness and, conversely, to generate the desire and the capacity to initiate and sustain recovery from it. And to learn more about both, we need to do at least four things:

1. develop effective ways of pooling expertise about texts and expertise about minds
2. understand theoretical and empirical progress as inseparable
3. be prepared to find that fiction—even great, canonical works of literature—can be harmful (in some respects for some people some of the time)
4. be prepared to find that fiction—even great, canonical works of literature—can be useful (in some respects for some people some of the time).

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