Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material for a degree at this or any other institution.

Desiree Boughtwood
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Abstract

This thesis argues that although the anorexic patient is subjugated in the medical encounter, subjects find ways to resist and disrupt this subversion. The analysis is largely based on life history interviews with teenage girls with a medical diagnosis of anorexia. Other data sources include interview field-notes, my research journal and selected popular magazines. The data was analysed using a discourse analytic methodology to explore how girls constituted hospitalisation, anorexia, doctors and patients, among other issues. The analysis draws on insights from poststructuralist theory, and is informed by the work of: Michel Foucault, Elizabeth Grosz, Judith Butler, Elspeth Probyn and Deborah Lupton. In the earlier chapters, an analysis of the complex medical, psychological and feminist theories of anorexia nervosa; and a description of the hospitals where girls are treated is developed to situate the study in its socio-historical context.

The analysis consists of three main arguments. The first is that clinical notions of food, eating and embodiment are in direct contrast to social discourses on these topics. Girls draw on this discrepancy in their resistance to hospital practices. The second argument is that girls are aware they are positioned as irrational because of their malnourished state and are also aware that if they blatantly resist treatment they will be subjected to further surveillance. Girls take up medical discourses in different ways and to different effects in constituting themselves as agetic subjects. The third argument focuses on the shifting construction of the anorexia subject in the clinic.
Although discourses of anorexia and psychiatry have a powerful impact on the girls; girls resist these positionings, finding other ways to constitute themselves.

The contention of this thesis is that clinical constructions of anorexia work to form the subject and provide the possibilities for the creation of other subjectivities. On the basis of this research, some suggestions for how inpatient treatment regimes may work differently are provided.
Dedications

This thesis is dedicated to my mother.
Acknowledgments

Firstly, to all the participants: thank you for trusting me with your stories and allowing me an insight into a part of your life.

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Thank you to all my family and friends for their love, support and encouragement throughout the thesis. To my brothers and sisters: Monique, Daniel, Reuben and Madeleine. Thank you to Ramesh for your love, support and also medical advice.
List of Acronyms

BMI  Body Mass Index
DSM  Diagnostic and Statistical Manual of Mental Disorders IV
USA  United States of America
NSW  New South Wales, Australia
MFT  Maudsley Family Therapy
EDI  Eating Disorders Inventory
APA  American Psychological Association
OCD  Obsessive Compulsive Disorder

Qualification of terms

There are instances throughout the analysis chapters where numbers of girls have made similar comments about particular issues, such as hospitalisation, other patients and doctors. This is a qualitative thesis and the concepts, not numbers are important; thus there no effort is made to quantify participants comments. However, I do not want to apply a uniformity of opinion, or provide numbers of how many participants said X, and so have used the following terms to indicate how many girls made a particular comment or felt a certain way about an issue. I have chosen terms that are consistent with their definition in the Macquarie Dictionary, eg. Several is defined as “two or three but not many.” These terms are also part of the vernacular and are used in this thesis as they are in general usage.

The following terms have been taken as meaning:

*Several* refers to five or less girls.

*Some* refers to 10-fifteen girls.

*Many/Most* refers to 15-25 girls.

*All* refers to all girls interviewed for this study.

*These* refers to the girls discussed in a particular section of the thesis.
Chapter One

Introduction

1.1. Appearance of anorexia

The emaciated anorexic girl is a familiar sight. She is frequently depicted in magazines, academic texts and current affairs shows, and appears as extremely malnourished, on the verge of death. Bony shoulders like sharp corners flank a singlet top, stick-thin calves ‘support’ wasted thighs that are barely covered by skimpy shorts. The scant clothing is perhaps intended to make a spectacle of the emaciated body. If a face is visible it appears frightened, vulnerable, half hidden by a fall of hair. Sometimes the anorexic is shown in an inpatient treatment centre. These representations further fuel the spectacle of the starving body: a cropped photo of thin legs on a scale, a plate of barely eaten food placed in front of a wasted figure, a young girl sitting forlornly in a stark hospital bed, surrounded by mottled green walls. A doctor sometimes appears alongside the anorexic, his clean-shaven features, expensive clothes and relaxed manner an outward display of ‘normality’ - a sharp contrast to the quivering anorexic on the bed. The emaciated body under the control of medicine is the dominant representation of anorexia. Although frightening, this picture sanitises anorexia and reassures viewers that the doctor is capable of curing the patient. The other, messier and distressing side of anorexia and hospitalisation is absent in such representations.

There are many complex tales of anorexia that are not attended to in mainstream depictions. Amongst this suite of concealed narratives, bodies are an ever-present
theme. Bodily difficulties become particularly pronounced when girls move between the clinic and their homes. Society celebrates thin bodies and, with a raft of diets, slimming lotions and cosmetic surgery becoming increasingly available to everyone, the implicit message is that women should be able to obtain the (thin) body that they desire.

Before coming into the clinic, many girls have adhered to a rigid eating and exercise routine. The discourses in operation in the clinic directly counter social notions of appropriate embodiment. Girls are confronted with regimes that are diametrically opposed to their pre-hospitalisation existence and aim to undo girls’ attempts at controlling their diet and exercise. In the clinics where the current study was conducted, inpatient treatment for anorexia requires the consumption of several large meals a day and three snacks, which is supplemented by bed rest (remaining on the bed half an hour after meals). Girls may vomit in attempting not to gain weight, or artificially inflate their weight by drinking litres of water- known as water loading by those versed in the language of anorexia nervosa. If a girl is found to be water loaded, she will be subject to greater external control including surveillance and random weighing. In hospital it is no longer possible for the anorexic to police and discipline her body. Girls leave the clinic up to ten kilos heavier than their admission weight.

In inhabiting a bigger body girls are not likely to be treated by family and friends with the same envy, repulsion, admiration or concern as they were when emaciated. For some girls, relief at feeling better physically is accompanied by uncertainty about how they might be received in different social circles. A larger body often means
relinquishing one’s identity as anorexic. Some girls become ambivalent about their bodies, an ambivalence that is often a subjective effect of a shift in public identity and how one is perceived by others. Girls can experience a number of conflicting emotions such as distress and anger in being told by family and friends “you look well.” Girls may interpret these comments to mean that they are fat. Anorexia is so often positioned and represented as a bodily act that once the spectacle of emaciation is lost; the girl, their family, friends and even doctors are unsure about how to name the body. Subjective accounts of ambivalent bodies are a constant and pervasive theme in narratives of anorexia nervosa and are the central focus of this thesis.

1.2. What is anorexia nervosa?

Anorexia nervosa has an ambivalent status in Western society. Although many commentators offer stories of anorexia, in public consciousness and scholarly writing, medical discourse is constantly positioned as the authoritative account. Medicine locates anorexia as a psychiatric and physical illness, characterised by a low body weight, amenorrhoea, fear of fat and a distorted body image (American Psychiatric Association, 2000).

Self-starvation is not a new or recent phenomenon. Throughout history incidents of food refusal and unusual food practices have been documented. In Brumberg’s words:

Today’s anorectic is one of a long line of women and girls who have used control of appetite, food and the body as the focus of their symbolic language. A
The historical perspective shows that anorexia nervosa existed long before there was a mass cultural preoccupation with dieting and a slim female body (Brumberg, 1988, p.2-3).

The Latin name, anorexia nervosa, literally means nervous loss of appetite (American Psychiatric Association, 2000). It is now widely accepted that this term is a misnomer, because anorexics rejection of food is unrelated to appetite (Palmer, 2003). The earliest recorded account of anorexia is a 1689 report by Thomas Morton, an English doctor. Morton discussed two case studies, one female and the other male, who were suffering from a wasting disease (Gordon, 2000). At the time, Morton’s work was not widely acknowledged. Doctors still made reference to God to explain what they believed were supernatural cases, linking self-starvation to sainthood (Brumberg, 1988). In 1873, two leading physicians simultaneously published accounts of the illness. The Englishman William Gull was a consultant of the Queen, and Charles Laségue was of French origin. Their respective reports varied in emphasis, as Brumberg explains:

Gull’s report was primarily medical, focusing on how the physician came to conclude that the condition involved ‘simple starvation,’ and no organic cause. Laségue’s commentary was psychological, outlining the mental stages through which patient and family passed in the course of the disease (Brumberg, 1988, p. 119).
Both Gull and Lasegue identified adolescent girls as a vulnerable population for anorexia nervosa. The publication and public recognition of Gull and Lasegue’s reports enacted a construction of the anorexic from saint to patient (Brumberg, 1988) and thus began the first of many debates over the cause and treatment of anorexia, and some of the initial accounts still inform present day medical discourses.

A popular nineteenth century construction of anorexia was that it was fasting for attention (Brumberg, 1988; Vandereycken & van Deth, 1993). Gordon (2000) notes that this construction is still evident in modern accounts; for instance, in the title of one of the better-known autobiographies of anorexia Starving for Attention (Boone O’Neill, 1992). In earlier constructions there was no mention of fat phobia or dissatisfaction with the body (Beumont & Touyz, 2003) unlike much contemporary debate, which is saturated with discourses about female body dissatisfaction (Black, 2000).

Contemporary twenty first century medical discourse construes self-starvation as a disorder. Beumont & Touyz (2003, p.1) note that “recognition of anorexia nervosa as an illness entity came from the need to differentiate various forms of severe wasting diseases from each other.” Clinical research identifies anorexia as the third most common illness in adolescent girls. Anorexia has a five to seven year duration (Touyz, 2005). With one in five sufferers attempting suicide, anorexia has an incidence rate higher than any other adolescent psychiatric illness (Touyz, 2005). Because anorexia is frequently diagnosed at adolescence first hospital admissions generally take place at this age (Powers & Santana, 2002). Hospitalisation is still the
The primary mode of treatment when the anorexic is medically compromised (Vandereycken, 2003). Hospitalisation however does not guarantee recovery with some patients having repeated, failed admissions throughout adolescence (Castro, Gila, Puig, Rodriguez, & Toro, 2003; Eckert, Halmi, Marchi, Grove, & et al., 1995). Admissions largely attend to re-feeding and medical stabilisation and patients often lose the weight gained in hospital shortly after discharge. Even when the sufferer maintains the increase in weight, termed ‘weight recovery’ in clinical literature (Eckert et al., 1995; Beumont, 2003) the psychic and emotional effects of anorexia remain, such as depression, long term difficulties with eating in social situations and dissatisfaction with the body. There are an increasing number of alternative treatment models emerging, which construe anorexia differently to medical discourses. For instance, narrative therapy constructs THE anorexia as an entity acting on and/or encompassing the individual (Monk, Winslade, Crocket, & Epston, 1997).

1.3. Medical definitions of anorexia nervosa

The Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2000) is used in clinical practice and research. The DSM-IV (p.263-264) defines anorexia nervosa as:

A. Refusal to maintain body weight at or above a minimally normal weight for height and age (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one’s body shape or weight is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of low body weight.

D. In postmenarchal females, amenorrhoea, i.e. the absence of at least three consecutive menstrual cycles.

The DSM-IV also offers two subtypes of anorexia nervosa:

**Restricting Type:** This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, or excessive exercise. During the current episode, these individuals have not regularly engaged in binge eating or purging.

**Binge Eating/Purging Type:** This subtype is used when the individual has regularly engaged in binge eating or purging during the current episode. Most individuals with anorexia nervosa who binge eat also purge through self-induced vomiting or the misuse of laxatives, diuretics, or enemas. Some individuals included in this subtype do not binge eat, but do regularly purge after the consumption of small amounts of food. It appears that most individuals with Binge-Eating/Purging Type engage in these behaviours at least weekly, but sufficient information is not available to justify the specification of a minimum frequency.
The diagnostic criteria for anorexia serve various purposes for different parties, such as clinicians, sufferers and hospital managers. These definitions provide clinicians with a means of classifying patients and, depending on their presentation weight and frequency of behaviours, a justification for admitting them into hospital. The relevance of the DSM to everyday practice continues to be debated (Andersen, 2002) including whether different definitions are useful in improving treatment (Touyz, 2005).

The diagnosis of anorexia has a multitude of effects on sufferers in the wider socio-political context. Financial implications are one effect, particularly in the United States of America (USA) but more recently in Australia, with sufferers seeking funding for private treatment (Garrett, 1988). For instance, sufferers have been recently negotiating for public health funds to be treated in the controversial Karolinska Institute (Touyz, 2005). A medical diagnosis of anorexia also has significant personal and social impacts, by defining an identity and a lifestyle, particularly if one has to be hospitalised.

1.4. Other conceptualisations of anorexia nervosa

Feminists have been critical of the use of the DSM and medical definitions more generally (B. Thompson, 1988; Way, 1995). American scholars Lelwica (1999) and B. Thompson (1994) suggest that terms like anorexia nervosa are highly loaded and reflect the social dominance of medical discourse. These authors use the term eating problems to escape the biomedical connotations attached to the term disorder,
suggesting women’s reasons for starvation may be a rational response to irrational circumstances. Nevertheless, Lelwica (1999) points out that these terms like anorexia and bulimia have become part of the vernacular of contemporary Western societies and are necessary to communicate to popular and academic audiences when discussing issues around eating and embodiment.

As Lelwica (1999) notes, anorexia has a significant status in popular discourse. Contemporary magazines such as Cleo proliferate with images of celebrities who have “caught anorexia.” Media have been criticised for glamorising anorexia/self starvation (Way, 1993). Media productions have played a complex role in anorexia’s popular profile, largely through the proliferation of autobiographical accounts, magazines, talk shows and documentaries, which are primarily aimed at female audiences (Bishop, 2001). In these popular forums it appears that the label anorexia does not carry the same stigma as attributed to anorexia and other psychiatric categories in a medical context. This social phenomenon is evident in the popular dictum, originally attributed to the Duchess of Windsor, that a woman can never be too rich or too thin (as discussed in Brumberg, 1988).

Other commentators oppose the definition of anorexia as a disorder, arguing that anorexia should be understood as “acts of ‘agency’…instances of resistance, critique, taking/wrestling responsibility and control” (Evans et al., 2002, p.208). In this

1 I use anorexia/self starvation here as the media personifies anorexia, by presenting it as a real object to be discussed through various frames.
construction, anorexia is situated as an embodied means of communication rather than an illness that takes over an individual. This is not to deny the serious physical consequences of starvation, but to examine the phenomenon of anorexia more critically.

1.5. Positioning the research: significance and focus of the study

The majority of research on anorexia has been quantitative and there have only been a comparatively small number of qualitative studies on anorexia (e.g. Bardone, Perez, Abramson, & Joiner, 2003; Garrett, 1997; Malson 1998) and these have focused overwhelmingly on populations who are past the non-compulsory years of schooling or have recovered from anorexia. There is a significant gap in the research literature about adolescent girls, although medical writings suggest this group has the highest incidence rates of anorexia nervosa (Polivy & Herman, 2002) which is my rationale for focusing on this age group, specifically attending to girls’ voices by using interviews (see Chapter Two).

The thesis is part of a larger study titled *Multiple Perspectives of Eating Disorders*. As the qualitative PhD student on the project, I conducted interviews with teenage girls with a medical diagnosis of anorexia. These interviews have been used as the basis of my thesis. The interviews have also been used for: journal articles, conference papers, as a part of another thesis, a support needs questionnaire (what girls think they need to get them through the experience of anorexia) and book of case studies of eight of the families interviewed for the project.
The analysis presented in this thesis focuses mainly on parts of the interviews that address issues related to medical constructions of anorexia nervosa and hospital regimes. Specifically, the thesis focuses on how girls’ constitute themselves through the governing practices of the clinic. Girls are both subjected and brought into being by discourses of anorexia and the discursive practices of the clinic.

1.5.1. How this thesis was conceived

The major questions that inform this thesis were conceived through my personal experiences of anorexia nervosa: as a sister to a girl with anorexia, as a researcher and as a scholar navigating her ontological positioning and her position within the eating disorders literature.

Like other researchers (Lelwica, 1999; B. Thompson, 1994), I believe the best scholarship is shaped by personal experience. My entry into the world of eating disorders happened when my sister was diagnosed with anorexia at age twelve. Throughout the last ten years my family and I have had many consultations with different doctors about my sister’s anorexia, because the family are frequently implicated as having some part in causing the illness and its trajectory (Brumberg, 1988; see 4.2.5). I discovered this construction through both my personal experiences and by reading different texts on anorexia nervosa. Before embarking on this project, __________________________

2 In addition to hospitalisation, there are other services like psychological and family therapies, which girls’ may engage with in addition to hospital. In this study I focus on inpatient treatment.
I conducted an earlier study about media’s relationship to eating disorders (Boughtwood, 2003). In reviewing the literature, I encountered medical writings that situated anorexia through various frames such as a physical and mental illness, a family problem and as an irrational response to social messages. I also read and engaged with a number of feminist texts on anorexia. Often in response to medical writings that pathologised anorexia as a mental illness, feminist writings on eating disorders (Chernin, 1981; Wolf, 1991) suggested women with anorexia were ‘victims’ of a society that objectified female bodies. Feminists bemoaned medicine’s emphasis on treating the physical aspects of anorexia, rather than what they saw as the root of the problem (Sesan, 1994). At the time I agreed with these feminist critiques of hospitalisation.

When I was recruited to this current study, *Multiple Perspectives of Eating Disorders* I expressed many reservations about interviewing girls in the hospital, suggesting that girls would not be able to speak freely about these experiences in a space of subjugation. However, when I began to conduct the interviews, the girls’ resistance to and creative mobilisation of medical discourses quickly became evident. This resistance was not overt rejection of medicalisation. Rather, girls engaged with medical constructions of anorexia, taking up and transforming these discourses to produce different subjectivities. For instance, one girl who was discharged before I could interview her described how she wanted to be healthy and that she understood the concept of health better than the doctors. It was by being witness to these interactions that I developed the research questions: how do girls negotiate anorexic subjectivity in the clinic, as framed by the possibilities of subjectivities other than passive, obedient patients.
1.5.2. Significance of the study

The study seeks to make a timely contribution to understandings of anorexia, as there is limited research that considers the shifting and complex ways in which patients negotiate diagnosis and treatment (Lupton, 2003). In the many of the sociological writings on the medical encounter, the patient is situated as passive. Various scholars whose work is often informed by feminist and/or Marxist frameworks have developed lengthy critiques of medicine. As Lupton (1997) explains:

In concert with liberal humanist ideals, critics argue that becoming ‘medicalised’ denies rational, independent human action by allowing members of an authoritative group [medical profession] to dictate how others should behave… This perspective has tended to focus on the ways that the medical consultation facilitates the power of doctors over patients and supports capitalise ideologies…the orthodox medicalisation critique has also been taken up by feminist critics of medicine (Lupton, 1997, p.96-97).

There is little work on doctor-patient relationships in the context of inpatient treatment for anorexia. Writings that investigate consumer perspectives on treatment (Bell, 2003) are to fulfil a different agenda, because these are largely intended to review a service. Medical writings on anorexia largely ignore these relationships (see 5.1.2), excepting cautioning clinicians to be wary of the deceptive behaviour of anorexic patients (Garner & Garfinkel, 1997). In the thesis I make reference to some
specific feminists who have written about anorexia nervosa, acknowledging that feminism is a diverse body of literature. Paralleling other feminist critiques of medicine (Ehrenreich & English, 1973) some feminist writings on anorexia bemoan medicine’s emphasis on the physical aspects of anorexia, thus ignoring the emotional dimensions and reinforcing women’s positioning as inferior (Sesan, 1994; Way, 1993). The small number of studies that explore patients accounts of treatment, generally situate the patient as powerless under the clinical gaze and do not move beyond anorexia and patient-hood in exploring how girls negotiate treatment (Segal, 2003).

Using a poststructural frame, this thesis argues that many girls do not unquestionably accept the position of patient in that they are obedient to doctors. Resistance to anorexia is enacted through a number of different strategies, such as girls couching their behaviour as normative dieting and exercise. While recognising that there are serious consequences of starvation, this thesis argues for a more nuanced understanding of how anorexia, clinical regimes and players within the clinic are constructed by girls in informing subjectivities that are other than positions of passivity. Following Lupton (2003, p.121) I contend that “power relations are dynamic and constantly negotiated and renegotiated between the participants in medical interactions.”

1.5.3. Clarification of some key terms used in the thesis

The three definitions discussed above (1.3. & 1.4) are illustrative of the diverse constructions of anorexia nervosa. In my project, I cannot provide a concise
explanation of how I am using the term anorexic. All the girls I interviewed had received a medical diagnosis of anorexia nervosa but not all girls responded similarly to the diagnosis. For instance, one reading of the interviews conducted for this thesis was that some girls were invested in being anorexic. The investment was not only in thinness, there was also a desire for medicalisation. Therefore, although anorexia can be a stigmatising label, it is erroneous to do away with the term anorexic for this project. I ask that readers remember this nuanced discussion when encountering the many different anorexics throughout the thesis.

In describing the space of treatment, I use the term clinic, rather than hospital. This is to delineate the eating disorders clinics as specialised units with a hospital, and is also consistent with my use of Foucault (1973). However, in the third part of Chapter Eight, I use psychiatric institutions to refer to sites specifically for the treatment of mental illness. In the thesis I use clinic and institution to make the distinction between sites for treatment of anorexia and hospitals that treat other psychiatric illness.

In the thesis, along with referring to the participants as anorexics, I also use two other terms, patients and most frequently, girls. I am aware that these two terms are problematic and may be viewed as infantilising and paternal (Malson, Finn, Treasure, Clarke, & Anderson, 2004; B. Davies, personal communication, January 2006; V. Ryan, personal communication, January, 2006). The term patient perhaps implies the researcher is complicit in maintaining doctor-patient hierarchies. However, my use of patient is deliberate, because I am analysing doctor-patient relations, and it is necessary to use the label patient to discuss girls’ negotiation of various positions. In
regard to my use of *girls* I have chosen to refer to the participants as *girls* rather than young women, as *girls* is the term used by the participants in speaking about themselves and others who shared the experience of inpatient treatment with them.

Finally and importantly I refer to *subjects* as researchers do in poststructural theorising and writing; to explain how the *subject* becomes subjected and simultaneously subverts the power of discourses in constituting other subjectivities (Davies, 2000). The use of different terms in certain places is to explain how subjects are positioned. For instance, I write about how girls are positioned as anorexic patients through time, space and surveillance.

1.6. Overview of thesis

Chapter Two describes the participants, the various types of data collected and how these were analysed. Both interviewing and generally being in the clinic (attending meetings, being in the clinic and running into doctors and patients in other parts of the hospital, like the coffee shop) brought about a number of issues that cannot be separated from the analysis. I offer a critique of the research process, as some of the issues I encountered informed the specific focus of the study.

The review of the literature is presented in two chapters, Chapter Three and Chapter Four. Chapter Three describes the theoretical frame for the research. The specific ideas of the different theorists used in the analysis are elucidated. These scholars are: Michel Foucault, Elizabeth Grosz, Judith Butler, Elspeth Probyn and Deborah Lupton.
These scholars offer different theoretical and conceptual tools that informed my reading of the data.

Chapter Four is in three parts: some of the demographic information on anorexia, an analysis of the medical, psychological and feminist literature on anorexia and a description of several studies that have some synergies with my own work. Medical writings have focused on understanding the epidemiology of anorexia and its physical and psychological manifestations (Beumont, 2003) and there has been a recent move to combine different perspectives of anorexia, including feminist conceptualisations. The integration of the different perspectives seems intended to produce a fuller picture of anorexia, but there are problems in this construction, because many of the different perspectives are not epistemologically compatible (Malson, 1998). Biomedical constructions of anorexia directly inform how anorexia is treated in traditional hospital settings.

Chapter Five describes inpatient treatment regimes for anorexia in the clinics where the research was conducted. Treatment largely consists of weight gain through supported meals, with extra supplements if necessary. Factors that dictate length of admission are explained in this chapter, including financial considerations and issues surrounding compulsory treatment. Medical and feminist critiques of treatment are also reviewed here. To provide context for my analysis of the interviews, the two clinics are described in the latter part of the chapter, including their specific regimes and therapies. The chapter illuminates that inpatient treatment for anorexia is a complex, distressing and costly venture.
Chapter Six analyses how girls discursively construct clinical regimes as in conflict with the social discourses on food, eating and embodiment. Girls engage in various forms of resistance to the governing practices of the clinic, drawing on social discourses to legitimate their refutation of medical discourses of eating and embodiment.

Chapter Seven focuses on constructions of patienthood, doctor-patient relationships and relations among patients. The clinic aims to nurture the girls to be autonomous, based on the premise that refeeding will mean girls become rational and will take responsibility for recovery. Such a construction of autonomy is problematic, because autonomy is constrained by rigid treatment regimes. Girls discursively construct a different type of autonomy in their negotiations with regimes and individuals, exercising agency in poststructural terms. Girls do not perform as patients, but trouble the governing practices and regulatory regimes of the clinic.

Chapter Eight explores the shifting construction of the anorexic subject through different constructions of anorexia, mental illness and psychiatric institutions. The chapter is in three parts. Part One examines how girls position themselves in response to doctors construction of the girls and anorexia as separate entities, a notion that doctors have borrowed and modified from narrative therapy. Part Two explores girls’ constitutions of anorexia in relation to subjectivity and identity. Part Three examines different constructions of psychiatry and how these inform how girls and others construe anorexia and inpatient treatment for anorexia; positioning girls as mad, bad
and sad. The major argument of this chapter is that while constructions of anorexia, mental illness and psychiatric institutions work to affix girls with medical identities, girls trouble these constructions and create spaces to constitute other subjectivities.

Chapter Nine contains the conclusions. I argue throughout the thesis that anorexia is a fractured, complex category and it is through this complexity that girls can find the space to be other than anorexic patients. This analysis re-theorises the anorexic patient not as subjugated by and submissive to the doctor and the governing regimes of the clinic, but as active and continually negotiating her positioning in the medical encounter. Girls deploy the discrepancy between medical and social discourses to construct alternative notions of embodiment in the clinic, thus unsettling the dominant medical discourses circulating within the clinic. Based on the analysis, there is a section in Chapter Nine that offers some suggestions for how inpatient treatment might work differently.
Chapter Two

Methodological Issues

This chapter is in three parts: Part One describes the sample and the five kinds of data collected, namely: interviews with girls, field-notes detailing my thoughts on interviews, notes from clinical meetings, a research journal and various popular magazines. Part Two is a discussion of the issues that arose in interviewing which form the major component of the analysis. The rationale for using interviews and how the interviews were positioned and analysed are discussed. Part Three explicates issues that were important to the research process and informed the focus of the thesis.

2.1. Data collection

2.1.2. Sample

The twenty-five girls that were interviewed for the study were recruited from two large public hospitals in New South Wales, Australia (see Chapter Five for a detailed description of the hospitals). Participants had one or several admissions in either or both of the eating disorders clinics within the hospitals at different times and were aged between 12 and 18, with a mean age of 14.8 years. The average Body Mass Index (BMI) for these girls was 15.6. BMI is a number that measures body weight adjusted for height. BMI is a universal measure in treating anorexia nervosa and related conditions. BMI has four categories: underweight, normal, overweight, or...
obese (Centres of Digestive Control and Prevention, 2004). A normal BMI is within the 20-25 range.

2.1.3. Interviews

Every girl in the clinics who met the medical diagnosis of anorexia was invited to participate in the interviews. Four declined to be interviewed, telling me that they were too uncomfortable with events in their lives to speak about their experiences or had been involved in other psychological or medical research that was being conducted simultaneously in the clinic and would prefer not to participate in further research. Paralleling the experience of other qualitative researchers in health settings, such as Tait (1990) some girls who participated expressed their pleasure that their experiences, by inclusion in my research, would be of use to others.

The interviews lasted between 30 minutes and two hours. The length of interviews was often determined by factors like clinical timetables or the girls’ physical condition and well being, because some tired easily. The interview questions were generated by identifying gaps in existing literature on anorexia, namely: subjective experience of anorexia, perceptions of causal factors, the relationship between anorexia and identity, the effect of ‘having’ anorexia on girls’ life and on relationships with friends and family, and identification, management and treatment of anorexia. A schedule was devised (see Appendix One) but this was used sparingly in keeping within feminist research methods (Stanley, 1990) in order to give priority to issues the girls’ raised and considered important to share during the interview.
The interviews were transcribed verbatim by an independent transcriber. When they were sent back to me, I checked and de-identified girls by pseudonyms. An amended version Jefferson transcription model was utilised (see Appendix Two), which includes intonations to indicate louder speech and other non-verbal cues because these are important in understanding the meaning of a particular account.

2.1.4. Other data

The field-notes were a valuable tool because they provided a contextual, physical, emotional and atmospheric record of the interviews (see Appendix Three) and these factors informed how I interpreted these data. These notes included a physical description of the participant and interview location, which was usually my own or another office in the hospital. In the notes, I recorded the atmosphere of the interview and postulated tentative explanations for this. I also described issues that girls seemed passionate about, such as strong feelings about specific treatments like nasogastric tube feeding. Also included in my notes were some methodological issues such as the abandonment of interview questions and problems with the equipment. There was a section for post interview interpretations, along with critiques of my interviewing technique. Because the subjectivity of the researcher informs the analysis (Halse 2002; Malson, 1998) I recorded my emotional responses here, as they informed my interpretations of the interviews and other data.
The chief investigators\(^4\) on the project (see Appendix Four) had established a research relationship with the primary doctors involved in the girls’ treatment. At the doctors invitation I attended the clinical meetings, two per week, one at each clinic throughout the research process. These meetings are attended by the majority of the clinical staff (see Chapter Five for further description of the meetings) and are primarily for the purpose of discussing girls’ progress through treatment. Attending the team meetings proved useful in understanding the clinical regimes and establishing relationships with the staff. Because the discussions from these meetings were not part of my data collection (I had not asked or received ethics approval from the hospitals or university to use this data) I only took some brief notes about the patients from the meetings. These included a physical description of the girls and their name so that I could identify and speak to them when I went into the ward, a few ‘clinical’ notes: age, weight, BMI and family background.

Girls were aware of my attendance at team meetings because they saw me enter the meeting room after I had spoken to one of them or concluded an interview. My attendance at these meetings seemed to lead girls to assume I was a clinician of some description, as suggested by comments like “are you going to your meeting now?” I

\(^3\) Nasogastric tube feeding is a method of weight restoration through the insertion of a tube into the nose and down to the stomach. Supplements are then passed through the tube using a feeding pump (Halse et al., 2005). See Chapter Five for further discussion.

\(^4\) As my thesis was one project within a larger study, the ethics approval notification letters are addressed to the project’s chief investigators (Appendix Four).
always took the opportunity to reiterate my role as a researcher, but as some of the girls’ presentations in the interviews perhaps revealed, I did not always convince them entirely, or perhaps they did not want to be convinced.

My journal was for the purpose of recording informative material I encountered throughout the research process. Specifically, the journal included: verbatim records of corridor conversations with girls, interactions with doctors, discussions with various other staff and comments about clinical regimes. It was also a forum for pondering on issues that I struggled with in engaging with the research setting and for statements of emotional/embodied investment in the research process. I encountered issues other feminist researchers have struggled with (Stanley, 1990; A. Williams, 1990). These included: the place and boundaries around emotion, a divergence between my own and how girls seemed to conceptualise the interviews, tensions in my positioning as researcher and other ways I imagined I was positioned. The notes from this journal informed the analysis because they captured my immediate reflections on these issues, thus providing a temporary contextualised analysis which I later revisited in analysing these data.

Popular media are used in the analysis in two ways: a commentary on the texts themselves and how girls deployed such media in discussing anorexia and the clinic. The media texts included contemporary women’s magazines, television shows and films. These media contained both images and written commentaries on food, bodies and mental illness. The texts formed the social fabric of the clinic. Magazines were heaped on bedside tables and images were cut out and pinned to the walls of girls’
cubicles. The magazines (that were visible to me) included: *Cosmopolitan, Cleo, Who, New Weekly* and *Dolly*. The presence of these texts was impossible to ignore in the clinics, thereby reinforcing the theoretical point made by Warin (2004) about the impossibility of disengaging from media’s depiction of anorexia: “anorexia is saturated by pervasive cultural systems of representation” (Warin, 2004, p.95). Mental illness and the sites in which mental illness are treated are also depicted in these texts.

The second rationale relates to girls’ deployment of these texts in the interviews. One girl, Jessica commented on how magazines were littered throughout the clinic. She noted that if people were susceptible to these images, because they had a desire to obtain the bodies of magazine models, then the presence of the magazines could reinforce their problems. She suggested it was “weird” that such media should be located in a “place” that treated eating disorders. Jessica’s comment about how anorexia is embedded in the social illuminates how there is an intuitive understanding in the public domain about a link between anorexia and social discourses, which this thesis explores in a theoretical frame (Chapter Six).

2.2. Data analysis

This section describes the theoretical frame through which the interviews are analysed as these are the primary data source for the thesis. The other data informed my reading of the interviews. The discussion includes the rationale for using interviews and how these were positioned and analysed.
2.2.1. Rationale

I have chosen to use interviews to address the absence of girls’ voices in the literature on anorexia nervosa. An aspect of standpoint theory, as articulated by Harding (1991) is that women’s voices have been absent in sociological research. I apply this theoretical point to my work by exploring the standpoint of adolescent girls. Using interviews is a strategy for illuminating girls’ voices; although there are issues like the power relations between interviewer and interviewee that need to be considered in analysis (Scheurich, 1997). Another, less important consideration was that this population are considered mentally ill and the project had to be cleared by both the university and hospital ethics committees, so it was necessary to choose an established research method.

2.2.2. Poststructuralism and positioning in interviews

The interviews were analysed using a poststructuralism frame and an extended discussion of poststructuralism is presented in Chapter Three. Interviews in a poststructural frame are positioned very differently to positivist traditions (Riley, Schouten, & Cahill, 2003). In a poststructural frame it is possible to generate multiple meanings of any data. As St Pierre writes “meaning can be strategically reinterpreted, reworked and deferred since there is no referent for the subject” (St Pierre, 2000, p.504). The interview is thus a particular narrative mobilised for a specific context.
Poststructural interviewing acknowledges that researchers do not hold power in the interview in that participants do not always adhere to the researcher’s aims. Participants may misunderstand the question, or deliberately misconstrue a question in ways that take the conversation in another direction. Both participant and researcher are actively involved in making meaning and the interaction between them is as important as the research topic (Scheurich, 1997). In the conversations that constitute the interview, both parties assume positions deemed appropriate for their interview performances (Y. Lee & Roth, 2004), but these shift over the course of the interaction. Thus in interviews, “speakers adopt multiple and different roles or presentations of the self during the speech or storytelling which is itself often multi-layered” (Y. Lee & Roth, 2004, p.6).

It was evident early in the research process that interviews were discursively constructed by the different positions that the girls took up in relation to anorexia nervosa. Although I used strategies such as using the interview schedule sparingly in an attempt to focus on issues that were important to the girls, some girls seemed to treat the interview as if it was more of a clinical interview by taking up the position of patient. This stance was evident when girls limited their responses to a perfunctory yes or no, or described themselves as an anorexic patient (although there are other ways of reading their response). In contrast, other girls rejected the medical identities conferred by their diagnosis and location in the clinic. For instance, although I did not see girls as only mentally ill, I took their emaciation as an unspoken given. Yet some girls could be read as rejecting the serious nature of their condition, because they modified and returned my own questions, such as “do you want to put on weight?” seeming to take up the common notion that all women are worried about their weight.
Other girls positioned me as a clinician. These girls seemed to use my research, and my (conferred) positioning as clinician to avoid parts of treatment regimes that they did not enjoy, such as attending the hospital school and physiotherapy. The conduct of the interviews involved constant negotiation with several stakeholders in the clinic, including both the principal doctors and all other therapists involved in the girls’ care. Despite my attempts to work around girls’ preferences and ward routines that could not be interrupted, such as meals, interviews were sometimes interrupted and postponed. This impacted on my own and girls positioning when the interviews were resumed. For instance, one of the doctors interrupted the interview to tell the girl about a particular treatment decision. She was pleased with the decision and thus referred to him favourably after the conversation resumed, which was in contrast to how she located him prior to the interruption.

2.2.3. Reading the interviews

Interview subjects, like any characters in cultural storylines, desire to construct themselves and be constructed by others as a coherent individual. I raise this point to illuminate the difference between how I positioned girls in the interviews and how this data was analysed. In doing the interviews, I positioned girls as telling me a truth of their experiences in that I did not interrupt a particular story to question its validity. However, in analysing this data I positioned the interviews in a poststructuralist frame in that I traced the subject positions girls mobilised in their descriptions of various encounters.
The first stage of analysing the interviews involved reading the transcripts several times, and extracting sections of data that were theoretically relevant in poststructuralism; specifically issues around power and positioning in the clinical context. These extracts were then analysed using a more detailed methodology that is informed by poststructuralism and discourse analysis (see Chapter Three).

Poststructural researchers suggest it is necessary to include a description of the flow of power and ambiguities that informed the conduct of the interviews in writing up the study (Y. Lee & Roth, 2004). I have taken up this suggestion, and in my analysis (Chapters Six, Seven and Eight) I describe some of the interactions between the girls and myself during the interviews. These include occasions in which we attempted to position the other differently, as well as some contextual factors that seemed, in my reading, to impact on the subject positions each of us took up in the interviews.

2.3. Researcher’s critique: Unravelling interviewing in the clinic

I encountered a number of complex issues in conducting research in the clinical context. Here I discuss two of the most relevant issues that have informed the thesis in interviewing and formulating the thesis questions and in my theoretical positioning.
2.3.1. Issues of disclosure

Some of the qualitative studies on anorexia are by feminist scholars who have suffered from eating problems, and these researchers disclosed their experiences of anorexia to the participants in their studies (Garrett, 1988, 1997; Segal, 2003; B. Thompson, 1994). The issue of self-disclosure was an important consideration in my positioning as researcher. I decided not to tell the girls about my sister’s anorexia and my experiences with her treating doctors’ (see Chapter One). The rationale for my non-disclosure was that the lives of the participants in this study are probably troubled enough, considering their age and the space in which they are located, and I did not wish to put them in a position that they felt they had to offer sympathy. Furthermore, I did not want my experiences to be a distraction in the conversations between us. Marshall's (1996, p.80) argument informed my thinking: “to be interviewed by someone presenting their personal experience would not only have flouted role expectations but more reciprocal disclosure would have been experienced as obtrusive.” I feel that self-disclosure must be mediated by context and that in my case disclosure would have been inappropriate and irrelevant to the focus of my thesis. Self-disclosure would have negated my aim of examining the shifting ways girls negotiate the clinic, because girls could have asked questions such as how their experiences compared with my sister’s.
2.3.2. (Re)framing the doctors

I began work in the clinic with some reservations, largely due to my prior experiences with doctors when my sister was a patient. However, the clinical location provided the space and opportunity for me to see the medical profession from a different position, although I want to emphasise that I have not wholly taken up medical discourse as a result of these experiences. I now appreciate that the doctor-patient relationship may be more complex than I recognised. In meetings, for instance, I have witnessed doctors requesting help to deal with aspects of their patients’ behaviour which they felt unprepared to deal with.

My initial view of doctors as only authoritarian is difficult to maintain when confronted with individuals struggling to make difficult decisions and attempting to mend troubled family relationships, rather than simply labelling families dysfunctional or pathological, words which frequently appear throughout medical literature. I acknowledge that my ability to see the doctors differently was aided by how I felt the doctors positioned me- as a colleague and collaborator, as my research would contribute to understandings of anorexia. This was in contrast to my previous positionings by other clinicians where I was located as part of my sister’s problem, as a family member of someone with anorexia.

In making this point, I do not want to contend that the doctors and girls are somewhat equal in the clinical context or deny that many girls feel powerless and distressed about being hospitalised for anorexia (Segal, 2003). However, viewing the doctors not
as only authority figures but as part of a web of power relations (Lupton, 1997) is a central focus of the analysis. As extrapolated throughout this thesis, the discursive practices of the clinic both subjugate and bring girls into being.

This chapter has illuminated my experiences of conducting research on anorexia nervosa in the clinic. I have described the various data collected and some of the issues I encountered. Like other feminist researchers (Halse & Honey, 2005) I have suggested that interviewing is a complex process and that ethical research involves continual negotiation with different players. The next chapter offers a more elaborated discussion of poststructuralism and the other theorists whose work has aided the analysis of the interviews.
Chapter Three

Poststructuralism, Discourse Analysis and Embodied Subjectivity.

Poststructuralism is the primary theoretical frame for this thesis. The thesis is informed by the strategic deployment of aspects of the work of Michel Foucault, Elizabeth Grosz, Judith Butler, Elspeth Probyn and Deborah Lupton. The work of these scholars has both conceptual and theoretical relevance to my analysis. Although none of these scholars use the term poststructural to define their work I find their theoretical insights useful for poststructural analysis, as have other poststructural scholars working in the area of eating disorders (Malson, 1998; S. Squire, 2003).

The chapter begins with a description of poststructuralism which is followed by a discussion of the term discourse. I then discuss some of Foucauldian theories I have employed, drawing primarily on: The Birth of the Clinic: An Archaeology of Medical Perception (Foucault, 1973) and Discipline and Punish: The Birth of the Prison (Foucault, 1977). The last four parts of the chapter are devoted to the particular aspects of the work of Grosz, Butler, Probyn and Lupton that informed the development of the thesis. Specifically these are: Grosz’s theories of embodiment, Butler’s work on power and subjectification, the conceptual tools Probyn offers concerning anorexia and food and Lupton’s theoretical insights on food, subjectivity and medicalisation.
3.1. Poststructuralism

As St Pierre (2000) reminds us, the difficulty in pinning down poststructuralism is that there is no coherent and unified body of poststructural thought, therefore it is easier to explain what poststructuralism is not. Poststructuralism is often defined in relation to humanism. Humanism conceives of the subject as a universalised, coherent and rational being who is capable of autonomous action (Halse & Honey, 2005; MacLure, 2003; McLaren, 2002; St Pierre, 2000). In contrast, poststructuralism rejects rationality as defining the subject and holds that subjectivity is shaped by the discursive practices operating in different ways and contexts. Thus the poststructural subject is never fixed and final but is always in the process of becoming and is subjected to forces that may not be open to conscious inspection and rational analysis (Davies, 1999; St Pierre, 2000).

The discourses and discursive practices that constitute subjects also position them and enable them to take up positions within particular discourses and social positionings that distinguish and differentiate subjects on the basis of positive or more marginalising attributes, such as gender, race and class (Davies, 1989, 1999). While certain attributes delimit the capacity to access certain social positions; these positions are not fixed or immutable; and it is in this unstructuredness that a space is opened up for poststructural subjects to produce themselves as something apart from the discourses in which they are constituted (Davies, 1999). The construction of the poststructural subject involves a “double move” as St Pierre (2000) points out,
whereby we are simultaneously subjugated and brought into being by particular discourses, power relations and social positionings. “The subject that exhibits agency as it constructs itself by taking up available discourses and cultural practices and a subject that, at the same time, is subjected, forced into subjectivity by those same discourses and practices” (St Pierre, 2000, p.502).

Thus, subjugating practices also carry within themselves the dual possibility of resistance and the (re) configuration of the subject. Poststructural notions of resistance do not situate resistance as a revolutionary overthrow of power relations. Resistance does not exist outside power but within the process and production of power. At a local and specific level resistance can modify the flow of power (St Pierre, 2000, p.492). For these reasons, St Pierre urges that “analysis of and resistance within power relations must proceed on a case by case basis” (St Pierre, 2000, p.492). However, resistance is difficult because the subjects are always/already implicated in the discourses that they seek to resist. The ability to resist can be dependent on the social and political power of discourses, one’s access to alternative understandings and positionings and the social and cultural context. Finally, it is important to note that resistance is not only reactive; subjects can take up a position outside the discourse, although it can be a struggle to maintain this as a coherent and useful position.

3.2. Discourse

MacLure (2003) draws a distinction between two discourse traditions. One stems from Anglo American linguistics and focuses more closely on language than the
latter. It is arguably associated with names like Potter, Billig and Cameron (MacLure, 2003). The other has its origins in European philosophy and is the tradition that informs poststructuralism. Foucault’s work has heavily informed poststructural approaches, along with the writings of Barthes and Derrida (MacLure, 2003). Malson (1998) summarises a poststructural understanding of discourse: “eschewing any notion of an objective, knowable reality existing anterior to discourse… discourses and discursive resources are constructive, rather than reflective, of their objects” (1998, p.44). MacLure (2003, p.175) explains that the discourses of an institution work by “producing meaning, forming subjects and regulating conduct within particular societies and institutions.” Sets of statements are visible in the talk and text of social groups and institutions and these discourses prescribe what is deemed ‘normal’ or appropriate behaviour for the subjects the institution organises.

Discourses are historically and socially contingent and open to colonisation and extension by counter discourses. Malson drawing on Foucault (1972) explains that “to identify a discourse is not to close it upon itself; it is to leave oneself free to describe the interplay of relations within and outside it” (Malson, 1998, p.27). Discourses do not exist in isolation but interweave with other discourses, working as a series of forces and counter-forces (Halse & Honey, in press). Discourses involve the operation of power that circulates around and through practices and institutions. Foucault (1977, 1980) argued that power and knowledge directly inform each other. “Power produces knowledge; there is no power relation without the correlative constitution of a field of power” (Keenan, 1997, p.148). In this way, discourses construct particular regimes of truth.
Power and knowledge create different subject positions “positions from which a person can speak or be addressed” (Foucault, 1972 in Malson 1998, p.28). Subjects constitute and are constituted variously through discursive practices of discourse, and in this way discourses have ‘real’ effects on the subjects they describe (Burns, 2004; Malson, 1998). Discourses “legitimate particular practices, particular forms of authority, constituting particular ‘truths’ about reality and positioning or constituting people” (Malson, 1998, p.29). An example of ‘real’ effects is the construction of anorexia as superior to bulimia (Burns, 2004; S. Squire, 2003). This construction has infiltrated both medical and popular discourse and shaped thinking about bulimia, so that people with bulimia feel they are not properly sick (Hornbacher, 1998). Research suggests bulimics seek treatment less frequently than anorexics (Boughtwood, 2003) which may be related to the construction of bulimia as located within a discursive hierarchy of eating disorders that is maintained by medical and social discourses.

Subjects are complicit in discourses because they take up positions within these and have an investment in their continuity. Bordo (2004) in discussing media representations of feminine beauty, points out that woman are not cultural dupes and that they are well aware of the social rewards for taking up discourses of beauty norms. Categorical definers of particular bodies are enticing and not merely repressive. Subjects are located simultaneously in multiple discourses and take up various subject positions in their negotiations with different knowledges and can thus mobilise resources to position themselves differently amongst the forces that regulate subjectivity.
3.3. Michel Foucault

Foucault’s theories, particularly his notion of power, the management of bodies and his arguments about the organisation of hospitals and prisons have informed my thinking about anorexia and the clinic. Yet Foucault’s work is not a template that can simply be mapped onto other sites and epochs, one must turn to the specificity of the site, as this thesis does in relating Foucault to the clinic. As Foucault wrote “I think there is no exemplary value period in a period which is not our period…it is not something to get back to” (Dreyfus & Rabinow, 1982, p.234).

Technologies of power are a principle focus of Foucault’s (1977, 1980) work, and Foucault (1977) illuminates as to how power operates in a circular, rather than top down, flow. Power is embedded in systems of knowledge; the two operate simultaneously to control populations by working on the minds and bodies of individuals and producing norms for bodily behaviour that subjects take up to perform appropriately in various contexts. Subjects are thus brought into being through power, discourses and material structures that create and are created by institutions like schools and prisons (Foucault, 1977). Yet power does not only oppress individuals, rather the material practices of institutions constitute particular subjectivities (assujettisement) and subjects take up these forms of power and create other ways of being.

*The Birth of the Clinic* (Foucault, 1973) scrutinises the emergence of modern medicine in France. The medicalisation of society took place during this period,
which brought about many changes including the function of hospitals, the training of
doctors and the documentation and place of medical knowledge. Prior to 18th century
reforms hospitals provided paupers with food and shelter. With medicalisation the
function of hospitals changed. In the 18th century doctors began to receive universal
training and emphasise was placed on clinicians’ experience—having the knowledge of
the correct way to diagnose and treat a patient. Medical knowledge was unified by an
elaborate process of documentation (Foucault, 1973).

Contagious diseases were identified along with behaviours that were seen to threaten
society, thereby enabling the classification of individuals in possession of these
behaviours or diseases (Foucault, 1973). These regimes of truth about bodies—as
articulated through documents like clinical case studies—made it possible to write a
history of an individual as part of knowledge about an illness. Foucault (1973)
suggests that this transformation in modern medicine was evident in the shift in the
exchange between doctor and patient from “What is the matter with you? [to] Where
does it hurt? [whereby the] operation of the clinic [became] the principal of its entire
discourse” (Foucault, 1973, p. xi). Modern medicine constituted “a form of authority
over its subjects; health care practitioners and patients, the site of teaching and patient
management as constructed through medical discourse” (Hepworth, 1999, p.21).

Foucault documents the shift in punishment of criminals from medieval torture to
imprisonment. Foucault (1977) argues that modern regimes of punishment were less
about the specificities of the crime and more about creating a subject who could be
identified as a criminal. “His way of life and his attitude of mind, to his past, to the
‘quality’ and not to the intention of his will” (Foucault, 1977, p.99). The category of criminal was also established in a more indirect way because the prison system brought criminals into contact with one another. The prison provided a space where criminals could interact and share knowledge, in effect the prison worked to produce more effective criminals. This criminal persona was created through means that aimed to control and correct the individual, such as continual surveillance.

Although the workings of power are visible on the body, punishment has a double working- aiming to correct the soul. Foucault (1977) maintains that the soul is the central entity regulating the body in his contention that the soul is the prison for the body (1977, p.30). The soul is produced through the dominant knowledge of the historical period. In the 16th century this was theology. The modern soul:

has a reality, it is produced around, on, within the body by a functioning of a power that is exercised on those it punished- and, in a more general way, on those it supervises, trains and corrects….its not a substance; it is the element in which are articulated a certain type of power and the reference of a certain type of knowledge (Foucault 1977, p.28).

The reformation of the soul was part of a new science of the individual. Populations were categorised according to their dispositions and techniques were developed with the aim of correcting the soul (Foucault, 1977). These changes reflected and articulated a shift in power and knowledge in society, where the aim was normalising individuals (Foucault, 1977). Individuals were analysed as part of a group, “in order
to provide information about a population as a whole” (Foucault, 1977, p.190). One way of categorising individuals as normal and abnormal was by the use of binary oppositions, defining individuals in relation to each other:

Binaries involve an oppositional power relationship in which one side of the binary becomes superordinate by constructing its oppositional Other as somehow lacking or deficit (Derrida, 1978)…[so that] the inscription of opposing moral attributes to each side of the binary seem natural, logical and fair (Halse, in press, p.17).

Techniques of normalisation originated in institutions like schools and prisons but were replicated in society more generally (Foucault, 1977). One of these technologies of normalisation was the Panopticon, a model for a prison designed by Jeremy Bentham in the 18th century. The design included a large tower located in the middle of the prison so that prisoners were permanently visible. The Panopticon was not widely implemented and its success is not recorded. Foucault (1977) uses the Panopticon as an allegory for the technology of surveillance; a disciplining, normalising mechanism within institutional spaces in society. Rather than a powerful gaze being imposed from above, the gaze became part of and was dispersed through social and institutional spaces so that surveillance became part of socialisation, and individuals took up this gaze in monitoring their own behaviours. Dreyfus and Rabinow (1982) point out: “If the Panopticon functioned perfectly, almost all internal violence would be eliminated. For the prisoner is never sure when he was observed, he becomes his own guardian” (1982, p.189).
Feminist scholars (eg. Bartky, 1988; Bordo, 1990, 1993, 2004; Brodribb 1992; Grimshaw, 1993; McLaren, 2002) have engaged with Foucauldian theory and suggest Foucault offers varying degrees of usefulness for feminist projects. Feminists situate Foucault in accordance to their own positioning. Reading Foucault through a radical feminist lens, Brodribb (1992) suggests Foucault’s theorisation of subjectivity removes autonomy from the subject. This claim is consistent with a theory of power as only repressive. Brodribb (1992) is critical of Foucault’s notion of power as shifting and unstable, on the grounds that it is necessary for feminists to have a definitive political platform to articulate their struggles. A frequently articulated critique of Foucault’s work is the absence of gender (Diamond & Quinby, 1988). Grimshaw (1993) suggests Foucault’s work on Greek morality ignores the reality that this way of life was only an option for a small group of Greek males “who are assumed to be free” (1993, p.68). Foucault’s lack of attention to ethnicity, age and social class has also been criticised (as discussed in McLaren, 2002).

I suggest some of these critiques hold unrealistic expectations of Foucault; they seem to suggest he should have accounted for all social contexts. Foucault was writing about specific historical sites and he never intended his work to be a map for all sites and the subjects they organise (Bordo, 2004; McLaren, 2002). Other feminists have situated Foucault’s writings historically and extended his work in another site. For instance, Bartky (1988) deploying Foucault within a feminist framework gives the example of contemporary beauty regimes in illuminating the forces that shape femininity and how women participate in self-surveillance to maintain thin, hairless bodies.
3.4. Elizabeth Grosz

Grosz’s contribution is important because she elaborates why Foucault is valuable when deployed through a feminist frame. Grosz understands and uses Foucault strategically and she offers possibilities for feminists to engage with Foucault, rather than being wholly negative in her critique (Scheurich and McKenzie, in press). Grosz (1994) takes up and extends Foucault in formulating her theories of embodiment. Although Grosz finds Foucauldian conceptions of power-knowledge and subjectivity useful (see Grosz, 1994, p.154-166), she has two concerns about ‘the body’ in Foucault:

My first concern is addressed to the status of the sexually different body in the various models of inscription outlined here; my second is addressed to the status and form these inscriptions take in being directed to different types of body…the concept of the body that he [Foucault] utilises is a “neutral” sexually indifferent and thus abstract body (Grosz, 1994, p.157).

Grosz sees Foucault’s body as pre-inscriptive “a blank, passive page, a neutral ‘medium’ or signifier for the inscription of a text” (Grosz, 1994, p.156). For this metaphor to be useful Grosz suggests it is necessary to examine the specific materiality of the body, such as its practical and physical capacities (Grosz, 1994, p.156-184). Grosz’s second point is that inscriptions produce a different text depending on the sex of the body, because the sex will modify the form that the
inscription takes. In her analysis Grosz (1994) pays close attention to the environment and historical context in which the body is situated, because these contexts mark bodies in particular ways.

In theorising embodiment Grosz (1994) sets out to disrupt Cartesian dualism. This dualist discourse separates mind and body in ways that constitute the body as unruly, out of control and threatening to the mind. Grosz (1994) problematises Cartesian duality, suggesting it is reductive both philosophically and psychologically. She emphasises the need for feminist philosophy to seek an embodied subjectivity (Grosz, 1994, p.22). For Grosz (1994) the body is a point of mediation between internal and external and should be analysed through this frame, rather than reverting to binaries of inner and outer bodies. Her work on bodily fluids emphasises the importance of attending to sex and context. Bodily fluids are perhaps the only ‘outside’ of subjectivity. Grosz (1994, p.194) proposes that:

> Body fluids flow, they seep, they infiltrate; their control is a matter of vigilance, never guaranteed. In this sense, they betray a certain irreducible materiality; they assert the priority of the body over subjectivity; they demonstrate the limits of subjectivity in the body, the irreducible specificity of particular bodies.

Grosz (1994) articulates a persuasive argument about bodily fluids, but one that is not generalisable to all arguments about subjectivity. It does not work with the physically disabled- despite their bodily disability these people still resist being colonised by particular discourses. Yet it is relevant to my analysis, particularly girls’ discussions
of menstrual periods. Menstruation is frequently discussed in relation to anorexia nervosa. Medicine sees the return of menstruation as a sign of recovery from anorexia (Beumont, 2003), yet anorexics are more ambivalent about their periods returning (Shute, 1992). As Malson (1998, p.119) writes menstruation “transgresses the bodily boundaries and can be read as a metaphor both of uncontrolled bodily eruption and of a disrupted self.” The prevalence of discourses of menstruation has the effect of positioning periods as central in anorexics’ negotiations of subjectivity and embodiment.

Grosz argues that subjectivity is tied to the specifics of sexual difference. She argues that embodied subjectivity is “a surface whose inscriptions and rotations in three-dimensional space [to] produce the effects of depth…materiality to be extended and to include and explain the operations of language, desire, and significance” (1994, p.210). Grosz offers a theory of embodiment that includes biology and sexual difference along with psyche and soul. This construction is useful in understanding anorexia, particularly because anorexia is a condition that has been colonised by many different disciplines, each of which offer various explanations and constructions of anorexia that the anorexic subject has to negotiate in the clinic and the wider social context.

3.5. Judith Butler

Butler might be called a feminist philosopher. Although some aspects of her work are poststructural other parts are more aligned with Marxism and psychoanalysis (Salih,
2004). Significant influences on Butler’s theories that I deploy for the thesis include Althusser, Foucault, Freud, Hegel and Nietzsche. That Foucault offers little definitive answers poses a problem for some feminists, but not for Butler. “The deliberate withholding of reassuring answers is not an epistemological evasion; it is a crucial element of critical subversion…it is impetus to extend the norms by which ‘humans’ are permitted to conduct livable lives” (Butler in Salih, 2004, p.4). Butler deploys Foucault’s notions of power in various aspects of her work; it informs her arguments about the instability of identity categories (Salih, 2004).

In Butler’s (1997b) theorisation, subjects are interpellated through particular discourses and become passionately attached to the forms of power they take up. The subject is formed through and dependent on this power, despite ambivalence about choosing this attachment. The place of power in the formation of subjects is also Foucault’s (1997) theorisation, but Foucault (1977) does not elaborate on how the subject takes up self-surveillance and discursive practices. He uses words such as marks and trains to describe disciplinary practices, but it is not clear in his writings how the individual comes to embody these (McLaren, 2002). Butler (1997b) extends Foucault (1977) further in showing how words become part of the psyche of the subject:

The psyche, which includes the unconscious, is very different from the subject: the psyche is precisely what exceeds the imprisoning effects of the discursive demand to become a coherent subject. The psyche is what resists the regularisation that Foucault inscribes to normalising discourses. Those
discourses are said to imprison the body in the soul (italics in original), to animate and contain the body within that ideal frame and to that extent reduce the notion of the psyche to the operations of an externally framing and normalising ideal...how might he [Foucault] account for psychic resistance to normalisation...(Butler, 1997b, p. 86-87).

Regulatory norms mediate subjectivity yet these norms “are not internalised in mechanical or fully predictable ways” (Butler 1997b, p.19). Butler (1997b) illustrates this point in relation to Freud’s theory of melancholia by arguing that melancholy and loss are part of subject formation. The subject must reflect on the loss to survive psychically, to continue as a subject. Her central point is that loss does not subjugate a subject but enacts it into being (Butler, 1997b) and that a subject may be able to act and to find agency through loss. In a similar vein, agency does not exist outside regulatory laws or discourses, but is negotiated through gaps in these laws and discourses. In one explanation of agency Butler argues “[t]he subject is produced through certain kinds of foreclosure- certain things become impossible for it…and that this makes for the possibility of a temporarily coherent subject who can act” (Butler in Salih, 2004, p.333). This acting is a performance of coherence, although it is an illusion of agency because it is conferred from elsewhere and delimited to a particular context.

For Butler, as Stern (2000, p.113) illuminates, “agency consists in reworking the script even as one participates in the play it structures.” The subject is thus determined by power and agency is derived from this power, but the exercise of agency exceeds
the power through which the subject is produced (Butler, 1997b, p. 14-18). Agency might involve a turn against how one is positioned within a particular discourse, taking up a different, more enabling subject position.

In her work on speech acts, Butler draws upon Austin, who distinguishes between illocutionary and perlocutionary speech acts. Illocutionary speech has immediate effects “the saying is a kind of doing” and perlocutionary speech acts “initiate a set of consequences” (Butler, 1997a, p.17). Austin claims that the force of the illocutionary act can be identified through understanding the total speech situation. Butler sees difficulties in this claim, arguing that speech acts can transcend their utterance and that excess cannot be captured or identified in any totality (Butler, 1997a, p.3, 24). What Butler is arguing is that the meanings of words are subject to change across time and place. For instance, labelling a marginalised group with a derogatory name has a string of enabling and negative consequences that have both immediate and historical effects.

Butler suggests that injurious terms can be re-cited to counter their original negative meaning. Butler brings Althusser and Austin together, offering “an account of how the subject constituted through the address of the other becomes then a subject capable of addressing others…the one who utters hate speech is responsible for the manner in which such speech is repeated” (Butler, 1997a, 26-27). Subjects are not simply interpellated by language (Butler 1997b), because utterances can fail and thereby provide the conditions of possibility for a critical response (Butler, 1997a). By discursively negotiating the terms through which a subject is constituted, instead of
simply accepting the terms and their negative meanings; terms can be reworked to be other than negative (Butler, 1990). Furthermore, as Butler argues, the appropriation of negative names to persons and groups can injure, but these names also guarantee a social existence (Butler, 1997b, p.2) although one may be ambivalent about their subjection to certain categories (Butler, 1997b).

The material body is much more conspicuously visible in Butler’s later texts than in Gender Trouble (Butler, 1990). Gender Trouble aimed to denaturalise the categories of gender through a genealogical critique. Butler develops a notion of gender as a social construct that is performative rather than natural. This text was heavily criticised by feminist scholars such as Benhabib (1997) who claims that Butler’s attempt to challenge heterosexist positions “completely debunked” all notions of selfhood, agency and autonomy. The subject is seen as completely determined by discourse. Bordo (2004) agrees with Benhabib on this point. “As long as we regard the body in drag as an abstract, unsituated linguistic structure, as pure text we may be convinced by Butler’s claim that the gender system is continually being playfully destabilised from within” (Bordo 2004, p.292). Bordo (2004) argues that the body is not just text and subverting bodily or other texts is dependent on the social and historical context.

The arguments proposed by Benhabib (1997) and Bordo (2004) seem justified, particularly because Butler herself suggests she may have neglected the material body in Gender Trouble. Kontos (2004) suggests Butler’s return to the body in Bodies that Matter and other texts:
Can be understood as a reaction to the inadequacies of social constructionism as a paradigm for feminist theory. Social constructionism espouses the primacy of the social as constructive form that acts upon nature, a passive and presignificative surface existing outside the social… Butler is critical of this position because it forecloses from critical inquiry the discursive practices by which the materiality of sex is itself rendered irreducible (Kontos, 2004, p.88).

Butler (1999) maintains her critical perspective in theorising the production of sexuality in *Bodies that Matter*, arguing that body matter materialises historically. Subjects are interpellated into a sex and gender from birth and this works to enable certain identifications and to foreclose others (Butler, 1999, p. 236-243). Butler (1999) is specifically referring to heterosexual identifications and practices here.

Bodies are constituted “by being interpellated within the terms of language that a certain social existence of the body first becomes possible” (Butler, 1997a, p.5). Language ascribes labels to particular bodies, locating certain bodies (heterosexual, white, thin and able-bodied) as appropriate and abjecting others. However, as Butler (1997a) argues, bodies cannot be collapsed into discourse and can exceed the speaker. In other words, while discourse is formative, it is not the only means through which bodies are constituted (Butler 1997a, p.141-142).

In summary, Butler’s theories of subjection, her arguments about speech acts, conceptualisations of agency and how bodies are formed within but exceed discourses are deployed in my analysis of anorexic subjectivity in the clinic. Butler’s theories can
be used to illuminate how girls become subject to these discourses, and the ways in which girls take up the governing practices of the clinic in creating other subjectivities. Butler’s theories on embodiment inform my analysis of how discursive practices work to constitute the materiality of anorexic bodies, and how these bodies are positioned by girls and others.

3.6. Elspeth Probyn

Two of Probyn’s texts are used in this thesis. These are *Anorexic Bodies* (1987) and a later book, *Carnal Appetites: Food, Sex, Identities* (2000). In *Anorexic Bodies* Probyn (1987) problematises the notion of the subject as simply ‘hailed’ by different contexts, such as Western societies idealisation of the thin body and texts such as popular magazines, in which these bodies are represented. Probyn (1987) argues that anorexia illuminates the contradictions between the discourses of a particular historical period. “The site of anorexia shows up the entanglement of discourses and articulations of any particular time, and leads us to consider how the meanings we live with, the significance of ourselves, are produced intertextually across a range of discourses” (1987, p.206). Probyn offers a historical example; a girl named Sarah Jacob from Wales who fasted for several weeks in the 1860s. Probyn argues that Jacob was positioned by medical and religious discourses of the time, each “trying to appropriate [bodies] with regard to producing knowledge” (Probyn, 1987, p.204). Probyn contends that any analysis must closely scrutinise the specificity of the anorexic’s situation, locating the subject within the discourses of the local and historical context because these inform how she is positioned and positions herself (Probyn, 1987).
Probyn’s later work (2000) is on the use and meanings of food in contemporary Western society and relatedly the relationships between food and subjectivity. Probyn (2000) appropriates Foucault to discuss eating, sex and bodies and how these work to create “an ethics of existence…ways of living informed by both the rawness of a visceral engagement with the world, and a sense of restraint in the face of the excess” (Probyn, 2000, p.iv). Probyn points out that eating has various qualities associated with it, including hunger, shame, disgust and pleasure. These qualities are constantly depicted in literature and the media. This later text is not used extensively in this project but it does provide some useful ways of thinking about food and subjectivity in relation to the anorexic subject.

3.7. Deborah Lupton

Lupton’s (1996) book *Food, the Body and the Self* explores the meanings and uses of food in relation to subjectivity, “the extent to which bodily experiences and physical feelings are constructed or mediated by society and culture” (Lupton, 1996, p.1). Lupton draws on various poststructural, social constructivist and feminist theories to build an argument about the links between people’s dietary habits and choices and complex medical, cultural and moral notions. Her writings on the food/beauty/fitness triplex, which are also termed “healthism discourses” (see 4.2.6 for a discussion of these discourses), illuminates as to how in contemporary society bodies have become a signifier of beauty, health, thinness and fitness.
Lupton’s (1997) work on medicalisation is particularly important to my analysis, because it is one of the few texts that depart from an orthodox medicalisation critique (also see the discussions of Gremillion, 2002; Malson et al., 2004; Hepworth 1999 in Chapter Four). In this particular text Lupton (1997) draws on Foucauldian theory to offer a framework for a re-theorisation of the medical encounter, where the patient is depicted as not merely as powerless under the remit of the medical profession. Lupton (1997, 2003) argues that assigning power purely with the doctor ignores the unintentional, circular nature of power in the clinical encounter. Lupton (1997, 2003) argues that some individuals are invested in or desire medicalisation, but are not always accepting a position of passivity in doing so. Her own research with doctors and patients (with different illnesses) suggests that “the medical encounter involves a continual negotiation of power that is contingent upon the context” (Lupton, 1997, p.1). Lupton suggests that doctor-patient relationships are complex and shifting as these are mediated by a number of different factors such as the patients age, illness, the individuals knowledge of their condition and the doctor’s professional manner (Lupton, 2003). My work extends Lupton’s (1996) writings on food in illuminating some of the multiple ways in which those diagnosed as anorexic position food. I also respond to Lupton’s (1997, 2003) call to theorise the doctor-patient relationship as shifting and complex, by examining how girls negotiate the medical encounter in the treatment of anorexia nervosa.

3.8. Use of theorists

Here, I briefly re-address the main arguments of these theorists that are used in this thesis. Foucault’s (1977) theories about how discourses regulate the body within
institutions capture the dual sense of how the subject is subjugated and formed by power, but Foucault (1977) does not address other controls working on the body. Scheurich and McKenzie (in press) note how unrelenting Foucault is in describing the institutional regulation of subjects and the lack of possibilities Foucault offers for resistance and change. Therefore, Butler’s work (1997b) about how power affects the subject has been especially important in addressing the theoretical chasm in Foucault’s (1977) work; namely the attention to the mechanisms and processes by which subjection actually occurs.

Butler’s (1997b) concept of agency is useful in theorising girls’ resistance to medicalisation; her arguments provide a way of analysing how girls trouble and reconstitute themselves through the limited discourses available. Butler’s (1997a) writings on the deployment of language, particularly around censorship of speech and the ambivalence about attaching to social categories also offer ways to theorise the complexity in girls’ constructions of anorexia.

Grosz’s work also adds to Foucault’s arguments, because Grosz writes at a more local, individual level than Foucault. Foucault (1977) attends to particular sites and how these sites produce particular subjectivities, whereas Grosz (1994) extends Foucault in illuminating how individual bodies negotiate the discursive practices of various contexts in producing other subjectivities.

There are some commonalities between Butler and Grosz, because both share a wariness of the sex/gender divide and argue that if the body is a point of resistance
there must be something beyond inscription in order for the body to resist (McLaren, 2002). Butler and Grosz’s different arguments about bodies are important for my work. Butler (1997a, 1999) illuminates how bodies are discursively constituted and can exceed their constitution through speech acts, which is useful in analysing the language of anorexia, such as girls’ claims that they are fat. Grosz’s work provides a means of engaging with the body at the local and specific level. The arguments Grosz offers about bodily fluids are especially relevant to my project, as some of the girls do not treat the body as a given or as irreducible biological fact, but troubled biological ‘truths’ of healthy bodies.

The work of Probyn (2000) and Lupton (1996) on subjectivity and constructions of food in contemporary society are important to my project. Lupton’s work on medicalisation (1997, 2003) offers insights as to how patients negotiate the medical encounter in multiple ways, whereas Probyn’s (1987) work illuminates as to how the anorexic negotiates the multiple discourses of medicine, religion, gender and class which attempt to contain her. Lupton (1997, 2003) attends to the patient and Probyn (1987) to the specific discourses that shape the anorexic. I have brought these two arguments together to elucidate my analysis of anorexia in the clinic.

Chapter Four reviews a different body of literature. It describes and analyses the effects of these medical writings on anorexia in terms of how they position the anorexic and their family. The final part of the chapter situates my project in relation to other qualitative studies on anorexia nervosa.
Chapter Four

Anorexia Nervosa in Text

This chapter situates my study within the contemporary published literature on anorexia nervosa. Part One describes how anorexia has been conceptualised in medical literature. Part Two reviews the current literature on anorexia nervosa; specifically focusing on the different discourses employed in constructions of anorexia nervosa. Part Three discusses four studies that have direct conceptual and theoretical relevance to my research and illuminates how my work adds to other qualitative studies within the field of eating disorders research.

4.1. Profiling anorexia

Anorexia has long been conceptualised as a female illness (Anderson 1990; Brumberg, 1988; Fallon, Katzman, & Wooley, 1994), despite acknowledgement of men’s eating problems (Berry, 1999). Until approximately fifteen years ago, medical discourse constructed anorexia as “a disease that selectively befalls the young rich and beautiful” (Bruch, 1978, p. vii) that was confined to higher socio-economic brackets and Western societies. However, this construction of anorexia neglected to address issues of race, class and socio-economic status and worked to exclude certain populations from admitting to having eating problems (Root, 1990; B. Thompson, 1988, 1994). Katzman & S. Lee (1997) point out the absence of cross-cultural studies in research on anorexia nervosa and suggest that in many clinical studies:
[the term] culture is often simply used to reflect geographical boundaries without any effort to dismantle societal constraints on behaviours and their constructed meaning…the meaning of self starvation for individuals in Eastern countries…is left unaccounted for” (Katzman & S. Lee, 1997, p. 387-388).

Many clinical studies rely on the *Eating Disorders Inventory* (EDI) to collect information about their patient population. The EDI was developed and validated with particular populations of white, middle class women (Smolak & Murnen, 2001) and a medical construct of anorexia that included fear of fatness (Katzman & S. Lee, 1997). Diagnostic tests like the EDI are used to measure attitudes, beliefs and behaviours towards food and the body. In clinical settings, the EDI is intended to provide information about the patient to assist clinicians in assessing patients and planning treatment. Researchers have utilised the EDI in collecting information about populations, both as an outcome measure and indicator of prognosis (Garner, 1991). Therefore, the EDI is the authoritative instrument in defining and ‘testing’ for anorexia nervosa.

That the EDI is culture bound is demonstrated by the findings of S. Lee, Ho & Hsu (1993) in their study of Chinese patients. This population were described as “not unlike Western anorexics in many ways” (S. Lee, Ho, & Hsu, 1993, p.999) but the authors observed no fear of fat in the Chinese group. There has been further research on Non-Western populations since 1997 but the EDI continues to be used (Garner & Garfinkel, 1997), perhaps because of a lack of other diagnostic criteria available to
clinicians. Katzman & S. Lee (1997) elaborate on some of the methodological problems in studying Non-Western cultures, which include the lack of “a definition and assessment of what typifies a culture as Non-Western” (1997, p.390). The early work on the occurrence of eating disorders in Non-Western populations was linked to exposure to Western values, particularly through media (B. Thompson, 1994). Nasser & Katzman (2003) suggest that this is a feasible explanation, yet “the questions remain of why women would be so susceptible to media programming, and what does the globalisation in the marketplace reflect in terms of women’s roles that might impact on the development of eating disorders” (Nasser & Katzman, 2003, p.142). Furthermore, in what is characterised as the technological age, notions of nationhood and geography are contested (Flew, 2002). Following Brumberg, (1988) who linked the changing structure of society and families to anorexia, Nasser & Katzman (2003) suggest that on-line cultures provide another forum to create new identities that are not constrained by embodiment and ethnicity. Clearly, there are some important areas in relation to Non-Western populations that demand further research, especially in an increasingly global society.

The rationale for including this discussion is that some girls that were interviewed did not fit these dominant constructions of anorexia but positioned themselves in relation to these norms in their interviews (Chapters Six to Eight), because they were aware these norms were seen as the definitive features of anorexia.
4.2. Discourses of anorexia nervosa

The specific focus of this review is the discourses of the causes of anorexia nervosa. Medical literature on causal factors has a pervasive influence on how anorexia is understood and treated. Other conceptualisations of anorexia, such as feminist writings often directly respond to and are shaped by medical discourses (Hepworth & Griffin 1995). Current medical models have their origins in earlier, competing theories of anorexia nervosa. As Malson (1998) writes:

By the mid 20th century ‘anorexia’ had become the object of several competing discourses, each of which constituted their object in quite different and often competing ways…it was not the case that one discourse simply replaced another in linear progression. Rather, the discourses co-existed…the many discourses in the late twentieth century have produced a plethora of different power/knowledges and different truths of anorexia (Malson, 1998, p.77).

Some feminist work on the causes of anorexia is also considered in this chapter, as feminist work has made an impact on theory and treatment of anorexia. However, as Hepworth & Griffin (1995, p.77) note: “feminist arguments have made an impression on the mainstream literature, but the two perspectives are not identical [in power of impact] because feminist literature starts from a position of marginality in relation to the medical and clinical psychological mainstream.”
The aim of this chapter is not to review the causal factors of anorexia but to examine the variety of discourses employed in constructs of anorexia nervosa. Four conceptualisations of anorexia are discussed: biomedical, psychological (including body distortion and drive for thinness), familial and sociocultural (including media). These categories are not conceptually independent, but like all discourses are colonised and extended by other discourses. For example bio-medical constructs of anorexia often draw on psychological discourse, as evidenced by DSM criteria that includes both biological and psychological factors. The chapter is not an exhaustive map of all the literature on anorexia; the examples used are pertinent to the discourses about anorexia, not an empirical ‘truth’ of anorexia. The literature I draw upon here relates to both adult and adolescent populations, but I also highlight the issues specific to adolescent girls, including issues related to age, gender, and adolescent development, including menstruation. In each section, an overview of the different bodies of literature is followed by a consideration of the possible effects of these discourses in signifying and entering into the articulation of particular constructions of anorexia.

4.2.1. Biomedical discourses

Biomedical research locates anorexia as an embodied defect and much research has focused on examining the physical manifestations of self-starvation, like amenorrhea, in the hope of ferreting out a biological cause. One of the earliest examples of these studies is Simmonds’ 1930s investigation into whether anorexics had pituitary insufficiencies, as this can cause severe weight loss. His paper on pituitary insufficiency “had a lasting impact and set the stage for endocrinological
approaches to understanding and treating anorexia” (Silverman, 1997, p.6). Despite the eventual differentiation from anorexia and the coining of this condition as Simmonds Disease, biomedical constructions of anorexia still implicate endocrinal disturbances as a cause of anorexia (de Zwann, 2001). This is possibly due to the need to treat the physical effects of starvation, particularly long term consequences such as osteoporosis (Herzog, Nussbaum, & Marmor, 1996; Zipfel, Lowe, & Herzog, 2003).

Medical investigations into the cause of anorexia have focused on brain chemistry, such as defects in peptide and neuropeptide (Connan & Stanley, 2003) but studies have revealed no conclusive findings (Hsu, 2001). Anorexia is also construed as an effect of abnormal growth hormones (Connan & Stanley, 2003), a construction reinforced in having amenorrhoea as a core diagnostic feature (American Psychiatric Association, 2000). Biomedical discourses attribute anorexia to a malfunctioning of the hypothalamus, which is the part of the brain which controls a variety of homeostatic process like hunger and water intake, metabolism, body temperature and respiration (Beumont, 2003; Connan & Stanley, 2003). There are various debates by those versed in medical constructions as to whether, in the case of anorexia the hypothalamus operates independently of and thus malfunctions to ‘cause’ anorexia, or whether the hypothalamus is influenced by cultural and environmental factors (Banks, 1992; Lelwica, 1999). The construction of anorexia as a physical problem has never been conclusively proven.

Medicine has searched for a genetic explanation of anorexia nervosa. Genetic discourses construe anorexia as an inherited predisposition (Keel & Klump, 2003).
There are genetic investigations into family studies, which compare the incidence of anorexia in families to the general population (Winchester & Collier, 2001). In analysing the incidence of anorexia in mothers and daughters Garner & Garfinkel (1982b) observed two cases out of 207 where a mother and daughter both had anorexia, but noted that the figure may be unreliable because the study was based on interviews with patients and family members. Studies of female patients suggest that 3-6 percent of sisters also have anorexia (Lask & Wren, 1993). In twin studies, monozygotic (have identical genes) have been compared with dizygotic (non-identical, sharing half their genes) twin pairs for particular traits. Studies suggest some evidence of concordance for anorexia with monozygotic twins that have grown up in the same household (Vandereycken & Van Vreckem, 1992). The crucial finding here is that monozygotic twins have greater concordance rates than dizygotic twins and this claim is mobilised to suggest a genetic contribution to anorexia. In medical circles there is debate over whether genetic causation operates independently of or is influenced by other factors, such as family dynamics or one twin’s anorexia (Kog & Vandereycken, 1989).

Biomedical constructions of anorexia imply an ontological split between the self and body, suggesting that anorexia can be understood simply by reading the body through a biological lens. Even if one accepts explanations of anorexia as an objective biological disease or problem that can theoretically be treated with the right drug, medicine’s lengthy search for a cause has been inconclusive. Hospitalisation thus aims to treat physical effects (see Chapter Five). However, constructions of the physically compromised body as an effect, not a cause, is contrary to the official diagnostic criteria (DSM) where it would seem that the emaciated body dictates
physicians’ perceptions of patients’ mental state. These biomedical discourses and technologies like the DSM have the effect of situating the anorexic in isolation from their sociocultural context. This discourse positions “women’s distress about food, eating, embodiment and identity as predominately the effects of hypothesised dysfunctions of our bodies” (Malson, 1998, p.80).

4.2.2. Psychological discourses

Psychological discourses about anorexia derive from and combine with biomedical discourse, yet simultaneously critique biomedical constructions by suggesting that they are reductionist and de-contextualise anorexia from its sociocultural context. Thus some psychological studies postulate a differentiation between starvation and anorexia, aligning the latter with psychological disturbances (A. Becker, Grinspoon, Klibanski, & Herzog, 1999; Hsu, 2001).

In the talk and texts of psychologists, anorexia is sometimes positioned as a “difficulty with normal adolescent development” (Cockett, 1992, p.11) or an individual psychological deficit (Polivy & Herman, 2002). Low self-esteem is postulated as a central feature of anorexia nervosa (Ghaderi, 2001; Serpell & Troop, 2003) particularly during adolescence (Gordon, 2000).

Restricting one’s food intake requires control and control has thus been construed as central to anorexia in psychological discourse. Anorexics are positioned as needing to control many issues including their food intake (Gordon, 2000; Hsu, 2001) because
they lack control over other aspects of their lives (Dolan, Lacey, & Evans, 1990). Anorexia is described as a vicious cycle of control and as a “control paradox” (Lawrence, 1984) because although the sufferer feels she is in control in restricting her food intake, the eating disorder is increasing its grip on the person (C. Brown, 1990). The need to control has been variously related to family dynamics, poor academic achievement or a response to sexual abuse and lack of control over global events (Dalgleish et al., 2001; de-Groot & Rodin, 1999; Laliberte, Boland, & Leichner, 1999).

Some psychological research reports high level of perfectionism in anorexia (e.g. Bruch 1988; Goldner 2002 in Serpell et al., 2003). Perfection is construed as either a cause of anorexia (Fairburn, Cooper, Doll, & Welch, 1999) or a performance to disguise deeper, more problematic issues (Finelli, 2001). Behaviours that have been constructed as perfectionist include being critical of one’s appearance and obsessiveness about academic achievements. Bruch (1978, 1988) suggests some of the “serious conceptual disturbances” that characterise anorexia are concealed under a veneer of perfectionist behaviours including “a defective self concept and the fear of inner emptiness or badness” (Bruch, 1988, p.5). In these writings perfectionism is constructed as a psychological truth of anorexia. Perfectionism is enshrined as a trait and as a defining quality of anorexia through its inclusion as an EDI scale and this construction is perpetuated by the continual use of this instrument in clinical practice (see 4.1).
Anorexia has been constructed as a fear of growing up and taking on adult responsibilities (Deluca, 2000) and/or retreat from sexual maturity (H. Becker, Koerner, & Stoeffler, 1981). Positioning anorexia as a withdrawal from sexual maturity has been challenged by some of the sociocultural arguments (as discussed in 4.2.6) where anorexia is seen as embodying the extremes of adult femininity (Boskind-Lodahl, 1976; Orbach, 1993). There was contestation amongst early researchers about the rejection of adult sexuality theory. Whereas some clinicians see this theory as central to understanding anorexia, others such as Bruch (1978) insist that the avoidance of sexuality is only one aspect of eating problems. That amenorrhea is a central diagnostic feature and part of the DSM criterion further legitimates the avoidance of sexuality model, because the absence of menstruation is read as signalling a desire for reversion to a childlike body. In these writings, as in other instances, psychological constructions of anorexia are mapped onto medical models.

Anorexia has been constructed as a variant of other psychiatric disorders, with studies reporting up to sixty-three percent of eating disordered patients having an additional disorder (Steiner & Lock, 1998). Commonly associated illnesses include depression, anxiety disorders, borderline personality and obsessive-compulsive disorders (OCD) (Cassidy, Allsopp, & Williams, 1999; Haworth-Hoeppner, 2000; Steiner & Lock, 1998). Research has attended to family histories of somatic, psychiatric and affective disorders, attempting to establish linkages between anorexia and other psychiatric illness (Casper, 1998; Friedmann et al., 1997) but results are inconclusive.
The association between psychiatric disorders and anorexia nervosa is debated in biomedical literature. Because of the low incidence rate of anorexia, such studies can only claim association or correlation rather than causality. For instance, it is disputed as to whether depression is actually a cause or an effect of starvation. Herpertz-Dahlmann, Wewetzer, Henninghausen, & Remschmidt (1996) for example, noted that most ‘recovered’ patients no longer experienced depression, which would suggest that depression is a result of malnutrition. Gordon (2000) points out that both anxiety and depressive symptoms can accompany an eating disorder, yet the two are separate illnesses. Furthermore, depression itself is a contested category (Karp, 1994) and people frequently report feeling depressed in stressful circumstances; and being hospitalised with anorexia nervosa undoubtedly is stressful. Gordon (2000) also distinguishes between eating disorders and OCD suggesting that while sufferers of OCD find their behaviours and thoughts intrusive and worrying, “the preoccupations of the anorexic patient with thinness and starvation represent highly valued, ‘ego-syntonic’ goals” (Gordon, 2000, p.34).

Psychological discourses about anorexia are contested and contradictory and the role that these factors play in anorexia is ambiguous. For instance, in the self-esteem research it is not clear whether self-esteem is a cause or result of anorexia. Contradicting claims that dieting produces low self-esteem (Polivy & Herman, 2002), authors such as Branch & Eurman (1980) contend that self esteem may improve when one is received positively in social circles for losing weight. Low self-esteem seems to function as an easily understood yet overly simplified explanation for a complex condition. This is also evident in explanations of anorexics as attempting to avoid adult sexuality. There is confusion in these writings about what aspects of sexuality
sufferers are allegedly attempting to avoid. It is not clear in the literature whether
anorexics are trying to avoid intimacy in sexual relationships, fears about pregnancy
or confusion about sexual orientation. Furthermore, sexuality discourses are perhaps
inappropriate for the age group they organise, because many first presenting anorexics
are in early adolescence and may be sexually curious but are not yet considering
themselves as sexual beings. It is also reflective of trends to immediately conflate any
bodily issue with sexuality, which may be an effect of the theories of Sigmund Freud
and Pierre Janet who were the first authors to link appetite and sexuality (Brumberg,
1998).

It does seem possible that a person may use food as a coping mechanism, such as a
means of exerting some control over life events. For instance B. Thompson (1994)
has noted that women frequently use food as a coping mechanism because it is more
easily accessible than, for instance, alcohol and drugs. Yet this explanation does not
account for the progression into more serious body and eating issues unless genetics,
low self-esteem and poor body image are implicated, as some studies have argued (eg.
Hsu, 2001). However, this contention sidesteps the fact that some of these factors, like
low self esteem and body dissatisfaction, are evident in ‘normal’ populations- despite
the absence of the official labelling of these populations as unwell (Black, 2000;
Boughtwood, 2003). There is much research suggesting anorexia and bulimia occurs
along a continuum in that many women engage in dieting and exercise (Blood 1996;
Bordo, 2004; Fallon, Katzman & Wooley 1994). Some psychological studies seem to
assume a transition from dieting to anorexia (Gowers & Shore, 2001), yet these
studies do not adequately explain this transition.
The discourses of perfectionism and control are frequently conflated and couched as positive attributes in popular forums. One discourse that is frequently represented in popular media and self-help literature is that people should exercise control around food and exercise to be successful in obtaining the perfect relationship and career. Thus, terms like perfectionism are idealised in popular discourses and have become part of the vernacular. There is no adequate explanation of how perfectionism becomes pathological, yet these terms remain a persuasive explanation for anorexia nervosa (Boughtwood, 2003). Psychological discourse seems to assume a line between desirable and pathological qualities but there is no explanation of the process by which this happens.

In comparison to medical models, psychological discourses do, to a limited extent consider the context in which the individual is situated. However, psychological discourses largely ignore social pressures and incidences of dieting and other behaviours among ‘ordinary’ populations. If there is an acknowledgment of the differences between ‘normal’ and ‘anorexic’ populations, it is to position anorexics as extreme dieters (Polivy & Herman, 2002), as particularly susceptible to social pressures and more vulnerable than normal women.

In concluding this section, it is evident that the psychological discourses have the effect of constructing the anorexic as internally flawed. Psychological constructions position women as overly emotional and medicalise emotionality so that it is construed as pathology (Boughtwood, 2003). Psychological discourses have the effect of marking the anorexic as Other to normal populations while simultaneously
constructing recovery as only possible with the support of psychological intervention and therapy.

4.2.3. The discourse of body image distortion

The discourse of body image distortion is epistemologically different to conceptualisations that construe anorexia as a desire for thinness (see 4.2.4) and centres on the anorexic’s distorted perceptions of their bodies (Gowers & Shore, 2001). The notion that anorexics have distorted perceptions of their bodies has existed since the 1920s (Brumberg, 1988). Some fifty years later, Bruch (1973) suggested that anorexics had trouble processing body experiences because of problems in their early childhood, contending that a “realistic (italics mine) body image concept is a precondition for recovery from anorexia nervosa” (Bruch, 1973, p.90). These constructions of anorexics as unable to see their bodies realistically have infiltrated popular discourses and are represented in magazines and self help books, often by drawings of an emaciated women looking into the mirror and seeing an obese figure reflected back at her (Bordo, 2004). Body distortion constructs have been extensively researched and modified and contemporary models suggest anorexics have both perpetual and cognitive defects (K. Thompson, 1996). A more recent definition of body distortion is “size estimation accuracy; however, it has been used to describe bizarre perceptual experiences, eg. Schizophrenia” (Cusumano & K. Thompson, 1999, p.10). These body distortion discourses are evident in diagnostic criteria, (Bizeul, Sadowsky, & Rigaud, 2001) including a questionnaire entitled Body Distortion Questionnaire (Cachelin & Maher, 1998).
The body distortion discourse is inherently problematic because it equates body image distortion with psychosis and evidences a misunderstanding of schizophrenia. Schizophrenia is a psychotic disorder and a cluster of systems that characterise a distorted perception of reality. Even if one accepts anorexics’ have unrealistic perceptions of their bodies these are different to the overwhelming delusions of a person with psychosis (personal communication, R. Vannitamby, June 2005). There are also legal implications. The mental health act is not invoked for anorexics alleged distortions (the mental health act is usually only utilised when an anorexic is severely physically compromised, see Chapter Five) but those with other psychosis are often placed under the mental health act for their delusions (NSW Mental Health Act, 1990). The effect of comparing anorexia with psychosis is that the anorexic is positioned as severely mentally ill.

These distortion discourses construct anorexics’ experiences of their bodies as distinctly different from ‘normal’ women’s bodily struggles. The implication of this discourse is that there is a normative means to viewing one’s body, a construction that ignores the varying and contradictory experiences of how people experience their bodies. Women have been socialised to position their bodies as objects that should be worked on to conform to social ideals (Bartky, 1988; Wolf, 1991). Research suggests that the ideal feminine body as represented in the media is steadily decreasing in size (see 4.2.7), which is perhaps why women struggle to conceptualise their bodies as thin even when emaciated (Malson, 1998).
4.2.4. The drive for thinness discourse

Another more clinically oriented discourse constructs ‘genuine’ anorexia nervosa as an overwhelming drive for thinness (Bean & Weltzin, 2001; Bizeul et al., 2001; Nilsson, Gillberg, Gillberg, & Rastam, 1999). For instance, Beumont (2003) defines “genuine anorexia” as evidenced by:

    grotesque beliefs. Patients are not worthy of eating, they don’t deserve any form of gratification, they punish themselves by unrelenting exercise, they are not like other people…Being emaciated is a goal in itself, not a means of achieving happiness. It is not that they are closed to reason about their physical condition, but rather that it is irrelevant because the sole purpose of their lives is their illness (2003, p.22).

From Beumont’s (2003) perspective, anorexia develops for different reasons yet “once fully established” it becomes a belief that maintaining emaciation should be accomplished at the expense of everything else. In comparison to the body distortion discourse, the construction of anorexia as a drive for thinness attends to the desire for a particular body and identity, rather than simply pathologising the person as delusional as in the work of Kevin Thompson. However, this discourse has the effect of constructing the person as irrational in that they are determined to be thin regardless of the consequences. Instead of looking to the sociocultural context, where thinness is highly valued and conceptualising this ‘drive for thinness’ as an attempt to be a legitimate social subject, the discourse positions the individual as flawed, in possession of “grotesque beliefs.”
4.2.5. Familial discourses

Discussions of problematic family dynamics draw on both medical and psychological discourses. Families have long been implicated in theories surrounding the aetiology of anorexia, as evidenced in the pioneering work of Lasegue (see 1.2) who claimed that parents of anorexics varied between spoiling and punishing their child, as the child refused food to annoy parents and disrupt the family (Brumberg, 1988). Familial theories have prevailed as one of the most popular explanations of anorexia nervosa over the last fifteen years (Lask & Wren, 1993).

The dominant construct in much of the family literature is that anorexia is a result of faulty family functioning (Eliot & Baker, 2000; Minuchin, Rosman, & Baker, 1978). One longstanding construct is that the child, aware of the problems in the family, develops anorexia as an attempt to mend the parental relationship (Bruch, 1988, Minuchin, Rosman, & Baker, 1978). The anorexic daughter is also seen as a submissive personality, which is the result of having overprotective parents (Calam, Waller, Slade, & Newton, 1990). Families are seen to prevent a child’s self-expression, have unrealistically high expectations, avoid conflict and fail to engage emotionally (G. Adams, Ryan, & Keating, 2000; Bryant-Waugh & Lask, 1995). The family has been characterised as too organised and controlled (Fisher, Golden, Katzman, Kreipe, & et al. 1995; Steiner & Lock, 1998).
Issues related to physical attractiveness are positioned as a further problematic area in family relationships. In explanations seemingly related to anorexia’s specific manifestations, it is suggested that families place too much emphasis on being physically attractive (Cohen, 1996; Haworth-Hoepner, 2000). Parents reportedly criticise their daughters’ weight and/or physical appearance (Burggraf, 2001). From a clinical perspective Branch & Eurman (1980) suggest that therapists will be ineffective if the family places too much emphasis on physical attributes.

Anorexia is one of several psychiatric disorders, including borderline personality and depression, that medicine has related to sexual abuse (Smolak & Murnen, 2001). L. Brown, Russell, Thornton, & Dunn (1997) found that 50 percent of their patient population reported a history of childhood sexual abuse. Sexual abuse is discussed in the context of the family in this literature (Collins, 2000; Rorty & Yager, 1996b; Russell, 1999; U. Schmidt, Tiller, & Treasure, 1993). Autobiographical accounts contain descriptions of fathers being accused of abusing their daughters simply on the basis of their daughter having anorexia (McCarthy & Thomson, 1996; Pick, 1993). The reasoning behind investigations into abuse is that abuse is reported to create and increase low body and self confidence (Rorty & Yager, 1996a). Smolak and Murnen (2001) noted that girls with already low body confidence are often targets of abuse. Medical writings suggest the linkage between anorexia and sexual abuse is that victims deliberately create an emaciated body so as to avoid becoming an object of male desire and thus repelling any further abuse, because emaciation is seen as ugly, undesirable to abusers (C. Brown, 1990; Calam & Slade, 1994).
Clinicians who look to the family as a causal factor in anorexia imbue the mother-daughter relationship with particular meaning. For instance, Eliot & Baker (2000) suggest the mother daughter relationship is problematic because mother and daughter are enmeshed and the father is absent. Other researchers contend that mothers promote eating disorders in their children by feeding their children irregularly, misusing food by using food for other reasons than appetite, like calming children (Haworth Hoeppner, 2000; Polivy & Herman, 2002).

Many of the familial discourses assume marital equality in the family (Malson, 1998) but as feminist researchers point out, this is frequently not the case (Brumberg, 1998; Chernin 1981, 1985; Malson, 1998). The mothers’ role is, or assumed to be, first and foremost domestic, which means mothers are more frequently blamed for children’s’ problems (Brumberg, 1998; Chernin 1981, 1985; Malson, 1998). The mother may also share the same weight concerns as her daughter and therapists may not be sympathetic but suggest such insecurities contribute to the construction of the mother as pathological. “There is some slippage in the discursive construction of ‘familial pathology’ whereby the family becomes the responsibility of the mother, and ‘familial’ pathology’ turns into the ‘failings’ of the mother rather than the father” (Malson, 1998, p.89).

Family blaming discourses position anorexia under the remit of the medical profession, specifically family therapy. Yet research into the place of families in the aetiology of anorexia displays contradictory findings. For instance, there is contestation within the literature about whether or not families with an anorexic
daughter possess certain characteristics and the nature of their impact on the child (Hsu, 2001). Furthermore, the review of the research studies reveals scant exploration as to whether such problems are unique to families with eating disorders (Polivy & Herman, 2002). Therefore, families are measured against undefined norms and/or unsubstantiated claims, such as in the case of sexual abuse; because the relationship between abuse and body dissatisfaction is not clearly established (Kinzl, Traweger, Guenther, & Biebl, 1994; U. Schmidt, Humfress, & Treasure, 1997). These familial discourses blame parents for specific behaviours and characteristics that are maintained and perpetuated through their inclusion in clinical questionnaires (Gowers & North, 1999), rather than exploring individual family relationships. There are some exceptions that disavow assumptions of family culpability (Le-Grange, 1999) yet much of the literature fails to differentiate between cause and effect. While it is likely that parental attitudes and behaviours will play a part in the development of anorexia, much of this commentary is derived from retrospective questioning. An ill child causes tension in the family. Adolescents in the chronic grip of anorexia are likely to view their families negatively, because parents are worried about their child and constantly urging them to eat. The constant urging is directly contrary to the adolescent’s wishes, modelling ‘normal’ parent-adolescent struggles that are not pathologised (as in the case of anorexia) because the adolescent’s physical and mental health is not a concern.

In summary, familial discourses broaden the range of sufferers by directly implicating the parents, thereby extending the necessity for (medical and psychological) intervention. These discourses have the effect of marginalising the family and perhaps
excluding them from treatment decisions and/or providing a rationale for family therapy.

4.2.6. Sociocultural discourses

Descriptions that link anorexia to specific social and historical factors are articulated in a diverse range of forums from women’s magazines to highly theoretical work. Feminists, writing from a range of different professional and theoretical positions have been the strongest proponents of sociocultural arguments (Lelwica, 1999). Feminists challenge traditional realist and positivist epistemologies of medical science, rejecting notions of anorexia as pathology or as a purely biological or psychological phenomenon. For instance, Steiner-Adair (1991, p.253) writes: “[w]hen I look at eating disorders as a body politic, rather than a body pathological, eating disorders becomes a symbol of a culture that does not support female development.” Writers cite the high prevalence of disordered eating, dieting and exercise among non-eating disordered women (Gowen, Hayward, Killen, Robinson, & Taylor, 1999), attributing these behaviours to attempts to conform to societal prescriptions of feminine beauty. Nasser and Katzman (2003) note “the phenomenon of extreme thinness does in fact blur and merge with what is considered to be normal or culturally acceptable, such as the practice of dieting, formed the basis of the continuum hypothesis” (Nasser & Katzman, 2003, p.141). Some feminist writers locate anorexia at the extreme end of the disordered eating continuum, where it is variously conceptualised as conformance or rebellion against social ideals for women (Orbach, 1993). Like medicine, feminist writing on eating disorders also has a
historical pathway; some of the earlier writings inform current literature, including the broadening of sociocultural models beyond Western societies (see 4.1).

However, medicine has more recently implicated the sociocultural in explaining anorexia. “The ‘why women’ [why does anorexia have such a lopsided gender ratio] question in the early 1980s was framed as a feminist issue although as writers later in the twentieth century revealed, the question of gender is one that impacts on all professionals working in the field” (Katzman & Waller, 1998 in Nasser & Katzman, 2003, p.141). The recent popularity of sociocultural arguments in medical circles may be because some symptoms, although implicated in the construction of anorexia (such as cessation of menstruation, anxiety and depression) are now recognised as a result of starvation (Beumont, 2003; Gordon, 2000).

Researchers have linked women’s eating problems to their subordinate position in domestic, social and professional realms (see Brumberg, 1988 for a historical discussion; also Chernin, 1981, 1985). More recent feminist writers have explored the prevalence of anorexia in contemporary societies, postulating that there has been an increase in women’s eating problems despite women’s recent occupation of more powerful positions in certain public spheres (Faludi, 1991; Smolak & Murnen, 2001; Wolf, 1991). It has been suggested that women are struggling to balance multiple and conflicting positions in today’s society, where the implicit message is that a woman can be anything she desires, as long as she maintains a thin body. “The dominant feminine role modelled for today’s girls and college women is the superwoman…”
women should be able to “have it all”: good career, happy marriage, healthy children, an active social life and good looks” (Smolak & Murnen, 2001, p.95).

Scholars have identified the prevalence of healthism discourses in society (Evans., et al., 2002; Evans et al., 2004), also termed the food/health/beauty triplex (Lupton, 1996). Healthism discourses construct thinness as a signifier of health, fitness and beauty (Halse, Honey, & Boughtwood, in press). Medicine, public health, science and economics drive healthism imperatives, couching these in a moral tone, holding that individuals must take responsibility for making healthy choices to obtain a thin body (Lupton, 1996). The message is clear:

> Just as the attainment and preservation of good health is perceived as a moral accomplishment, the achievement of a slim body represents the privileged values of self-control and self-denial. A slender/attractive body is interpreted as a healthy, normal body, tangible evidence of rigid self-discipline. By contrast, an obese/ugly body is understood as unhealthy and deviant (Lupton, 1996, p. 137).

Social psychologists Waller & Calam (1994) propose three explanatory theories of responses to healthism and other social messages. These theories are: social identity theory whereby the thin body equates to social acceptance; social learning theory where one positions an ideal body type as a role model; and social comparison-comparing one’s body with this ideal. The cultural pressures Waller and Calam (1994) refer to include: contemporary attitudes to thinness; the association between thinness and control and the persuasiveness and increasing numbers of diet articles in
the media. These messages imply that thinness is attainable if one is willing to invest time, effort and money to create a thin body.

Peer pressure is one aspect of sociocultural analysis and also part of other explanations of anorexia. Peer pressure takes the form of teasing about physical appearance or body shape from one’s peers (Ghaderi, 2001; Polivy & Herman, 2002) particularly during adolescence (Paxton, 1996). To illustrate this point, in one of the most famous biographies of anorexia, Liu (1979) details the weight loss and starvation habits of three of her friends and the competition that ensued between them. Conversations about weight, food and dieting have become a common linking point between women of all ages, ethnicities and educational backgrounds (Gordon, 2000). A female academic who was interviewed about eating disorders noted the prevalence of these conversations. “I used to notice that one way to connect with other women was to talk about your clothes…or ‘I’ve eaten three cakes this morning, I shouldn’t have done that…kind of common ground, even though it goes against your philosophy” (Boughtwood, 2003, p.103).

The sociocultural discourses have become increasingly pervasive in clinical and popular explanations of anorexia (Gordon, 2000). However, there is some contestation about the scope of sociocultural arguments. In particular, writers suggest it is important to distinguish between personal conflicts, traumas and simply seeing women as victims of an appearance-oriented society (Boughtwood, 2003; B. Thompson, 1988, 1994). The lack of attention to this distinction is implicit in some sociocultural arguments where the discourses seem to rely on a model that links
anorexia to concern over physical appearance (Singh & Rosier, 1989; Tebbel, 2000). Hepworth & Griffin (1995) have suggested this distinction is not often clear in feminist arguments, suggesting writers such as Chernin (1985) offer a broader model as she examines identity issues and family conflicts in conjunction with sociocultural arguments. Lester (1997) points out the importance of not overvaluing the individual at the expense of the social, or vice-versa.

Some more recent writers (Bordo, 2004) acknowledge complexities within different social, political and economic structures and furthermore, that women do not naturally and inevitably succumb to social messages from the media and other forums. “[I]n understanding the female ‘anorexic’ body and the cultural symbolisms, identities and conflicts that are played out on it, it is necessary to explore how it is culturally, discursively constructed in its changing socio-historical specificities” (Malson, 1998, p.97). These more recent writings acknowledge that anorexia can signify a multiplicity of meanings and that it is important to attend to the specificity of the individual’s situation (Probyn, 1987), rather than collapsing anorexia into reductionist explanations such as the desire to embody magazine models (Boughtwood, 2005; Probyn, 2005).

4.2.7. Media blaming discourses

Since the reported increase in eating disorders in the 1980s (Gordon, 2000) there has been much research into the relationship between anorexia and media. Feminist writers have critiqued media presentations of female bodies (eg. Bordo, 2004; Wolf,
More specifically, Western media is cited as the forum for portraying prescriptions for feminine beauty, in both clinical and academic literature (Levine, 1994).

Media are charged with portraying an unrealistically thin image that women aspire to, as thinness is promoted as the key to success and happiness (Bordo, 2004; Bowers, 1994; McVeagh, 2003). Bowers (1994, p.106) writes that “media have capitalised upon and promoted this image and through popular programming have portrayed the successful and beautiful protagonists as thin. Thinness has thus become associated with self control and success.” Garner & Garfinkel (1980) examined the figures of the winners of Miss America contestants from the period 1959-1978. Their analysis involved measuring the women’s figures in media reports and the authors conclude that “winning over the last decade has been clearly associated with being thinner” (as cited in Bowers, 1994, p.110). Banks (1992, p.872) disputes the validity of the conclusions of this study, suggesting that the study simply “reflects changing male preferences for thinner women.” There is a long-standing divide between medical and feminist researchers over the positioning of anorexics and non-eating disordered women, as illustrated in Banks’ (1992) response. Banks (1992) and other feminist scholars like Wolf (1991) would position the media as representing the ideals of a patriarchal society, communicating prescriptions of feminine beauty to both men and women.

Although blaming the media is an increasingly pervasive explanation for anorexia nervosa, a relationship between anorexia and media messages has not been clearly
confirmed. Nor has it been established that media “help form a processing schema or whether they [media] simply refine, strengthen and maintain it” (Smolak & Murnen, 2001, p.98). Like some other sociocultural explanations, the media blaming discourses, as articulated in studies like Garner and Garfinkel’s (1980), position the women as cultural dupes who simply conform to the ideals promoted in media, and strive to embody these ideals through dieting and exercise. More recent work has disputed the notion that media audiences are simply passive subjects (Bordo, 2004; Boughtwood, 2005). In these media blaming writings like other discourses, there are inherent contradictions in the structure and presentation of these arguments. Medicine ‘blames’ the media for anorexia whilst simultaneously constructing anorexia as an illness, thus reinforcing the dominance of medical discourses in explaining and treating the condition (Boughtwood, 2003). Medicine thus implicates the media to strengthen its position as the authority on anorexia nervosa.

4.3. Conflicting discourses of anorexia nervosa

Anorexia and anorexics are discursively constructed through multiple discourses, contributing to a construction of anorexia as a complex illness. In clinical texts, anorexics are positioned as pathological, deviant and abnormal in relation to a normalising discourse of femininity. Many causal factors are implicitly gendered; early notions about inherent feminine propensity to illness are still present in contemporary medical and psychological texts (Ehrenreich & English, 1973; Turner, 1992). “The discourse of femininity can show us the assumptions made in the construction of femininity when certain psychiatric categories are assigned mostly to
women” (Hepworth, 1993, p.181). However, the discourses of anorexia hide from view the situated subjectivity of anorexia and the anorexic. As Hepworth (1999) points out, these discourses conceptualise anorexics mainly as pathological subjects and sidestep the social and familial contexts in which the anorexia developed and in which subjects are currently located.

There is an increasing tendency in medical literature to recognise anorexia as a multifactorial illness (Bryant-Waugh, 1993; Natenshon, 1999; Polivy & Herman, 2002), although this shift might be read as a means for biomedical and psychological discourse to maintain their hegemony over anorexia. Scholars have critiqued this shift. Bordo (2004) points out that eating disorders may be multidimensional, but this does not mean all dimensions play an equal role. Malson (1998, p.98) extends Bordo’s point, noting that the different positions are not epistemologically compatible. “How can we coherently combine a biomedical construction of ‘anorexia’ as a physiological disorder with a feminist construction of ‘anorexia’ understood in terms of patriarchal oppression?” Multi-factorial conceptualisations seem to assume that anorexia is a universal category and that the different causes are known by those fluent in discourses of anorexia and different frameworks can be mobilised to understand particular patients who can then be allocated to an appropriate therapist versed in that construction of anorexia. Certain power relations are played out in these construals of anorexia (Malson, 1998) as evident in the widely accepted claim that refeeding is the first step in any treatment (see Chapter Five) which comes from a biological construction of anorexia. Thus, three hundred years after Morton’s 1689 description of anorexia (Gordon, 2000), biomedical discourse, which includes psychological and familial (and to a lesser extent sociocultural), remains privileged,
despite having not yet explained or provided a successful means of treating or even managing anorexia (Ben-Tovim, 2003).

4.4. Situating ‘anorexia nervosa in the clinic’

The work of four researcher(s): Helen Gremillion (2002), Julie Hepworth (1999), Helen Malson, D.Finn, Janet Treasure, Simon Clarke and Gail Anderson (2004) and Jacqueline Segal (2003) have some conceptual and theoretical synergies with this thesis. The following discussion provides a brief overview of each of the studies and discusses their substantive and theoretical relationship to my project.

The studies of Malson et al. (2004), Segal (2003) and Gremillion (2002) all examine participants’ experiences of inpatient treatment for anorexia nervosa. I have chosen to include this particular article of Malson’s in this discussion, rather than her more significant work, *The Thin Woman* (1998), as this (2004) article focuses on hospitalisation, whereas *The Thin Women* does not. Malson only uses discourse analysis in this particular analysis (she has utilised poststructural theory in her other work). Hepworth’s (1999) study is included because it examines treatment of anorexia. Hepworth (1999) interviewed a range of health workers all of whom had treated anorexia nervosa.

Malson et al. (2004) draws on interviews with 39 inpatients with anorexia and bulimia and employs discourse analysis to examine participants and participants’ reports of health professionals’ constructions of the ‘eating disordered patient.’ The article is
part of a larger project that “emphasises the significance of a more elaborated, personalised and empowered construction of the patient” (Malson et al, 2004, p.485).

Segal (2003) explores young women’s accounts of inpatient treatment, using interviews and a grounded theory methodology. Segal (2003) also draws upon her own experiences of treatment for anorexia nervosa, which she discussed with the participants in the interview context. Based on her own experiences and validated by her findings, Segal (2003) contends that inpatient treatment is a wholly negative experience.

Gremillion’s (2002) article is informed by social constructionism. This study is based on fourteen months of ethnographic fieldwork in an inpatient programme for anorexia in a hospital programme in the United States of America. Gremillion’s focus in this article is how patients and doctors construe the body as a resource for healthy body practices; and, drawing on a case study, how clinicians interpret patient’s resistance to gain weight.

There are a number of differences between these studies and my own. As Segal (2003) and Malson et al. (2004) have pointed out, how participants experience hospitalisation remains a neglected area of research. These studies have focused specifically on how participants constituted hospital treatment. My work extends these two studies by examining how participants experience and construct inpatient treatment, but unlike these authors I also attend to how girls deployed other knowledges in the clinic and how these inform the ways girls take up positions other than patient.

Hepworth’s (1999) work illuminates how anorexia becomes somewhat fractured in clinicians’ discourse. Her analysis revealed that anorexia is frequently relegated to the medical domain, but also that clinicians conceptualised anorexia as a complex category. Hepworth (1999) has focused on clinicians’ constructions of medical explanations of anorexia: I explore how girls’ engage with the different discourses and treatment of anorexia nervosa.

Gremillion (2002) positions the patient as active in the treatment encounter, as negotiating and resisting treatment. Gremillion (2002) conceives of resistance as not outside medicine but operating within “the interstices of medical discourse, pointing up its instabilities” (Gremillion, 2002, p.409). The clinicians in Gremillion’s study construed patients’ resistance as healthy, suggesting that patients were developing an independence from the hospital that would be necessary in overcoming anorexia. This construction is different to how resistance was construed in the clinics where I was working. The different constructions of resistance by doctors demonstrate that the
clinics are not uniform sites and multiple analyses need to be conducted to map the domain.

My work is epistemologically different to Malson et al. (2004), Segal (2003) and Gremillion (2002) as it employs poststructural theory. This study also adds conceptually to the other studies, particularly Gremillion’s (2002) as I illuminate how girls enact resistance to treatment in a site where resistance is construed differently. My work also explores other dimensions not addressed in these studies, including: constructions of relations between patients, girls’ use of social discourses and media representations in negotiating subject positions in the clinic, girls’ reports of family and friends constructions of the clinic and the deployment of psychiatric and historical knowledges in constituting oneself.

4.5. In summary

This chapter has examined the different writings on anorexia and in doing so, has described and analysed the discourses through which anorexia is constituted, along with explaining where my project fits within the literature. The following chapter explores the hospital treatment of anorexia. Medical constructions have sustained anorexia as the remit of the medical profession, which is reflected in how anorexia is treated in contemporary public hospitals. To provide context for my analysis, Chapter Five describes inpatient treatments for anorexia and the specifics of the treatment regimes of the two clinics in which I conducted research.
Chapter Five

Inpatient Treatment for Anorexia Nervosa

This chapter is in two main parts. Part One contains: a description of inpatient hospital regimes, a discussion of the perspectives on inpatient dynamics, views on doctor-patient relationships and feminist critiques of these systems and relations. Part Two is an explanation of the clinics in which my research took place and the specifics of their inpatient programmes and therapies.

5.1. Description of inpatient hospital regimes

The major purpose of inpatient treatment for anorexia nervosa is weight restoration (Halse et al., 2005; Segal, 2003; Vandereycken, 2003). There is debate about the best methods of treating anorexia, arguments that involve both medical and ethical considerations (Garner & Garfinkel, 1982a). However there is a general preference for initial weight restoration to take place in hospital, even by alternative therapists (Claude-Pierre, 1997). Due to a growing recognition of the psychological factors involved in eating disorders (Winston & Webster, 2003), since the 1970s behavioural techniques have replaced force-feeding and patients are more frequently admitted to psychiatric units rather than medical wards (Richards, 2003; Sesan, 1994). However, re-feeding is still the central focus of treatment regimes in clinical settings (Vandereycken, 2003).
In adult services a psychiatrist usually heads the eating disorders clinical team and his or her role is diagnosis and medical management, including prescribing medication (Winston & Webster, 2003). In adolescent clinics the director may be a paediatrician, with a part time psychiatrist (Jarman, Smith, & Walsh, 1997). Other clinical team members include junior doctors, dieticians, nurses, occupational therapists, psychologists and social workers. Psychologists and social workers work with the patient and their family, because the family has a significant role in the treatment of adolescent patients (Winston & Webster, 2003).

There is dispute amongst clinicians over the criteria for hospitalisation. Contentious issues include the admission and discharge criteria and the specificities of the inpatient programmes (Vandereycken, 2003). In attempting to develop a systematic and standardised approach (Richards, 2003) the American Psychiatric Association (APA) and other psychiatric colleges provide guidelines for admitting patients with anorexia to hospital:

The decision to hospitalise should be based on psychiatric and behavioural grounds; including rapid or persistent decline in oral intake; decline in weight despite maximally intensive outpatient or partial hospitalisation interventions; the presence of additional stresses- such as intercurrent viral illness- that may additionally interfere with the patient’s ability to eat; prior knowledge of weight at which instability is likely to occur; and co-morbid psychiatric problems that merit hospitalisation (American Psychiatric Association Work Group on Eating Disorders, 2000, p.18).
Despite these guidelines, as Vandereycken (2003, p.411) points out, “there is a world of difference between agreeing on physical criteria for hospitalisation and agreeing on behavioural indications” as some of these behaviours may be related to patients anxiety about treatment. In admitting a patient to hospital, physicians emphasise the importance of gaining the cooperation of both the girl and her parents (Vandereycken, 2003). Patients are usually admitted involuntarily or when critically ill, and may need stabilisation in a medical or cardiology ward (Winston & Webster, 2003) before transfer to eating disorders services.

Some clinicians are aware that being hospitalised for anorexia is confronting to the patient. Vandereycken (2003, p.143) writes: “hospitalisation in a specialised eating disorders unit implies an official labelling.” Medical writings seem to assume that anorexics are likely to be uncooperative patients, as hospitalisation incites fear for numerous reasons, particularly the requirement of gaining weight (Garner & Garfinkel 1982, 1997) along with the stigma attached to being admitted to hospital with a psychiatric illness.

Hospitals use various means of refeeding patients with anorexia including supported meals, nasogastric tube feedings, total parenteral nutrition and surgical interventions (Halse et al., 2005; Neiderman, Zarody, Tattersall & Lask 2000; Neiderman, Farley, Richardson & Lask, 2001). There is a preference for weight gain to take place through supported meals as general goals of hospital programmes include the patient being able to eat a larger variety of food, particularly ‘forbidden foods’ like carbohydrates or meat. Clinicians emphasise the importance of re-establishing typical eating patterns
during hospital meals, such as eating speed, as anorexics are renowned for taking exceedingly long periods to eat (Eisler et al., 1997; Garner & Garfinkel, 1982a; Shute, 1992). As a patient gains weight, she is prompted to go shopping and purchase new and more suitable clothes (rather than those worn when underweight) and is allowed some leave from hospital to attend social functions. The patient is encouraged to discuss school and career plans with clinical staff, parents and teachers. The ultimate end point is for the patient to take responsibility for herself and her life when leaving the hospital (Cockett, 1992; Touyz & Beumont, 1985).

Treating clinics have different specific measures to determine appropriate weight gain, including matching to normal populations, BMI or low normal body weight, and anticipated return of menstrual periods (Sullivan, Bulik, Fear, & Pickering, 1998). clinicians differ over whether or not to set a target weight on admission (Winston & Webster, 2003). Garner and Garfinkel advocate a target weight as best practice: “the patient’s target weight should be specified and agreed upon at the onset of treatment…to reassure her that her weight gain will not be allowed to continue indefinitely. The patient should be reassured that she won’t be forced, or even permitted, to become too heavy” (1982, p.238). Other clinicians prefer the target or discharge weight to be more flexible, although they may set a safe zone, a minimum healthy weight (Cockett, 1992). The recommended weight gain is 1-1.5 kilos per week (Vandereycken, 2003). Patients frequently lose weight post hospitalisation; anorexics are renowned for their high relapse rate (Colton & Pistrang, 2004; Garner & Garfinkel 1997; Levendusky 1985). However clinicians are trained in putting safety first and see it as crucial to treat the immediate physical dangers of malnourishment.
Some doctors are more positive about inpatient treatment, suggesting it can reduce eating disorder symptoms, such as depression (Lowe et al., 2001).

Bed rest may be part of inpatient programmes in order to facilitate weight gain and requires the patient to remain on her bed or a specified couch after meals. Some programmes may institute bed rest for the entirety of the hospital stay, whereas other clinics only require a patient to be on bed rest till they reach a certain weight or are no longer physically compromised. Griffiths et al. (1996) have noted that many patients experience boredom and isolation on bed rest, and that there is a need to provide some activities to treat the individual needs of patients placed on bed rest. Recently, clinicians have modified inpatient programmes (Touyz & Beumont, 1997) to allow patients to move freely about the ward after eating, albeit resulting in a slightly reduced required weight gain. The rationale for this different approach is that “the use of lenient operant programmes within a humane framework does appear to add to the treatment of patients with anorexia” (Touyz & Beumont, 1997, p.370).

A level system that involves progression from one level to another has been integrated into many contemporary Western clinics that treat eating disorders. Some clinics require patients to sign a treatment contract to comply with the level system. The level system is based around giving patients more privileges: allowing the patient to choose her foods from a limited range of options that are set out by dieticians, length of bed rest, more movement around the ward, outings for particular periods of time and visitors. The expectation is that “as [patients] are able to meet the requirements of a higher level, they are allowed great privileges and autonomy” (Williamson,
Duchmann, Barker & Bruno, 1998 in Vandereycken, 2003, p.415). However, as Hepworth (1999, p.94) notes, such a contract assumes compliance with treatment and dilemmas arise when a patient is non-compliant.

Financial considerations are evident in the (changing) guidelines for length of admission, particularly in the United States of America (USA). Garner, writing in 1982 suggested 8 to 12 weeks was a reasonable admission, while Castro et al. (2003) in a more recent study suggested a shorter stay of 24 to 40 days so to not interrupt adolescents’ social and academic lives. Gordon (2000) notes that anorexia was described as “the psychiatric disorder of the 1980s” which resulted in an abundance of treatment services. The pendulum now appears to have swung in the opposite direction, in that there is a severe lack of funding for treatment of eating disorders in the majority of Western countries (Beumont, 2003; Gordon, 2000; Touyz, 2005).

“The abuse of inpatient treatment has been followed by a backlash, resulting in an inappropriate denial of hospital coverage or absurd limitations of coverage for eating disorder patients, which have put many patients at unnecessary risk for chronic illness or death” (Garner & Needleman in Vandereycken, 2003, p.410). Economic arguments versus most effective treatments pose a continual struggle (Vandereycken, 2003).

Medical reports suggest that a decrease in length of (initial) stay has resulted in a rise in readmissions, as patients who leave hospital at a lower weight than ideal are likely to be readmitted (Howard, Evans, Quintero-Howard, Bowers, & Andersen, 1999).

Making treatment compulsory in the case of anorexia nervosa is a contentious issue. Various countries have different laws about compulsory treatment. For example, in
Israel it is not possible to involuntarily hospitalise a patient with anorexia (Melamed, Mester, Margolin, & Kalian, 2003). Both the USA and Canada have attempted to develop a uniform legalisation to hospitalise anorexic patients but have been unsuccessful (Griffiths & Russell, 1998). There is some contestation as to whether anorexia is like other mental illnesses, which has implications for the compulsory treatment of anorexia (Coote-Pearce & Wylie, 1994; Griffiths & Russell, 1998). One of the most problematic issues is whether the patient is delusional or just resistant to treatment, an issue that raises questions about what a clinician can legitimately claim about a patient’s competence to make an informed choice about treatment (Winston & Webster, 2003).

In New South Wales, Australia, compulsory treatment for anorexia nervosa is under the Guardianship Act 1987. The Guardianship Act stipulates that a tribunal can appoint a guardian for people over 16 years whose decision making is impaired because of various disabilities, such as mental illness (Guardianship Act, 1987). The guardian is either private (usually a family member) or public (employee of the court, may be a doctor) and their role is to advocate for what they see as the best interests of the patient, particularly their physical well being (Coote-Pearce & Wylie, 1994). The rationale for appointing a public guardian is often to relieve the family’s anxiety about making difficult decisions (Melamed et al., 2003), as families often try to balance the patients’ wishes against the advice of health professionals.

Initial orders are usually of a period of one year (NSW Guardianship Tribunal, 2003-2004). When clinicians apply for guardianship of a patient, they need to state
precisely what treatments the patient will be subjected to, for instance, bed rest, nasogastric tube feeding and medication. Clinicians have criticised these stipulations, on the basis that a patient may become sicker than anticipated, and measures that are not listed in the order may be necessary to save a life; however clinicians do not have authority to implement other treatments based on a patients’ progress (Coote-Pearce & Wylie, 1994).

Another issue is that guardianship does not guarantee compliance with treatment. Although this issue pertains to the use of guardianship in the case of any mental illness, clinicians suggest the nature of anorexia, in that patients are often non compliant and resistant to treatment, makes guardianship harder to enforce. Coote-Pearce & Wylie (1994, p.11) in their study of guardianship and anorexia noted that: “coercive guardianship orders have their limits. They allow us to admit and maintain an individual in hospital but cannot force the person to cooperate with treatment.”

Doctors prefer to try to negotiate with patients instead of using guardianship, by using strategies like providing information about the long-term effects of malnourishment. Education and the threat of guardianship are more frequently utilised than official orders. Carney, Ingvarson and Tait (2004), in a four and a half year study found that formal law was only engaged in hospitalising 11.5 percent of their sample of patients with anorexia nervosa.

Due to the prevalence of psychological discourses of anorexia other therapies are integrated with hospitalisation, usually through individual therapy sessions. Some of these therapies aim to target a particular psychological problem or anorexic cognition.
Cognitive behavioural therapy (CBT) is widely used and involves “education about regular eating patterns, body weight regulation, starvation symptoms, vomiting and laxative abuse… a strategic element in treatment (Garner, Vitousek, & Pike, 1997, p.95). Desired clinical outcomes include a lessening in patients’ concern with their weight and the ability to monitor one’s feelings and behaviours. Other therapies include art and narrative therapy (Hepworth, 1999) and different family therapies (Eisler et al., 2000; Le-Grange, 1999; Ma, Chow, Lee, & Lai, 2002).

5.1.1. Different positions on patient dynamics

Clinicians differ over whether anorexics should be separated from other patients in hospital (Garner & Garfinkel, 1982a), as do sufferers (Colton & Pistrang, 2004; Segal, 2003). Levendusky and Dooley (1985, p.213) writing as clinicians and making a case for integration, suggest anorexics should “have the opportunity to learn from individuals who have a more normal approach to eating…[yet]…anorexics should not be treated in a population that is primarily thought-disordered.”

The disadvantages of having anorexic patients together in a ward have been documented in clinical literature (Gowers, Weetman, Shore, Hossain, & Elvins, 2000) and sufferers’ biographies (McCarthy & Thomson, 1996). These disadvantages include competition between patients over losing weight and being the lowest weight (Segal 2003; Way 1993). Way (1993) charges treatment programmes as directly promoting this competition among patients, suggesting that the constant weighing means weight is the focal point of patients’ conversations. In contrast to this position, Sesan suggests that sufferers can provide each other with support and understanding.
“This is a vision of connection, of women breaking through pain and shame as they voice their pain to one another” (1994, p.262). Garner and Garfinkel (1982) suggest some of these competition problems can abate if patients and staff are willing to work together. “The advantages of an ‘anorexic unit’- staff expertise and the spirit of working together that may grow among the patients- outweigh these disadvantages” (Garner & Garfinkel, 1982, p.220). Such a statement reads as a hopeful assertion rather than one that is substantiated by empirical research.

5.1.2. Medical explanations of doctor/patient relationships

In traditional doctor patient relationships, the patient behaves passively and accepts the doctor’s position as expert (Frank, 1999). The patient submits to the clinician’s authority and follows the clinician’s instructions about treatment so as to become well (Enelow & Swishler, 1986). Anorexia is a very different kind of illness because many patients refuse treatment, particularly refeeding regimes. There is a paucity of information on doctor/patient interactions in the treatment of anorexia, perhaps because clinicians tend to focus more on patients’ physical condition, at least during the period of hospitalisation (Cockett, 1992; Derman, Kanbur, Coskun, & Pehlivanturk, 2004; Steiner & Lock, 1998). Doctors may not invest time in building a relationship with their patients. As Sanders and Gaskill (2000, p.2) write:

Hospitalised sufferers and their families commonly report difficulty in developing positive relationships with staff who they often see as judgmental and punitive. Professionals need to accept that this is a real issue, and education
programmes need to extend beyond the information and skill level to address attitudes.

The sparse literature on doctor-patient interactions in anorexia nervosa is reviewed in this section. It is suggested that people with eating disorders are viewed as difficult patients (Beumont, 2003; Marks, 2000). Other mental illnesses such as schizophrenia were seen as more of a biologically based illness and out of the patients control whereas patients with eating disorders were seen as responsible for their illness (Fleming & Szmukler, 1992). Therefore, words like difficult and unco-operative are frequently used to describe patients with anorexia (Fleming & Szmukler, 1992), both because of what is seen as a dubious illness along with anorexics non compliance with treatment. Medical literature suggests that patients make numerous attempts to avoid eating, to the extent that clinicians are surprised when patients eat without complaint (Garner et al., 1997).

Clinicians suggest caution in approaching a non-compliant patient. “If a patient has been deceptive about hiding foods, excessive exercising, or vomiting, she must be confronted in a non judgemental manner” (Bowers, 1994, p.240). Here, clinicians are arguing for girls to be treated gently as they are mentally unwell and unable to think rationally. For example Stephen Levenkron, who gained notoriety for treating Karen Carpenter, advocates a ‘Nurturant Authoritative’ approach for doctor patient relationships in the treatment of anorexia. “We have to be very careful with this patient because we have to communicate something very important to her: We have to indicate that we are aware that she is not competent (Levenkron, 1982, p.241).
Levenkron is positioning himself as an authority figure, able to help the vulnerable adolescent, and makes no apologies in doing so.

There are tensions in the therapeutic alliance when a patient is resistant to the doctor’s power (Gans & Gunn 2003). Strober (1997) suggests that patients must be willing to be helped. He notes that treating anorexia is “a stark example of how impotent we can be rendered as would be helpers” (Strober, 1997, p.237). One way of combating this, Strober suggests, is to make a human connection with the patient. The role of therapist, following Stober, is to “compel the patient’s attention, reinterpret the obscure language of her symptoms, and finally move her gently but persuasively to unravel these conflicting tensions…[these] are the most crucial elements of the psychotherapeutic engagement” (Strober, 1997, p.231). More recent clinical work suggests individual practitioners may be self-reflective on how they approach their patient, such as Beveridge (2002) who seems to be suggesting that doctors should try to initiate more of an equal relationship in the treatment context.

Doctors’ anxieties about treating anorexia nervosa are largely invisible in the published clinical literature. However, the findings of Hepworth’s study (1999) suggested doctors had some uncertainties in making conclusive statements about the causes of and treatment of anorexia, which contrasts with the expert voice articulated in the work of Levenkron (1982). Although the clinicians in Hepworth’s (1999) study still relegated anorexia to medicine’s domain, her study reveals some of the difficulties clinicians experience in treating anorexia, including uncertainty about prognosis and lack of faith in current treatment methods (Hepworth, 1999).
5.1.3. Feminist critiques of hospitalisation and clinicians

Feminist writers (Fallon, Katzman, & Wooley, 1994) have criticised inpatient treatment of anorexia. Sesan (1994) points out that male doctors head the majority of eating disorder units, and may have less sympathy for some of the reasons why women choose self-starvation and this may be reflected in their approach and positioning of patients as mentally unwell. Feminists criticise treatment regimes for their focus on food and weight and the attention to the physicality rather than the self (Gremillion, 2002; Malson et al., 2004; Segal, 2003; Sesan, 1994). Lawrence (1984) emphasised the need for a balance between refeeding and therapy in treatment and suggests it is damaging to women to wholeheartedly accept medical interpretations of anorexia. “[T]hat she is stupid and rather childish and wrong…leads to compliance with a rigid feeding routine at the cost of not really learning and understanding what their needs were in relation to food” (Lawrence, 1984, p.85-86). Lawrence (1984) suggested women may hide their eating disorder simply to avoid the rigid control and surveillance of clinical regimes. Other feminist scholars have articulated this argument in more sophisticated terms. Eckermann (2003, p.6) drawing on Foucault, writes:

Ironically a modification of the Panopticon architectural design is adopted in the large hospitals where self-starvers are treated. The concept of surveillance and the production of docile subjects are central to the treatment process in treatment regimes based on behaviour modification…the rooms chosen for
these undergoing behaviour modification [are] within sight of the nurses station, with glass panels internally and large windows outside to allow uninterrupted vision.

Although feminist writers point out the self destructive aspects of starvation, they see inpatient programmes as a simplistic approach to a highly complex disorder. These writers suggest that refeeding will invariably foster a backlash, in that women will lose the weight they gained, either within hospital or upon discharge, because hospitalisation has not allowed them to address the issues that underlie their eating problems (Lawrence, 1984; Segal, 2003; Sesan, 1994).

Along with criticising treatment regimes, feminist writers also suggest that female patients are silenced in encounters with doctors (Dundas-Todd, 1989). This view is articulated in feminist book titles like For Her Own Good: 150 Years of the Experts Advice to Women (Ehrenreich & English, 1978). Some feminists, including Ehrenreich and English (1978) and Hepworth (1999) locate such relationships historically. Hepworth (1999, p.34) in her genealogy of anorexia nervosa from the 16th century to the 21st century, writes that:

The historical inequalities in power within the physician patient relationship, where the physician occupies the autonomous position and the patient is positioned as the subject of medical processes, was a further process that facilitated the connection between anorexia nervosa and medicine.
In feminist critiques of the doctor-patient relationship in the treatment of anorexia, doctors are invariably constructed as male, and women are positioned as inferior to the doctor (Boughtwood, 2003). Hierarchical power relationships are evident in sufferers’ biographies, where doctors are accused of being rigid in their approach to patients (Johnstone, 1993; Margolis, 1988) and having a lack of understanding of the sufferer’s personal situation (Johnstone 1993). The published accounts of anorexia, some of which incorporate feminist perspectives into the narratives reveal that doctors positioned themselves as superior to patients (Hornbacher, 1998; Shute 1992). These accounts also suggest that doctors misuse their power and authority, in making assumptions about patients based on medical constructions of anorexia, rather than events in the patients’ lives (McCarthy & Thomson, 1996; Margolis 1988).

In a response to traditional psychiatry, feminists have developed other treatments, which have attempted to “move away from the passive and neutral stance of traditional therapies; have generally become more interactive, capitalising on capacities of both patient and therapist” (Fallon, Katzman & Wolley, 1994, p. xiii). Stockwell and Dolan (1994) suggest a female therapist may be more effective on the basis that she is “physically and emotionally a woman” and may be better able to empathise with particular issues her clients are experiencing like body dissatisfaction. These therapists take the position that a woman’s conflicts are not unique to her, but socially embedded and shared by the therapist to varying extents (Chernin 1985; Sesan, 1994; Stockwell & Dolan, 1994). Feminist therapists have strived to imbue their clients with agency (eg. Goodman, 2001), yet feminist therapists give little description of the form this agency takes and the ways in which it might empower their clients to make changes in their eating behaviours or how they feel about
themselves. Feminists offer alternatives to medical constructions and treatments of anorexia, but some of these are not radically different from the clinical model.

5.1.4. Convergence of feminism and medicine in current debates about anorexia

Irrespective of whether they identify as clinicians or feminists, the majority of therapists struggle with a lack of resources in an unfunded health system, a lack of public understanding of anorexia (Richards, 2003) and the burden and challenge of treating critically ill patients (Beumont 2005; Jarman, Smith & Walsh, 1997). The reluctance to treat anorexia (see Brumberg, 1988) has increased further as a result of the bad press traditional treatments have received lately (Touyz, 2005). In Australia, much of this press was sparked by Ben Tovim’s (2003) controversial article, which was based on the progress of 220 Australian women with eating disorders over a three-year period. In an interview in *The Australian Women’s Weekly* Ben Tovim concluded that no available treatment “seemed to change the likelihood of final recovery...Anorexia is a terrible, heart rending condition, where people can become very ill. Many don’t get better and they live as semi invalids” (Health Report, 2005, p. 125-127).

Perhaps due to the lack of success of any treatments, some therapists have abandoned the medical/feminist debate, suggesting it is more productive for practitioners with different backgrounds to work together. The combination of different knowledges and epistemologies is seen as valuable in aiding understandings of anorexia (Halse & Honey, 2005; Katzman & S. Lee, 1997; personal communication S. Clarke, 2004;
personal communication C. Wearne, 2003). Despite the division between medicine and feminism in other facets of social and professional worlds where feminists still talk of oppression, it seems that there is some integration in theory and treatment of anorexia. There has clearly been a shift since 1983 when Steven Levenkron publicly charged feminists working in eating disorders with “sacrificing the care of ‘helpless, chaotic, and floundering children’ in the interests of a ‘rational,’ political agenda” (Bordo, 2004, p.60).

5.2. Description of the clinics in which research took place

In NSW, a state of nearly 8 million, beds for treating anorexia nervosa are scarce. The number of beds stands at: 8 adult (public), 14 adolescent (public) and 36 adult (private) which are spread across six hospitals all based in Sydney (Touyz, 2005). Children as young as eight are treated in public adolescent beds and adolescents that are over 16 can be admitted to private adult clinics. Participants were recruited from the adolescent medical units at two of these hospitals. The hospitals are geographically adjacent, public teaching hospitals that annually treat up to 100 inpatients and 250 outpatients with emaciating eating disorders, primarily anorexia nervosa. In this discussion, each clinic (labelled A & B) is discussed individually and then some of the issues relevant to both are outlined.

The Department of Adolescent Medicine (Clinic A) is located in a public children’s’ hospital where the patients range from newborns to sixteen years, although the majority of those diagnosed as anorexic are between 10-15 years of age. Patients with
anorexia are admitted into one of three wards. The wards include patients who have psychiatric diagnoses and illnesses such as cystic fibrosis. The reason for the spread of patients is related to resource issues rather than medical reasons. Nurses who have been specifically trained in treating eating disorders work across all three wards. The Department has a pediatrician and a child psychiatrist as its co-directors. Other staff members include a psychiatric registrar, dietitian and four members of a Maudsley Family Therapy (MFT) team. MFT has been recently implemented in the clinic (see discussion below).

Eating disorder outpatient clinics are held one morning per week. Patients seen in these clinics are mainly new referrals, many of whom go on to become inpatients. Former inpatients also attend these outpatient clinics for check ups. Staff meetings take place after the clinic. These include a brief medical review of patients, usually by one of the directors. One afternoon per week the directors meet with the parents of inpatients to discuss medical management plans.

Inpatients are allocated a level depending on their physical condition. In Clinic A, Level One includes complete bed rest, patients are not allowed any choice in their diet and only immediate family is permitted to visit. Level Two involves 30 minutes bed rest and patients can select from a limited range of foods that are offered and monitored by dieticians. Level Three includes the same amount of bed rest and food choices and patients are allowed one other visitor outside of family as well as one or two half days leave dependent on their weight gain and general compliance. Level Four comprises of 30 minutes bed rest, dieticians monitor menu selections and
patients are allowed one or two half days leave. Anyone may visit, although only in certain times.

Re-nourishing patients is the major aim of the programme, along with correcting disordered eating behaviours (eating slowly, eating only one type of food at a time). While gaining weight in hospital is an important part of the programme, the MFT is equally significant. Most patients are discharged when medically stable, although at a slightly lower weight than ideal as 90 percent of patients go on to do MFT. The expectation of MFT is that if the family has an active role in treatment, patients can be managed on an outpatient basis (Eisler, Le Grange, & Asen, 2003).

MFT is described here as it is an integral part of Clinic A’s programme and the consultants are currently conducting research on the efficacy of MFT with their patient population. MFT developed initially in the Maudsley hospital in London, and clinicians who developed the therapy have conducted numerous outcome studies with positive results (Eisler et al., 1997; Eisler et al., 2000; Eisler et al., 2003), which informed the consultant’s decision to use MFT in Clinic A.

One of MFT’s most important tenets is that “the family is not the problem but a resource” (Eisler et al., 2003, p.293). MFT has three phases, with gradually less therapist involvement. The first phase includes a family meal and the therapist observes family interactions around eating. Families are encouraged to work out ways of refeeding their daughter and the therapists role is to “reinforce a strong parental alliance around their efforts at refeeding their offspring on the one hand, and align the
patient with the sibling subsystem on the other” (J. Lock & Le-Grange, 2003, p.3). The MFT manual suggests that in phase two, parents are relieved as they have “taken charge” of the eating disorder “and weight gain with minimum tension is encouraged” (J. Lock & Le-Grange, 2003, p.3). Other issues, including strain in the parental relationship are now discussed with the therapist, but only in relation to the impact these have on refeeding the child. Phase three is theoretically characterised by a stable weight. “The central theme here is the establishment of a healthy adolescent or young adult relationship with parents in which disordered eating does not constitute the basis of all interactions” (J. Lock & Le-Grange, 2003, p.3). The phases of treatment are not intended to last for a specific period of time; for instance a family might spend six months in phase one, working closely with the therapist throughout this time and only spend a month in phase two (J. Lock & Le Grange, 2003). MFT is aimed at patients who are under 16 (J. Lock & Le Grange). For this reason, it has not been implemented in Clinic B.

Clinic B is an adolescent department in a public hospital. Patients are primarily girls between the ages of fifteen to twenty with anorexia, however when required by the hospital, patients of all ages with varying types of illnesses take up the spare beds. The medical director is a paediatrician, who is assisted by a paediatric fellow on a full-time basis. Two paediatricians are also half time staff members, one from Clinic A, who runs an outpatient clinic one day a week. An adolescent psychiatric clinic is attached to the unit and the consultant and his registrar assist the outpatient clinic with psychiatric help. Other clinical team members include the nursing clinic manager, two half time clinical nurse consultants, a full time social worker and two half time psychologists. There is also a half time occupational therapist and a dietician.
The Department runs two half-day outpatient clinics and a full day outpatient clinic per week. Patients are mainly comprised of former inpatients and new referrals, the other (non-eating disordered) patients have adolescent illnesses such as Attention Deficit Hyperactivity Disorders, depression and first episode psychosis (precedes schizophrenia). A six-hour time slot is allocated for new patients as 95 percent of these patients present as severely physically compromised and will be admitted to hospital. New patients are usually seen in the full day outpatient clinic. Patients are expected to arrive early in the morning with their parents, complete the EDI and then are seen individually and as a family by various members of the clinical team.

In Clinic B’s inpatient programme, bed rest is only required when a patient’s vomiting is out of control. Bed rest is ordered as a mechanism for combating this behaviour. Afternoons and evenings are basically free time for patients. Girls watch TV or do homework, and are permitted to leave the clinic (although not the hospital) as long as they inform the nursing staff of their whereabouts, using a sign-out book. There are no restrictions on visitors, or use of the phone. The major consequence for gaining or failing to gain weight is the amount of weekend leave allowed. Dependent on weight gain, girls are given: a between meals pass, half day, full day, overnight or weekend gate pass.

Dependent on the patient’s medical condition and the clinician’s assessment of family dynamics, family therapy may begin on admission. Families work with a social worker, psychologist or psychiatrist, dependent on availability. In addition to family...
therapy, patients also have individual therapy sessions. Both family and individual sessions focus on why the illness developed, strategies for recovery, strategies for changes to certain practices such as vomiting and more practical issues like when and if girls should return to school or get a job.

Team meetings take place three times a week. The majority of the clinical team attends all three meetings. The half time doctors usually attend one meeting weekly. Girls are weighed three times a week, at 6 am on the morning of the meetings, and the meeting usually takes the form of doctors reporting on patients’ weight gain and patients’ behaviour generally. Major decisions regarding treatment are usually made on a particular day and changes to individual plans are largely a result of weight gain or loss. Before the team meetings, patients take turns to speak to the clinical team to discuss their feelings about their treatment. Girls’ requests are put to the team as part of the discussion about each individual. After the meeting the medical director speaks to patients individually to inform them of their amended management plan, emphasising that the entire clinical team are involved in decisions about treatment, in order to avoid patients attempting to create divisions between the staff.

As patients are sometimes deemed too chronic for the adolescent service, team discussions sometimes centre on the best facility to relocate a patient to. The doctors have links with more comprehensive services such as other adolescent clinics in the city and adult wards both within and outside the hospital. The team meetings also provide a space for staff to discuss their concerns about particular patients and to review treatment procedures.
There are some similarities across both the clinics. A quarter of Clinic B’s patients had a previous admission in Clinic A. When girls turn sixteen they are transferred to Clinic B but their primary doctor remains the same. Admissions to both clinics are usually because a patient is medically compromised and on rare occasions patients are admitted because family dynamics are so troubled that the family or the patient needs ‘time out.’ Guardianship or the threat of guardianship is put in place to keep patients in the hospital. During the period of my research, guardianship orders were put in place to: sedate so to feed a person, administer nasogastric tube feedings and to retain girls in the clinic. Parents were usually made their daughter’s guardian, but several of the girls were under public guardianship.

In the clinics, the food served is based on healthy eating principles as instituted by public health nutritional guidelines. These guidelines decree: 30 percent fruit and vegetables, 30 percent carbohydrates such as bread, potatoes, rice and pasta, 15 percent milk and dairy products, 15 percent meat and fish and 10 percent fat and sugar (Healthy Eating Guidelines, 2005). Meals consist of Western foods: meat, potatoes, vegetables and bread. Menus are intended to satisfy all food groups as per the guidelines. Full fat foods make up the menu, no diet products are allowed until maintenance weight (maintaining at minimum health weight as determined by BMI) is achieved. If girls reported anything specific about their diet such as being vegetarian, the dietician would investigate this in relation to the eating disorder’s onset. For example, if an individual had been vegetarian for five years and only had the eating disorder for one and the patient’s parents were also vegetarian, then this claim would be perceived as legitimate, not as an attempt to avoid certain foods. All
hospital food is prepared on site by commercial caterers contracted by tender. The suppliers for products such as juice, milk, bread and meat all change regularly, largely dependent on price. There is no clinical involvement in the brands of food served and dieticians have to work with what is available. The type and quality of food is outside the direct control of the clinical team. The kitchens do not make any exceptions for anorexic patients, except when they are asked by dieticians to add more protein, in the forms of different foods, to the meal trays.

The basic requirement of both inpatient programmes is that girls gain a kilo per week. The preference is for girls to eat meals, but the specific food plan depends on whether girls are taking other supplements. For instance a patient may be on a 50 percent meal exchange, which means that half her calorie intake is made up of food and the other half through dietary supplements. The most common supplements used in hospital are Ensure Plus or Sustagen. Sustagen is described as being nutritionally balanced with low GI and provides protein, energy and essential vitamins and minerals. One glass of Sustagen provides a similar level of nutrients to a meat and salad sandwich, plus a tub of yogurt and strawberries (Sustagen, 2005). Ensure is used as a snack, rather than a meal replacement. It contains protein, calcium, and vitamins and minerals and is sold in eight-ounce servings. Ensure comes in chocolate, strawberry and vanilla flavours (Ensure, 2005). Patients are generally required to eat three meals a day at the meal table with the other patients and a nurse, and to finish their meal within the allotted time. Three snacks are included in daily meal plans and supplements have to be fitted around or within eating times. If an individual’s programme includes more than five cans of supplements these are administered by using a nasogastric tube. If a patient is
receiving between seven to nine cans of supplement the nurses will administer these at night while patients are sleeping.

Doctors take a BMI on admission, which they use to determine a target weight. The exact number is usually not relayed to the girls; if they ask they are given a rough figure, so that girls do not get tied to a particular weight which is suggested to be a problem with anorexic patients (Garner & Garfinkel, 1997; Vandereycken, 2003). The clinics use several determinants of medical stability. Dual Energy X-Ray Aborptonetry (DXA) is a frequently used measure. DXA is a measurement of bone mass in the spine and limbs, using a very low dose of radiation. It is used to scan patients with who have or are at risk of osteoporosis. Measurement of skin folds are another means of assessment, and are sometimes used as an alternative to weighing the patients who are suspected of artificially inflating their weights. Random weighing is also instituted on these occasions.

Some patients are diagnosed with other psychiatric illness, primarily major depression, obsessive compulsive disorder and anxiety disorders (Halse et al., 2005). These patients receive psychiatric consults and some are given medications that are reviewed in tandem with treatment plans for anorexia. An oromaxillofacial surgeon is consulted if a patient has teeth or other dental problems, usually as a result of excessive vomiting.

The majority of patients in both wards attend school. Hospital school runs from 9-12:30, with a break for morning tea. To cater for a range of different ages and
abilities, the hospital teacher consults with the patient’s school and the school sends work to the hospital teacher so that while in hospital girls can keep up with their classmates. Occupational therapists run a group four days a week and groups sometimes involve activities like embroidery, quilting, jewellery and card making. A nurse or a clinical psychologist takes the group on the fifth day. The psychologist usually engages with issues relevant to anorexia. Occasionally there is an excursion to a show, film or shopping centre. Physiotherapy takes place for half an hour each weekday morning. This is the only exercise the girls are allowed.

This discussion has illuminated that inpatient treatment of anorexia nervosa is a very complicated and difficult process, not only for patients and their families but for all therapists involved in their care. This chapter maps the terrain for the data analysis in the following three chapters. Chapter Six analyses the construction of food, eating and embodiment in the clinic. Girls suggest that the clinic’s use of food and notions of healthy bodies are in direct opposition to wider social discourses on these topics and draw on these discrepancies to validate their resistance to treatment.

Chapter Six

Construing Hospitalisation Through Embodiment

6.1. Introduction
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Chapter Six

Construing Hospitalisation Through Embodiment

6.1. Introduction
The contention of this chapter is that there is a marked dissonance between the clinic and wider society in terms of how food and bodies are conceptualised. Drawing on the discrepancies between medical and social worlds, many girls constitute their resistance to the clinic as necessary and justified. Social discourses continue to inform subjectivity despite girls’ clinical location, as the clinic is not a discrete entity; social discourses have a visible, physical presence in the clinic as they infiltrate the clinic by various avenues, such as through friends coming in after school. Girls’ engagement with these social discourses enables the production of subject positions other than medicalised identities.

The chapter is in six parts. Part One focuses on the contrast between healthism discourses and the foodism culture of contemporary Western societies. Part Two examines the presentation of food in clinical regimes and how girls engage with food in the clinic. Part Three examines how girls use food in other contexts outside the clinic. Part Four analyses the dissonance between medicine and wider society’s measures of physicality. Part Five explores girls’ constitutions of their bodies as unique, a strategy deployed to resist medicalisation. Finally, Part Six examines how girls negotiate the mind/body split that is instituted in treatment regimes.

6.2. Reading magazines: Healthy, wealthy and wise

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5 This chapter focuses on girls’ discussions of food in the hospital context. Therefore it does not include MFT as this takes place in the family home.
Social discourses are continually present in the clinic through the influence of friends and the magazines that friends bring with them and leave for girls to read. Some girls engage with these social discourses; specifically pictures of bodies and the practices of eating as contained in these magazines.

Healthism discourses (see Chapter Four) are becoming increasingly pervasive in wider society and are frequently promoted in women’s magazines. The dictum “a woman can never be too rich or too thin” is reflected in the pages of magazines like Vogue (Bordo, 2004). These magazines depict extremely thin bodies as desirable rather than pathological. In these forums extreme thinness appears as a legitimate and desirable aspect of the culture. As a consequence much research has construed a relationship between anorexia and media images of thin women (see 4.2.7). However, other studies that are based on research with girls diagnosed with anorexia suggest that although sufferers acknowledge that anorexia develops in contexts informed by the idealisation of the thin body, other factors also play a role in ‘having’ anorexia nervosa (Boughtwood, 2005; Probyn 1987, 2005). As Probyn (1987, p.207) writes: “in looking at instances of what seems to be simple positioning by discourse (such as anorexia, reading teen mags) we encounter complex webs of meaning.”

Several girls in this study emphasised the contradictory nature of social messages about appropriate bodies and noted that these contradictions are evident in magazines. One particular issue of Cosmopolitan offers “a curvy girls guide to sexy style” (W. Squire, 2005). This text is accompanied by an attractive, well dressed, larger woman. However this size acceptance message is counterbalanced by another suggestion:
“fake a perfect body!” Presented in large text on the front cover, it appears next to actress Cameron Diaz’s (perfect) leg. There are contradictions in these messages about bodies. The first feature promotes body satisfaction despite body size. The second clearly indicates there is only one ideal body shape that all women must strive to achieve, even if girls/women have to fake it.

Social messages about food are also contradictory. In Western countries there is plentiful supply of different foods that can be consumed any time and anywhere: in the home, restaurants, at work, whilst driving, on trains, at carnivals and with the advent of twenty-four hour serveries, in the small hours of the morning (Brumberg, 1988). Yet this ever increasing supply of different foods and their promotion in the media sits alongside healthism discourses. As Liddlelow (2002) writes:

Society condemns what it most encourages….the customer responding to two advertisements, for food or drink, and for body discipline, pays twice: first to ingest the coke or pizza or ice-cream, and then- should she be so lucky, to expel them (2002, p.47-49).

There is an excess of food in society, but as the thin body is continually promoted as obtainable, thus “hedonism and self-discipline must co-exist” (Brumberg, 1988, p.260). This ever elusive search for thinness is evident in Western society’s embrace of dieting (Brumberg 1988; Liddelow, 2002; Wooley & Wooley, 1982). Some writers have checked this enthusiastic embrace of diets, exposing the pitfalls and physical consequences of faddy diets (Knight, 2005; Wooley & Wooley, 1982) such as collapse of vital organs and electrolyte imbalance. Perhaps because of the expose of
the consequences of these diets some are now promoted as real meals. For instance *Weight Watchers* aims to attract clients by promoting their foods as *real* meals made up of low fat ingredients. *Weight Watchers* appears to work on the premise that it offers its clients real food, claiming that *Weight Watchers* food is enjoyable while still allowing people to lose weight.

Antonia takes up the discourse and rhetoric of restraint in the extract below. In her interview Antonia made a number of assertions in claiming she was not anorexic, including that she eats a variety of foods that “most anorexics would not touch.” Antonia reiterated several times that she ate meat, seafood, nuts and cheese, although she was disciplined around her consumption of these foods:

> *Antonia*

*I always planned on having the next meal, but it was-I’ll do extra exercise now; we were in Queensland, like on holiday, and you expect to gain weight in the holidays. Um, so it was always- just in case the next meal is really fatty, cheesy, I’ll scale back now, we know that lunch and breakfast don’t have to be particularly big, like you wouldn’t have a big lunch and then go have a lobster dinner.*

Antonia says she is aware she could gain weight on holidays and worries about the food she might eat. Antonia monitors her food intake by positioning food in binary categories: good foods are healthy, bad foods like cheese, are fatty, and fatty foods are only to be eaten in small portions or balanced qualities. Antonia thus constructs her disciplined eating not as anorexia; she instead deciphers herself as having agency and
as free to eat cheese and lobster, as long as she is disciplined at other times. Antonia constitutes herself as a disciplined subject who has the knowledge to institute measures to obtain the desired thin/healthy body.

Maria contended that a lot of people “don’t know how to eat.” Her use of “eat” is a synonym for her disciplined consumption of food. In making this statement, Maria constructs a binary between herself and other people- the implicit suggestion is that others (her family and friends) lack Maria’s discipline. Maria explained how she removed chocolate, fried food and burgers from her diet several years ago. Maria noted that these foods are readily available and that people often choose such foods for the sake of convenience without thinking about the consequences of eating such foods. What she had been doing for the last few years, Maria explained, was using her knowledge of good nutrition to operationalise “sensible, logical eating.” Lupton (1996) writes about how food consumption is frequently conceptualised in terms of good and bad foods, which “comprise an integral way of conceptualising different types of food…[and] by extension, transfer their meanings to the individuals who incorporate these substances” (Lupton, 1996, p.93). By choosing healthy (good) foods, Maria constructs herself as a virtuous, wise and healthy subject.

In the interviews, some girls pinpointed the contradictions in the media messages about food and bodies, and illuminated how people have to negotiate these contradictions on a daily basis. Aware of the contradictory nature of their social worlds, girls enter the clinic and are confronted by medical discourses of food and bodies which add another level of complexity to the confusion they have to navigate in attempting to become appropriately embodied.
6.3. Discourses of dinner: Meals inside the clinic

Magazines offer various tips as to how one can be restrained in a culture of abundance. These include drinking a glass of water half an hour before meals, putting a cigarette out in a half-eaten plate of food and half-filling one’s plate and making a deliberate attempt to eat less than their (male) partners (Cosmopolitan 2005; Probyn, 2000). Social discourses of eating are a sharp opposition to clinical requirements for the treatment of anorexia. As if in opposition to social discourses, the hospital requires girls to eat 5000 calories per day made up of a variety of foods. Several girls articulated the struggles they experienced at meal times because of the food, general climate around the table and the perpetuation of discourses of fat, food and weight through the meal conversation. In this extract Bettina discusses her aversion to butter and her struggle with eating butter in hospital. Bettina gave doctors a lengthy explanation as to why she does not eat butter, but to no avail:

_Bettina_

_It’s like I- I just do not like butter. I don’t know; I just haven’t ever really had it yeah. Dad eats it but none of us eat it. (D: Mm) And so they [the hospital kitchen] always put heaps and heaps on sandwiches and we just tried to scrape a bit off, it was just like a centimetre thick, it was so disgusting._

Biomedical discourses might read Bettina’s dislike of butter as fear of weight gain, as medical literature cautions clinicians to be wary of anorexics’ claims that they dislike
certain foods. Clinicians are likely to assume the refusal to eat is motivated by the
food’s fat content. Bettina anticipates and refutes these criticisms by asserting that her
aversion to butter is longstanding, preceding the eating problems and is part of family
identity, rather than related to her having anorexia. Bettina mobilises a discourse of
universal dislike of butter “none of us it eat it” and argues that the thickly spread
butter used on hospital toast and sandwiches is disgusting. Lupton (1996) illuminates
how Western societies have developed a cultural practice of categorising foods as
good, bad and disgusting and that people’s judgments are sometimes based on the
texture or residue of the food. Bettina positions hospital food as disgusting, a pointed
contrast to the healthy food she would eat at home.

Bettina claims to struggle at meals, particularly during her third admission to hospital,
although this admission was also described as a more positive experience. She found
the nurses were “nicer” than on previous admissions. Furthermore, she “just wanted to
get better” and made an effort to engage with the hospital programme. Bettina found
herself enjoying food again after depriving herself from eating for over three years.
Although she found some foods such as butter unpalatable, after starving herself for
such a long time she relished any food. However, Bettina felt she could not share her
enjoyment of food with the other patients:

Bettina

they ’d [other patients] be like, oh, I’m so sick of eating, I’d be- °I am too,° but
I enjoyed it. I was really full, there was just so much food and it wasn't much
time in between each meal. But I liked the taste and it was the only thing to do in there.

Bettina struggles with eating both psychologically and physiologically “feeling full.” She found that her struggles were compounded by the other patients’ claims of being sick of eating. Bettina felt she needed to verbally concur in order to ‘fit in’ with the other girls’ values by performing aversion for food “I am [sick of eating] too.”

Sophie’s deployment of the meal plan as a truth about how one should eat perhaps illuminates the rigidity the clinic enforces around eating. Sophie has been treated for anorexia for over four years. She has had admissions in both clinics but for a long period of time managed to remain as an outpatient. Since Sophie was discharged at 14 years old, she claims to have followed a strict meal plan that dieticians told her would ensure that her weight was maintained. Sophie claims that this plan was never reviewed until she came back into hospital at 17. In this extract, she elaborates on what it was like having this eating plan:

Sophie

So it’s basically that [meal plan] for four years, um, oh no for the last three years I think. Um [sighs] I didn’t get bored surprisingly. I didn’t care because foods not like exciting for me so it didn’t really matter what I was having. Um, um so I just stuck to that, um it wasn’t really an issue but, just in the last few months I think the portions have cut down, or my requirements have gotten a bit larger.
In her description Sophie takes up the meal plan as a regime of truth, whereby following the plan enables her to construe herself as a good person and patient. Sophie may have known the quantity of food was insufficient because she was growing older, but positions the plan as a benchmark for proper eating practices. Her phrasing emphasises that the weight loss was not deliberate or her fault, she did not intentionally cut the portions down, but thinks “the portions have cut down.” Sophie generates a story that “food isn’t exciting…so it didn’t matter what I was having” and she can thus perform an aversion to food that appears plausible in light of the popular belief that some anorexics are literally scared of or disinterested in food. Such a notion has gained notoriety through the televised story of Bronte Cullis; Australia’s most widely publicised anorexic. Bronte provides Australians with a reference point for anorexia, including the girls I interviewed, because she frequently appears on television and radio current affairs shows. Bronte had severe anorexia for many years, and recovered through treatment at the Montreux Clinic in Canada and her mother has since opened two outpatient clinics that are based on Montreux Principles in Australia (Percival, 2004). In one of the earliest \textit{Bronte} shows, Bronte is depicted as literally scared of food. Lying in bed at night she appears to be hallucinating, seeing food coming out from under her closed bedroom door.

Contrary to this image, most of those diagnosed with anorexia are not scared of food or, indeed, disinterested in food; it is that they have other reasons for abstaining. Probyn (2005) conducted focus groups with anorexics of a similar age to the girls I interviewed and discovered that their favourite television shows were cooking programmes. The fascination with cooking shows is perhaps because anorexics
constantly deny themselves food, although they enjoy eating (see 6.4). Despite some
girls having a desire for food, they have restricted their eating for long periods before
coming into hospital. In hospital, being forced to eat is confronting for girls:

Abby

I'm not used to [...] being forced like I am in here. It's weird 'cause when I went
out yesterday, it's like I still ate everything [...] but; it was weird 'cause I wasn't
being forced to do it, so I felt I didn't have to as well, so [...] <I don't know it’s a
bit> yeah, it's, like I'm glad they force me but, yeah, I'm not used to it and I
don't like it.

Abby says that she finds eating when she is not forced to outside of hospital “weird.”
Her word choice in describing the difference between being forced and not forced to
eat suggests that hospital routines have made normal eating unusual, atypical and
strange. In effect, medicalised eating has become Other to ‘normal,’ everyday eating
practices.

The procedures that are enacted around hospital meals assume anorexics will not eat
their meals, but try to dispose of food covertly. As Hepworth writes: “the nurses
become subject to this representation of anorexics by having to carry out practices to
prevent them from not keeping food down or as punishment for their deceit” (1999,
p.91). Antonia found meal times the hardest part of hospital life. In the interview she
reported how she was caught in a double-bind at hospital meals: if she talked she was
reprimanded for trying to distract the nurses, while silence was frowned upon as an
attempt to avoid the nurses’ scrutiny. Antonia claimed she was very upset by these accusations:

_Antonia_

*If you are talking [at meals] you are trying to distract them, you know. And some nurses are; like they're almost indifferent and they're human beings and I understand and it's their job, but, so you've got to, the nurse who [..] and when someone is like that with you, like; you get the feeling that they hate you.*

Antonia seems to antagonise nurses because of her non-compliance and what may be perceived as a rather superior manner. Antonia constructs nurses as drawing from a bevy of unspoken rules that dictate how the anorexic should behave whilst eating. Nurses punish girls if they do not comply; often by imposing greater surveillance such as checking under girls’ tongues for any food they might plan to dispose of later. Antonia’s description evidences the surveillance ever present at meals, which is an effect of clinicians’ construction of food as medicine, and relatedly the positioning of anorexics as deceptive and reluctant to take this medicine.

The interviews exposed the dissonance between medical and social notions of normal eating. The effect of this dissonance is, in Butler’s terms, how the “seeking to catalogue and institutionalise normality become a site for a contestation of the concept of the normal” (Butler, 1997b, p.59). Doctors have coded a model of the anorexic patient, namely, that anorexics only eat the minimum amount possible. Such a construction is both explicitly and implicitly visible in medical discourse and in the
practices of the clinic. However, Antonia contests what medicine positions as normal eating, explaining how she eats all that is required and more, including other patients’ desserts, which she prefers to the supplements that “make vomit rise in [her] throat.”

Antonia assumes that in eating the desserts she will receive a positive response from the doctors, because she sees these as more ‘normal’ food than the supplements, but finds the opposite. Antonia related how the doctors and nurses berate her for eating the desserts, telling her she’s behaving badly and that she should eat what is on her tray because this constitutes a “proper meal.” Instead of submitting to the clinics, Antonia questions these dominant discourses, suggesting they should be inclusive and flexible and attend to what is normal eating. This theme is apparent in the following extract:

Antonia

*Um, you know, and so you’re sitting there thinking, I really would’ve liked an M&M sundae from downstairs [the hospital cafe] but I can’t now because if I put anything else in my mouth, I’d be sick. I’ve got to have dinner and then like, you know, they [doctors] don’t accept that you had something before. Most other normal people, if they thought they would like something would be able to go and get it and you know that you can’t, because you’ve got to fit in dinner.*

The interviews revealed how hospital regimes work against bodily desires for food, because hospital food is unappetising, repetitious and bland. Several girls explained that they never had an appetite in hospital because food was such a focal point- and also as food was never positioned as having any other function except as increasing
one’s weight. It is perhaps not difficult to understand why girls lose their appetite
when repetitious hospital food and weight inform the majority of interactions in
hospital. The emphasis on eating 5000 calories of unappetising food and supplements
negates all other meanings of food. Other, more enjoyable aspects of food are ignored
in the hospital context. Food is undeniably embedded in cultural discourses but
doctors seem to ignore or suspend their beliefs about the meanings of food; in the
clinic food functions simply as medicine. As Hepworth writes:

The flavours of food and pleasures of eating are largely absent from medical
scientific, nutrition science and psychiatric discourses about anorexia nervosa.
Health care professionals’ discourses about food reproduces and maintains a
narrow focus on eating explained in relation to scientific indices of nutritional

6.4. Framing food: Eating in contexts other than the clinic

This section considers girls’ discursive constructions of food in other contexts besides
the clinic. In interviews, girls described family meals, going to out to eat with friends
and (after they had been discharged) I ran into some of the girls I interviewed in
restaurants and food halls in large shopping centres. It became evident that many girls
constructed food in multiple ways when eating in other contexts outside the clinic.

In interviews, some girls expressed likes and dislikes for certain food, couching their
behaviour in terms of what is ordinary eating for adolescent girls. For instance several
girls claimed they were vegetarian for several years before being diagnosed with anorexia. Such an account is plausible outside a biomedical construction of anorexia. A British survey found that women were 50 percent more likely than men to be vegetarian (as discussed in Lupton, 1996). However, in the clinic, doctors attributed girls’ claims of disliking meat to anorexia. Claudia articulated exasperation at the doctor’s refusal to accept that she hated the taste of red meat: “they always assume your thoughts have to do with eating disorder things.” Claudia suggested that doctors needed to stop thinking in this way, and return to what society promoted as normal, healthy eating—such as limiting one’s consumption of red meat.

Lupton (1996) in her study of the eating habits of Australian people noted how people categorised food into masculine and feminine foods: “vegetables denotes femininity, while femininity denotes a preference for vegetables…red meat [is] nominated as a masculine food” (Lupton, 1996, p.107). Traces of these categories of male and female foods were mobilised by the girls I interviewed. Sophie explained that her family would often order take-away and that she would not eat pizza as her father preferred, but liked the same foods as her mother and sister: “Chinese, Thai, Fish…whatever.” Sophie took up this discourse in another context—when I bumped into her at a sushi bar. Sophie and her mother were choosing pieces of sushi to take away. Sushi is perhaps another feminine food, because most sushi contains fish. Sophie, in her discussion of the hospital meal plan, positioned food as not “exciting to her” but perhaps her resistance to food is not food per se; it is to the medicalisation of her eating practices.
Antonia asserted throughout her interviews that she was not a “typical anorexic” because she ate a large variety of different foods. In making this claim, Antonia is drawing on the popular construction of anorexics as scared of food. Antonia went into elaborate detail about the last meal she had at a restaurant, how the octopus she ordered looked and tasted, stressing how much she liked going out for meals. Her elaborate descriptions invoked the rhetoric of a gourmet chef. Antonia also emphasised how important the conversation was to the whole dining experience and contrasted what she thought hospital meals would be like with dining out or eating at home. Antonia was concerned about the restrictions the clinic would place on her eating:

_Antonia_

_I'd come from a family where I'd always had control. Like it wasn't like my mum made my lunch in the morning (D: Mm) or always made dinner because, because I like a wider variety of foods than my Mum… Um, so I always had a lot of [...] freedom in that respect [in the foods and the times that she ate]._

Antonia suggests her family allowed her to be flexible in the foods she choose and the times that she ate. Antonia’s descriptions of “having control around food” function as a synonym for having control over her body and her life (Malson, 1998, p.123). Antonia thus establishes a binary between her family home and the clinic. In the former she is happy and in control. In the latter, she is controlled.
Girls’ awareness of the other meanings of food was apparent in an incident that took place at Easter time. Two days after Easter, four of the girls went to the large shopping centre near the clinic where they purchased a large quantity of cut price Easter eggs. Back in the clinic and un-wrapping their purchases to show the other girls, the nurses saw what was happening and confiscated the eggs. The clinicians were unsure of the girls’ intention in buying the eggs - they were particularly concerned that girls were going to binge on the eggs and vomit. Yet the girls may have had multiple intentions in buying the eggs, such as: a desire to take part in the festivities of Easter, as food plays a central role in celebrations (Probyn, 2000), as a gift to family members and, as Maria did, construct oneself as controlled and disciplined than other people (family) by resisting chocolate. The girls may have bought the eggs simply because they liked bargains. The multiplicity of possible readings of girls’ actions reveals how girls’ engagement with food is read differently by various players in the clinic.

It is evident that the diagnosis of anorexia or the investment in a public persona as anorexic (see 8.3.1) does not impact on the desire for and enjoyment of food. The enjoyment of food can be seen in what is termed the chew and spit eating disorder, currently classified under the broad category of Eating Disorder Otherwise Not Specified (EDONS). Chew and spit is characterised by chewing on foods but not ingesting, by spitting into a handbag, cup or another receptacle (D. Adams, 2000). Putting the pathology and dangerous physical consequences aside, the specific behaviours of chew and spit allow individuals to momentarily taste the food they desire.
I have suggested that food and eating are as enjoyable to those diagnosed as anorexic as for any other group of people. Girls used food to rupture discourses of anorexia, especially the popular representation of anorexics as food avoidant and to constitute themselves in particular ways, such as feminine subjects. As Probyn (2000, p.7) writes: “eating now constitutes a privileged optic through which to consider how identities and the relations between sex, power and gender are being renegotiated.”

6.5. Negotiating corporeality: Construing social and medical bodies

Wider society unequivocally celebrates thin bodies and equates thinness with health and the dominant discourse in contemporary media is that people can have any body they choose, as long as they are willing to invest time, effort and money to create this body. For instance Cleo (2005, p.32) offers readers an “instant and total body make-over…suck the cellulite right out of your thighs plan.” Like Cleo, other magazines, weight loss companies and cosmetic surgeons position bodies as capable of continual maintenance and transformation in the quest for thinness. In contrast, medicine continuously attempts to educate girls about what continual starvation does to the body, trying to make girls aware of the biological necessity of reversing the physical effects of starvation. Medicine uses technologies like bone scans and DXA (see Chapter Five) to assert the legitimacy of biomedical discourse, claiming bodies must have enough fat to be deemed healthy.

The physicality of the body is important in both social and medical discourse, but each deploys different criteria in gauging the physicality of the body. Medicine uses
numbers to measure weight, body mass and fat and society focuses on outward appearance. The curious doubleness of the clinic in that social discourses readily interweave with medical notions, means that girls are simultaneously located in contradictory discourses in the clinic. Carrie’s comment illuminated the dissonance between medicine and wider society’s measures of bodies:

Carrie

People are going to say you’re thin, but no one will care or notice if you’ve put on half a kilo.

Thus, in the clinic both the visual and numerical come into play in terms of girls assessments of their own and others’ physicality, although biomedical discourses remain dominant in accessing and treating anorexia nervosa.

In the following extract, Jessica refutes medical measures of bodies, claiming that it is unnatural for anyone, irrespective of their size, to try to put on weight.

Jessica: Umm, well, do you want to put on weight?

Desiree: No, but I’m not as thin as you are

Jessica: I mean, it’s got nothing to do with being thin, or how much you or I weigh. I feel; do you know how much you have to eat to put on weight?
Jessica acknowledges that she is thin but does not want to put on weight. In what seemed to be an attempt to normalise her behaviour she draws me into the dialogue, asking whether I want to put on weight. Jessica rejects my comment about our situations differing in that I am not as thin as her, asserting it is unnatural for any person to try to put on weight. In making this claim, Jessica legitimates her reasons for not following the clinic’s programme. Jessica constructs herself not as an anorexic requiring treatment, but as a feminine subject who takes up social discourses about thinness as appropriate and desirable, thus constituting herself as an a-genetic subject in these discourses of weight and femininity.

Doctors claim that malnourishment affects the brain (Strober, 1997) and once girls are re-fed they will be able to conceptualise their bodies correctly. In the interview, Abby reconstructs the message doctors gave her:

*Abby*

*And like, even though it's only the 3 kilos, it feels like such a great deal of my body, like it distributed fat everywhere, but [. ] I don't know. They also tell you that before ° your eyes don’t work properly, so-° and we can’t see reality really.*

Abby deploys biomedical discourses for purposes unintended by the clinic; namely to maintain a subjectivity as a thin person, despite putting on weight. Abby takes up a strand of biomedical discourse, medico-cognitive theory (medicine institutes re-feeding and cognitive scientists say cognition is a brain activity) “your eyes don’t
work properly.” In invoking this construction of anorexics as cognitively impaired and not able to “see properly” because they are malnourished, Abby can maintain her image as a thin person despite feeling fat. In medico-cognitive discourse a weight gain of three kilos would not “distribute fat everywhere.”

In the extract below, Jamie is pondering the long-term consequences of anorexia that the doctors have discussed with her. Jamie articulates her concern that she will not be able to fall pregnant. The possibility of infertility is a pressing concern for Jamie because she would eventually like to have a child:

**Jamie**

*It might be a minor breach at 17 or 18 again [...] probably about 19 I’ll have my period and then it doesn’t reach that again like I might not get it back. That’s not good because I won’t be able to have a baby or anything, things like that are a worry, I’ll be stuffed up.*

The majority of discourses about anorexia explicitly construct it as a female condition and there are a number of biologically based discourses on anorexia that pertain to females. For instance, anorexic women will not be able to conceive, and may give birth to premature and underweight babies (Beumont & Touyz, 2003). In discussions of fertility and anorexia there is again the clash between social and medical discourses of appropriate female bodies. Anorexics, specifically those of child bearing age and in the throes of recovery, “encounter the contradiction between the productive body and the reproductive body which requires a level of fat to remain fertile” (K. McDonald,
1999, p.166-167). Girls have to negotiate an appropriate female body: one capable of bearing children or a thin body, as venerated by healthism discourses and the media, which girls perhaps strove to achieve in initially losing weight. The dissonance between the clinical and social discourses creates an ambivalent, uncertain space where what is reasonable, possible and desirable embodiment remains obscure.

Elise experienced the discrepancy between her own and medical notions of appropriate physicality in an embodied way when the doctor told her mother that she had gained enough weight to be discharged from the clinic. Her mother interpreted the doctor’s words to mean that Elise was well, but Elise used a more complex criterion in judging her embodiment:

*Elise*

*Once I got out of hospital, she [mother] thought everything was back to normal and that I wasn’t purging and what not. And then I got depression. ‘Cause I hated the way I looked. Like, it [anorexia] might be the numbers [on the scale] but doesn’t the look also depend on the numbers as well?*

Elise and others articulate a discourse of physicality as the definitive bodily marker of anorexia. Warin (2004) illuminates as to how this emphasis on physicality is problematic, because anorexics possess many different bodies at different times during the illness trajectory: onset, post hospitalisation and recovery. Yet these different stages are invisible in both bio-medical and social discourses of anorexia, which reveal that the discourses of anorexia do not match with girls’ subjective
experience of ‘having anorexia’ and being hospitalised. As Elise’s words reveal, in addition to the discrepancies girls have to negotiate in shaping their bodies, some girls become very distressed in being plagued by anorexic thoughts in inhabiting a larger body. Perhaps because medical measures of physicality are the dominant discourse in the clinic girls begin only to think of themselves in terms of numbers because they need to obtain a weight that medicine deems healthy in order to be discharged. Girls often struggle in re-entering their social worlds where they are again solely accessed on their appearance. Elise is unable to engage with medical criteria for appropriate bodies, maintaining that there is an irreconcilable binary between medical and social criteria that shapes girls ambivalent construction of themselves and their feelings of embodiment. Elise is told that she is a “healthy weight, normal,” yet Elise “hates” her body.

Elise made a number of references throughout her interview about what she considered to be a perfect body. Elise’s ideal accorded with societal standards, as she describes Nicole Kidman and Madonna as having perfect bodies. Elise bemoaned that she could not emulate her idols even with continual dieting and exercise because she is Chinese. Her ethnicity plays into her ambivalence about her body. Elise describes the limited possibilities of body modification in the extract below:

Elise

*I want a like; bigger chest and all that stuff, don't even mind if I have to have periods, well, I don't really want to, but I want thinner limbs and; my stomach doesn't really matter that much 'cause I know I can't change it. I've had an*
operation there and so there's a line and two flab's; like a bit of flab hanging
loose and when I was really thin, I hadn't had that flab and it was nice, but I
can't change it. Like, I've always had that bit of flab there.

Elise’s description resonates with Grosz’s (1994) argument that embodiment, class,
sex and ethnicity constrain subjectivity. Sex and ethnicity both shape Elise’s body and
she has to negotiate norms for Chinese women in trying to create a different body by
diet and exercise. Elise is aware that to have larger breasts means she would have to
possess a reasonable degree of body fat and get periods. In Elise’s construction, one
positive attribute comes at the cost of another. Although Elise can create her body by
dieting and exercise, her body is constrained by the corporeal effects of her operation
and especially by biology and ethnicity. Elise is aware of her limited choice-
starvation provides a means of obtaining a thin body, but this is not a Western
woman’s body. Chinese women do not normally have big breasts. For Elise, anorexia
is, perhaps, partly a struggle over whether to inhabit an unsatisfactory woman’s body
or a childlike body.

In wider society girls and women are encouraged to pay attention to their outward
appearance, particularly body size. In contrast, in the hospital the visual is eclipsed by
the numerical. However, this discussion has suggested that both the visual and the
numerical are important in the clinic in assessing the physicality of anorexia nervosa.
Girls engage more with the visual than the numerical, because the visual is the more
important consideration in the creation of a socially appropriate body. Yet some girls
move between medical and social criterion in gauging their physicality; such as Abby
who deployed medical discourse to maintain a subject position as a thin person. Others take up biomedical discourse because this is the dominant culture of the clinic. These girls begin to think of themselves in terms of numbers while in the clinic and some struggle to reconcile their own and others visual assessments of their bodies upon discharge.

6.6. A body like no other: Individual bodies in the clinic.

In the interviews some girls constructed their bodily functions as specific to them as an individual. Such a construction provides girls with a justification for claiming that medical interventions that worked for other anorexic patients did not work on their bodies. For example, in explaining to the doctors why she had not gained weight, Maria claimed that food went right through her for the first three days in hospital. Grosz’s (1994) claim that there is no body, only bodies, is important in analysing how girls produce their bodies as different from other anorexic patients. Grosz (1994) argues that bodies are individual in that they are distinct from other bodies and shaped and marked by a variety of different forces, such as sex, ethnicity and historical context. Grosz’s (1994) contention is useful in analysing the counter discourses mobilised by girls to resist biomedical constructions of anorexia, ‘normal’ bodies and ‘healthy’ body functions.

On two occasions the doctors told Rita that her potassium levels were so low that she should be dead. I asked how she felt about being given this information:

Rita
You don’t feel much different when it’s that low (D: Mm) like they say you could go into cardiac arrest or whatever, but it doesn’t feel like that, you just feel normal.

Rita rejects biomedical measures of healthy bodies as she defines her body as “normal,” rather than physically compromised. Rita’s construction of her body thus exceeds the medical discourse that attempts to contain it. In contrast to Rita, Jamie seems invested in being anorexic:

*Jamie*

*I've never had a skinny build like anorexic girls. I've never lost the weight in my arms but people look at my arms and say look, you've got fat on your arms, like; but my stomach was always very, very abnormally thin, so people lose it in different parts of their body.*

In this extract Jamie positions herself as anorexic by pointing out parts of her body that are thin, yet these are not areas where people usually lose weight. Normally weight loss takes place first in the peripheral areas, like face, arms and legs and then later in the central part of the body, including the stomach. In 1837, the time of the pioneering work of Gull and Lasegue, medical texts contained pictures of anorexic patients, to illustrate how the weight loss progressed (Brumberg, 1988) a practice that has continued into the present day. In describing her anorexic body, Jamie produces an alternative construction to medical norms; that there is no natural bodily progression for losing weight. The use of medical photographs is perhaps the only
instance in which medical texts deploy visual criteria in measuring anorexia. Jamie explicitly refutes these norms of weight loss to inscribe herself as anorexic, questioning medical discourses as the truth of anorexia.

These girls recognise and resist medicine’s interpretation of their (anorexic) bodies. Some girls, like Jamie construct a careful argument that includes and widens clinical discourse, claiming that although backed by medical authority, anorexia is not a fixed category but is shifting and contested and can be taken up for different agendas.

6.7. The power of the mind versus the body

Anorexia has long been conceptualised as a separation of mind and body (Ball, Butow & Place, 1997; Shelley 1997; Shute 1992). In conceptualising anorexia in this way, these writers intuitively or explicitly draw upon a discourse of Cartesian dualism in which the body and mind are separated (see section on Grosz, 1994 in Chapter Four). A mind/body dualism also seems to be the philosophical predicate for the medical model. In treating anorexia, clinicians emphasise the importance of refeeding before attending to the psychological causes and manifestations of anorexia (see Chapter Five). Some girls invoked a mind/body dualism in negotiating treatment, perhaps as a response to clinical regimes.
Angela had numerous admissions to both the adolescent clinic and the adult psychiatric ward where patients are admitted even if they are adolescents but seen as requiring more rigorous care. A few of the clinicians suggested I should interview Angela as she had a “very good knowledge of hospital,” because of her numerous admissions. These doctors recounted to me how they once had to sedate Angela and stitch the nasogastric tube into her nose, a desperate measure but one they deemed necessary to prevent her from dying. In the extract below Angela describes the re-feeding process, with which she is very familiar:

*Angela*

> Because the actual treatment makes you feel big and *fat* and just, 'cause you're full all the time and you're sort of bloated and uncomfortable and-, but now, I've just written a list with all these positive things and I just sort of read over that every time, and then I know like °its hard, but° I want to do it, so.

In this extract Angela constructs herself as a good patient because she complies with treatment. Lupton (2003, p.134) illuminates the discourses surrounding the binary of good/bad patient; that: “good patients do not bring the disease or illness upon themselves, are not responsible for its control, respond quickly to treatment and are compliant… conversely, ‘bad’ or ‘difficult’ patients are held responsible for their disease… are querulous and non-compliant.” Angela outwardly performs as a good patient, showing compliance with ward routines. The re-feeding process evokes painful bodily sensations of being big, fat and full, but she attempts to counter her anxiety about weight gain by making a list of things she will be able to do once re-fed.
and healthy. Angela can perform compliance with treatment through asserting the importance of the mind over the body; however, she is not persuaded of the viability of this manoeuvre as her distress at gaining weight was evident in many of my interactions with her. For instance, during my first interview with Angela, about half way through our conversation a few of the clinical staff interrupted us, wanting to re-weigh Angela. After being weighed she passed me in the corridor on her way back to her cubicle. Incoherent with tears, she told me she was too upset about how fat she was to continue talking at this time. I assumed that doctors had been sceptical about whether Angela’s weight gain was real, and either the re-weighing confirmed that it was, making her feel fat, or the weight gain was found to be artificial and Angela’s supplements would be increased, causing her to fear becoming ‘fat.’ Angela employed a mind/body split in an attempt to comply with treatment. Yet her distress revealed that focusing solely on the mind does not create an identity that is comfortable in the newly fattened body.

Jessica also employed a mind/body split in negotiating the discourses of the clinic. When Jessica was first admitted to hospital she had an extremely low heart rate. Jessica was placed in the cardiology ward and was to be moved to Clinic B once she stabilised medically. Once Jessica was left alone in the cardiology ward she absconded. Doctors sent a letter to her home, informing her they were seeking guardianship (see 5.1 for a discussion of guardianship) and a hearing was scheduled. In response to this letter, Jessica returned to the clinic and agreed to be admitted. Nevertheless, she refused to comply with the programme. Her non-compliance meant she left the ward when she chose, did not eat hospital food and had her mother bring in a bag of gourmet lettuce leaves. Jessica also refused to be weighed. Because of her
non-compliance the guardianship remained scheduled. The hearing was to take place
two days after her interview. In the following extract, Jessica describes what she
believed would happen if the doctors got guardianship. She expected that doctors
would immediately start feeding her through the nasogastric tube:

Jessica:  if you can’t manage to drink that shit three times a day they shove a
tube up your nose, through your nose into your stomach and then you're fed
through the tube, it’s really quite terrible.

Desiree:  Yeah. So you're mainly worried the physical treatment, or?

Jessica:  Well, what other treatment is there?

Desiree:  Possibly psychological treatment?

Jessica:  Yeah, but I mean they can't, even if they get a guardianship order,
what are they going to do? Stand around and psycho analyse you against your
will...It's only physical things that they can only do to me really.

Jessica’s rejection of the clinic as able to control her evidences how subjects are not
always subjugated in the same ways, despite subjection to the same discourses. The
clinic employs a mind/body split in treating anorexia, yet Jessica does not take these
governing practices of the clinic in “mechanical or fully predicable ways” (Butler,
1997b, p.19). Jessica takes up this mind/body split to maintain an anorexic
subjectivity that is separate to the clinic and outside the realm of medicine, by
asserting that her mind is still anorexic despite the size of her body.
These girls suggest that medicine’s neutral and impartial approach to treatment is disconnected with the subjective experience of anorexia. Rather, several girls claimed that their anorexic thinking (thoughts of food and weight) persisted despite what the practices of the clinics and doctors forced upon their bodies. Angela saw this split as distressing, whereas Jessica deployed a mind/body split as a strategy for resisting medicalisation. The dissonance in these accounts revealed one commonality; that girls’ constructions of anorexia work in opposition to clinical regimes.

6.8. Leaving food

In the clinic girls attempt to negotiate the dissonance in social and biomedical discourses and technologies of gauging of appropriate bodies. Before coming into hospital, girls may have been envied by their peers for their ability to lose weight, perhaps up until they began to look emaciated. On admission to the clinic girls receive a different message, namely- eat high calorie foods in large portions to gain a kilo per week. Weight loss is a positive attribute in one context but a negative one in another. Girls are aware of the stark contrast between these regimes, which they take up and resist in different ways.

Medicine and wider society deploy different criteria in measuring physicality. In the clinic, society’s emphasis on the appearance of bodies was somewhat superseded by biomedical measures. Girls have to negotiate these conflicting measures, both in the clinic and upon returning home. Because doctors see the body principally through numbers, girls may begin to talk of their body in these terms whilst in hospital. On
discharge they are then confronted with others visual assessments. Jamie refuted medical norms about the physicality of anorexia as applicable to her body.
Constituting one’s body as unique was a position taken up to retain anorexic subjectivity, despite not embodying medical norms for anorexia such as thin arms.

In the clinic meals are fraught with tension. Meals are strictly timetabled, beginning at a specific time and lasting for a certain period. The aim of the treatment seems to be to instil a constructed notion of ‘normal’ eating, but these practices are not normal, healthy eating by societal standards. Girls have to eat even when they are not hungry, which is perhaps the opposite of what might be considered healthy and normal. Furthermore, many of these practices are not likely to be able to be maintained in everyday life where work, school and other activities are negotiated around meal times.

Food is presented in a very reductionist way in the hospital. In the clinic girls are deprived of all the conditions that make people hungry: the smell of good food, its attractive presentation, good company and physical activity that builds up an appetite. For those girls who actually want to eat again, clinical regimes can work to perpetuate girls’ resistance to food. The double irony of the hospital’s refeeding regimes is that they erode the possibility of exactly what the treatment hopes to achieve: ‘normal’ eating.

It is possible to read some of the girls’ resistance to eating as other than a ruse. Hospital food is generally thought of as so unappealing that many patients, not just
those diagnosed as anorexic, refuse to eat it and ask visitors to bring them food. The discussion of girls’ use of food outside the clinical context revealed that girls are aware of the enjoyment and social aspects of food and try to partake in these foodism activities, despite being in the clinic at the time of certain celebrations and feeling uncomfortable about eating particular foods.

Clinical regimes for the treatment of anorexia nervosa invoke the Cartesian duality of a mind/body split and the intent of treatment is re-feeding girls to rationality. However Jessica’s resistance to treatment is possible precisely because of the way these regimes are structured. Jessica’s resistance revealed that clinical regimes do not work as intended, as all subjects do not take up the discursive practices of the clinic in the same way.

In these clinics, there is the possibility of being discharged quickly by performing compliance. Hospital may be only a short-term disruption to girls’ lives if they engage in appropriate performances. Yet some of the strategies utilised in performing for doctors; vomiting, exercise, water loading, hiding weights about their person, drinking salt water and putting food in pockets and plants are anti-social and dangerous to girls’ physical health.

It can be presupposed that one of the reasons for the low rate of success of inpatient programmes is that hospitalisation works against social discourses of restraint around food and thin as beautiful messages. Some clinicians have recognised that girls are social beings and have made some attempts to incorporate this into treatment
practices, such as reducing the length of stay in hospital (Castro et al., 2003). The measures instituted by Castro et al. (2003) and others are to encourage girls to ‘get back to normal’ in terms of their emotional and social life. Normality however would be difficult to achieve in the clinic, as it is an environment that eschews any notions of normality in regard to food and bodies. This analysis has illuminated that social and medical discourses of food and embodiment are in stark opposition to each other.

The focus of Chapter Seven is how girls negotiate their positioning as anorexic patients in the clinic. The specific focus of the analysis is how the disciplinary regimes work to constitute girls as obedient patients, and how girls take up and reconfigure these positionings to produce themselves differently.

Chapter Seven

‘Autonomy’

7.1. Introduction

Autonomy is a problematic and complex concept in the clinic. Medical discourse takes girls malnourished state to mean that girls are irrational (see 4.2.1). The focus of clinical regimes is weight restoration, because the clinic works on the premise that it is implementing the means for girls to be autonomous, holding that once girls are renourished they will be able to think clearly and take responsibility for their recovery.
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There are problems in such models of treatment and the medical discourses that inform this construction because it reduces anorexia to a physical problem. Many of the girls suggested that clinical regimes actually erase any autonomy because the rigid structures and governing practices of the clinic work to control girls in time and space; a construction exemplified in the comparison between patients and prisoners, as articulated by one of the girls (see 8.4.1).

The analysis in this chapter centres on constructions of the patient. In popular discourse the patient is generally constructed as obedient and compliant with the doctors’ orders (Lupton, 2003). For instance, the *Macquarie Dictionary* (Blair & Bernard, 1998, p.768) offers several definitions of patient. Two of these definitions are; “someone who is under medical or surgical treatment; someone or something that undergoes action (as opposed to *agent*).” Both descriptions construct the individual as subjugated by medicine and medical practitioners. In my analysis of the interview transcripts, many girls construed the notion of patient differently and as not only obedient. The subject/patient that emerges from this analysis is more slippery and ambivalent.

The specific argument of this chapter is that a different kind of autonomy emerges in girls’ responses to and constructions of being positioned as patients in the clinic. The analysis draws upon Butler’s (1997b) theorisation of agency: “the subject emerges both as the *effect* of a prior power and as the *condition of possibility* for a radically conditioned form of agency” (1997b, p.14). Medical discourses create particular ways
of being, known as subjectification in Butler’s (1997b) terms, and subjects take up these forms of power in different ways and to different effects in constructing their subjectivities.

The chapter is in three parts. Part One focuses on girls’ discursive constructions of clinical regimes. Part Two examines girls’ constructions of relationships between clinicians and patients, which are mediated by discourses of anorexia and patienthood. For instance, anorexic patients are often marked as dishonest in medical discourses and girls are constrained by these discourses but take them up in creative ways in producing other subjectivities. Part Three explores relations between anorexics. Rather than simply competing over weight, some girls discursively constituted themselves and others through discourses of normality, anorexia, competition and femininity. Girls trouble the traditional meanings of medical discourse and patienthood, searching out other possibilities and new ways of being.

7.2. Constructions of the clinic

7.2.1. Affixing anorexia

A medical diagnosis of anorexia nervosa has particular effects on the subjects this label is inscribed upon. As Eckermann (2003) writes:

Medical and psychiatric discourses act as definers of truth around the self-starving body. The almost universal use of the DSM Manual as an
administrative process attests to this…a person needs to fulfil the criteria set out in the DSM (Eckermann, 2003, p.11).

Medical constructions of anorexia, which position anorexics as possessing certain attributes, behaviours and familial backgrounds, are imposed onto girls simply by diagnosis. When Samantha was first diagnosed with anorexia she queried whether she fitted the criteria described by the doctors:

*Samantha:* They [doctors’] said the girls like to exercise a lot and they take laxatives and I wasn't sure what they were.

*Desiree:* Oh okay. What laxatives were?

*Samantha:* Yeah.

Foucault (1973) illuminates how medicine allocates individuals a place within an established category of disease and his analysis resonances with Samantha’s account. Samantha suggests that doctors drew from a body of knowledge about anorexia that they measured her against, namely that an anorexic “exercises a lot and takes laxatives.” Yet Samantha claims she did not know what laxatives were prior to her diagnosis. While the diagnosis may have enabled doctors to classify Samantha, it also provided Samantha with further knowledge about specific anorexic behaviours and opened up the possibility that she could take these up to become a better anorexic. The diagnosis brings Samantha into a different being and thus she is positioned and constituted in a new way that she has to negotiate in the clinic and in the wider social world.
In the clinic, girls deployed various strategies to question anorexia as a category of person that is imposed by medical discourse. Jessica’s general practitioner referred her to Clinic B because her periods had stopped. Jessica saw the cessation of menstruation as the sole reason for the referral. In the interview, she expressed disbelief at being diagnosed anorexic at her first consultation. To explain why she is ambivalent about anorexia, Jessica evokes what is recognisable as the DSM:

Jessica

Well, I'm under 17.5% body fat, which I, a low BMI which is tick number one, I don't want to put on weight which is tick number two. Um, I have amenorrhoea as a result of being underweight which is tick number three, umm, and then, and the fourth one is that I don’t want to put on weight. So I mean obviously, it is a hard thing to answer, do I have anorexia nervosa, the physical symptoms I can’t deny ... I don't think that I have the, these, ah the psychological trademarks of the condition.

Jessica’s use of “tick number one” works to mock the criteria contained in the DSM. Jessica takes up a quasi-medical interpretation of anorexia as defined by a suite of rigid criteria. In Foucault’s words, this criteria “establishes the individual in his irreducible quality…it becomes possible to organise a rational language around it” (Foucault, 1973, p.6). Jessica deploys the DSM as the authoritative measure of anorexia, but troubles the way in which it is applied to individuals by splitting anorexia into psychological and physical components. Jessica mobilises a
construction of anorexia as inseparable from the psychological components and rejects the “psychological trademarks” as having any association with her. Jessica has knowledge of medical constructions of anorexia and its diagnostic criteria and she troubles particular aspects of these, thereby providing a counter discourse to the powerful scripts that aim to capture and control girls’ subjectivities and identities.

7.2.2. Contesting the clinic

Medical constructions of the anorexic subject are evident in the organisation of the clinic. Foucault’s (1977, p.124) explanation of surveillance, whereby “life is partitioned… according to a strict timetable, under constant supervision” seems central to the experience of inpatient treatment for anorexia nervosa. Surveillance is ever-apparent and ever-present, even to the extent of the signage. *No beverage carts through these doors* is emblazoned in bold lettering on the front door of the clinic. This sign indicates the nature of the illness being treated within; namely that the illness is related to food and that patients cannot use food properly and responsibly so are not permitted to purchase it.

The constant surveillance in the clinic is intended to signal that girls are physically and mentally unwell and in need of constant monitoring. For example, the only privacy that patients have is the curtains that separate the cubicles. There is a litany of spoken and unspoken rules about the use of these curtains, including that they are drawn back at 6am when the girls’ are woken and only closed at bedtime, around 10pm. The logic for surveillance is suspicion about girls’ behaviour and doubts about
the girls’ honesty, and this extends to many other aspects of how girls are constituted in the clinic:

_Amanda_

_Nurses still accuse you of trying to vomit, or exercise in the bathroom and, some girls do that but it's really annoying when you're not doing it [.] And then, and you think oh well, maybe I should be, heh heh._

In Amanda’s account surveillance is construed as ever present. Amanda is aware that anorexics are positioned as deceptive, but still finds the accusations that she vomits difficult to deal with. Amanda suggests that because nurses believe she vomits despite her assertions to the contrary, then perhaps she should vomit and lose weight. If she is labelled as always deceitful, she might as well take up the benefits of being positioned in this way. Amanda’s account exposes one of the problems inherent in medical discourse, namely that how one will (or can) behave as an anorexic patient is informed by explanations _prior_ to the event of coming into the clinic. Therefore, the positions girls can legitimately occupy are delimited by constructions of anorexic patients that are always/already present in medical discourse.

The clinicians hold girls to account if they have lost weight, often by an investigative discussion about what might have caused the weight loss. In the clinic, there are consequences for girls if they lose weight, including an increase in meal requirements and being denied leave from hospital. Some girls had lengthy discussions with doctors
almost every time the weighing sessions take place, which is three times a week. Elise found the continual focus on her weight disabling:

Elise

Like, if everyone didn't like to weigh me so much, you know...I’d probably just slowly go back to the weight; but because of Dr W; I'm like, god, I have to get weighed again, um, I have to try and lose or have to try and gain. It's like my weight is a really big issue to others, when I'm trying to say, make everything [weight] not an issue anymore.

In the clinic a series of technologies associated with weighing operate as an ever-present means of surveillance: “I’m like, god, I have to get weighed again, um, I have to try and lose or I have to try and gain.” Elise becomes an unwilling subject of rigid medical regimes that regularly monitor her weight. She suggests that if “everyone didn’t like to weigh me so much, I’d probably just slowly go back to the [normal] weight.” Elise seems to suggest that if she could exercise agency this would be through not feeling she has to achieve a certain weight, as she is tired of having to continually gain weight in the clinic and, feeling uncomfortable about the weight gain, lose this weight once she goes home.

The structure of treatment regimes leads girls to assume that clinicians’ uppermost concern is girls’ physical condition. Although Jessica agreed that she was malnourished, she disputed the diagnosis of anorexia, and initially resisted being admitted to the clinic. As discussed in Chapter Six, the doctors issued a guardianship order to keep Jessica in hospital. A week before the guardianship hearing was to take
place Jessica came to the clinic and volunteered to be admitted, because she believed this would position her as compliant in the eyes of the guardianship board. Nevertheless, she refused to follow the clinics programme and her refusal was detrimental to her plan to be seen as an obedient patient and meant that doctors could provide further evidence to the guardianship board about Jessica’s non-compliance. One concession Jessica made on the day she re-admitted herself was to participate in some medical tests, the results of which she dug out of her bag with elation in the interview.

Jessica

Um, mm, yeah, I am in the top percentile for um, bone density, in every part of my body, so that’s great.

Jessica suggests that medicine’s primary concern is the physical effects of anorexia. By submitting to self-selected tests, she invokes the medical technologies (bone scan) to refute medicine’s construction of her as anorexic. By defining herself in relation to medical discourse, she reduces the doctors’ scope for arguing that she is physically unhealthy.

7.2.3. Doing docility

Medicine’s focus on weight constructs an anorexic identity for many girls. The organisation of space, time and surveillance mark girls as anorexic and can be overwhelming to girls to the extent they lose any sense of themselves as a person.
Renee was diagnosed with anorexia at 14 and found the admission to hospital confronting:

\[\text{Renee}\]

\[\text{The hospital stay was a lonely experience and you know, there was sort of nothing to occupy your mind except for the anorexia [... (D: Mm) and that made that even worse I think, because there was nothing else to concentrate on.}\]

Renee constructs being in the clinic as helping to make the anorexia more deeply ingrained within her mind. Renee suggests her identity as anorexic intensified whilst in the clinic because “there was nothing to occupy your mind except for anorexia.” Renee does not choose anorexia as an identity, except perhaps for her weight loss before admission. However, the clinic confers a medicalised identity that Renee suggests is the only option whilst in the clinic. Foucault (1977) wrote about how subjects become subjugated by the practices of institutional settings and Renee seems to take up a passive subjection: “nothing to occupy your mind except for the anorexia.”

Some girls chose or performed docility to survive and have a short stay in the clinic, as Megan did. In the extract below Megan summarises her experience of treatment:

\[\text{Megan}\]
He said it was anorexia (D: Mm) and then he said that I would have to go to hospital and then I was on bed rest for like 5 weeks [...] I don't know- I was still losing weight on bed rest and so he- um, put the tube down and then I was still losing weight, but I eventually put it on.

Throughout her interview Megan positioned herself as not engaging in any explicit resistance to the construction and practices of the clinic. Rather, Megan positions herself as an object of the clinical sciences “a describable, analysable object” (Foucault, 1977, p.190) that can be classified and treated accordingly by the clinic.

It is possible to read some girls as taking up a subjectivity of docility as described by Foucault (1977). Foucault (1977) argues that the disciplinary practices of institutions produced docile subjects. Samantha seems to embody docility, because she describes the clinic as “friendly and easy.” The extract below suggests what Samantha found “easy” about the clinic was that all patients receive the same treatment, whereas at home her brothers are treated differently to Samantha because they are considered to be better behaved than she. Although Samantha is subject to control both within the clinic and at home clinical controls are positioned more favourably than parental coercion. Samantha sees the position of ‘sick girl’ as signified by medical technologies as a more positive positioning than being called a disobedient child as she does not eat. In the discursive space of the clinic she is constituted as unwell and this is a much easier position to occupy than that of a disobedient child. In the clinic her non-eating and behaviour is seen as an illness; she is not simply positioned as a disruptive influence within the family.
Desiree: How did you find hospital?

Samantha: I thought it was easier than being at home [...] cause everything was set there. There wasn’t as much pressure as home.

The initial evaluation is an important part of a clinical assessment. Clinical literature places much emphasis on this initial consultation, suggesting that it provides an opportunity for patients to explain what they think is wrong with them (Enelow & Swishler, 1986, p.5). Jo describes her individual evaluation:

Jo

He asked me questions [in the eating disorder assessment] you know, and I got the shits big time ‘cause it was like the same stuff I had been asked before so I got really angry and yeah.

Jo had many consultations at different hospitals before coming into the clinic and was always asked the same questions. Unlike Enelow and Swishler’s (1986) contention that the patient can explain what is wrong with them in this first consultation, Jo suggests the evaluation had the effect of immediately categorising her as anorexic. Jo however resists this label, using anger to disrupt and fracture the construction of herself as always/already anorexic, a label bestowed on her by the questions of the admitting doctor.
Some girls employed various strategies to resist gaining weight in the clinic. Carrie described water loading (drinking litres of water to increase one’s numerical weight) as an unstated but well-established practice of anorexic patients. In Carrie’s account water loading operates as a band-aid; a temporary and problematic ‘solution’ to being forced to gain weight. Carrie suggests that eventually one’s water loading will be discovered as some doctors are versed in ascertaining whether weight gain is real and might perform additional checks on other body parts like bones, another measure of physicality. Girls have to decide whether they want to relinquish the anorexic body for a time and gain weight to get out of hospital, or prolong their stay in the clinic by water loading.

Carrie suggests it is easier to gain the required weight quickly to get out of hospital rather than trying to fool doctors with artificial weight gain. Carrie described eating large amounts of chocolate so as to put on weight fast, although the anticipated weight gain from the chocolate upset her so much she cried herself to sleep. Carrie overzealously takes up the regulatory regimes of the clinic, eating high calorie foods over a short space of time to put on weight. Carrie found out later that her over-compliance meant that she risked doing further damage to her body by gaining weight too fast, which is termed re-feeding syndrome in medical literature (Mehler & Crews, 2001) and has dangerous consequences, like electrolyte imbalance.

Carrie’s subjection to clinical regimes unwittingly exposed one of the issues around weight gain. As length of admission and privileges allowed during one’s stay are largely based on weight gain and because girls are not given a target weight which
they have to reach (see 5.1 for a discussion of the rationale why); reaching one’s target weight is an open ended and elusive goal. Therefore, the production of a good patient involves gaining weight, but there are no limits around how much weight one should gain.

Carrie takes up the construction of a good patient that is articulated in the clinic. However, her actions may also be read as a performance for doctors, doing what is required to get well but with the purpose of getting out of the clinic, which is in contrast to the doctors’ intent of facilitating recovery. Carrie’s actions resonate with Butler’s discussion of performativity: “the imposture of the performative is thus central to its “legitimate” working: every credible production must be produced according to the norms of legitimacy” (Butler, 1997a, p.151). In other words, the audience must believe the performance is genuine. Carrie must produce a credible performance of wanting to recover for the doctors, which is why she only cries at night; she cannot let the doctors see her unhappiness about gaining weight.

In drawing on Foucault’s concept of the docile body and the subject of docility (1977) to inform this analysis, it seems that there are important ways in which this analysis differs from Foucault’s. Girls’ immersion in and knowledge of treatment regimes provided the space for some girls to take up the clinical controls in multiple ways. These girls took up medical technologies in different ways and for different effects, such as a performance for another agenda, unintended by the clinic.
7.3. Doctor/patient relationships

7.3.1. Domination and difference

Silence is often a theme in descriptions of doctor-patient interactions (Johnstone, 1993). Silence extends across all aspects of the clinical encounter, initial consultation, diagnosis and stay in hospital. The patient’s voice is never heard- they become an (ill) object. As Frank (1999) writes:

The more critical my diagnosis became, the more reluctant physicians were to talk to me. I had trouble getting them to make eye contact; most only came to see my disease. This ‘it’ within the body was their field of investigation; ‘I’ seemed to exist beyond the horizon of their interest” (1999, p.222).

As Frank (1999) suggests, patients’ voices are not often legitimated in the clinical encounter. Frank (1999) speaks from his position as a white, male academic, whereas youth, especially girls, are likely to be further silenced in the clinic. Yet this analysis reveals that girls’ encounters with doctors do not only render them submissive, rather girls continually position and re-position themselves within the discourses within which they are constituted.

Doctors occupy the authoritative position in the medical encounter; they make the decisions about admission, treatment and discharge and are treated with respect by nurses and patients. This positioning of doctors as the authority was evident in
Renee’s account. Renee had been simultaneously starving, bingeing and vomiting during the four year gap between being hospitalised and seeking treatment for anorexia. As she explains in the extract below, there had been no changes to her behaviour over this period but consulting the doctor “made it more officially a problem.” Dr F. categorises Renee as anorexic and she is given instructions: “you have to do something about it.”

Renee

I saw it as more officially a problem once it was recognised by Dr F - you know, like medically. He told me you have to do something about it [.] because before that it just seemed like oh, if I just ignore it, it’ll go away. But until then until he actually said you know, you do have a problem, there’s something you have to do, it sort of made it - made it more concrete and that it was a big problem.

Renee had read a lot about anorexia. Her research included medical, psychological and feminist texts. Yet, as evident in the extract, Renee positions medicine as the authoritative discourse. Renee has an understanding of the different discourses and she is aware of the discursive weight of the words of an authority figure that pronounces the ‘truth’ of the dominant discourses. Renee’s reflective awareness is visible in the extract; it is through awareness of the ways that power works that Renee can perform as an appropriate subject in the medical encounter and constitute herself differently in other contexts.
Elise also invests medicine with authority over anorexia. In this extract she summarises her ten-week admission. Elise put on one kilo a week, as required by doctors, which meant she went from 30 to 40 kilos. Yet she has also “figured out” that this weight gain could continue indefinitely:

Elise:  Figuring that out, I went oh my god well, that's actually more like 10 weeks I did it. I said okay, if I can put on 10 kilos in 10 weeks, what can happen in another 10 weeks? (D: Mm) Like, I'd be like 50 kilos.

Desiree: Did you talk to the doctors about that?

Elise:  He's promised me that he wasn't going to allow me to become obese.

Elise construes the doctors as knowing the truth of the body. Elise’s concern that she will get fat is visible in the extract, but Elise’s words suggest that this concern is not called into question in her consultation with the doctor; there was no questioning of the terms she was using to speak about her body. Elise claims the doctor is certain she will not gain weight: “he promised me that he wasn’t going to allow me” as if it is a real possibility, however the doctor’s words appear to eliminate her anxiety.

Girls’ resistance to being positioned as patients sometimes involves troubling treatment regimes. Madeline describes some of the strategies used to sabotage treatment and terms them “mischief.” These activities often take place in the dark of night. Girls collect syringes from different places around the clinic to suck the overnight feeds out of the nasogastric tube, run up and down the stairs and exercise in their cubicles, keeping an eye on the nurses’ comings and goings so they do not get
caught. Madeline explains that these behaviours can be learnt by talking to other patients and reading the journals of former patients that are left in the clinic. In the extract below Madeline illuminates why the mischief occurs:

_Madeline_

Yeah. It comes and goes. It sort of depends on how the, if the doctors have, [...] you know, been mean and put people on nine ensures or whatever [laughter] then more mischief tends to go on than when it's, everyone's sort of on low ensures or [...] "low food." 

Madeline argues that more “mischief” occurs when doctors have been callous, meaning that doctors have increased food and _Ensure_ requirements. Madeline re-codes herself and others not as uncooperative patients but as rebels, resisting the unreasonable impositions of unjust superiors. In making this point, Madeline gives a self-censored version of events in the clinic. Butler points out that censorship works through “the insistence that certain kinds of historical events only be narrated one way” (Butler, 1997a, p.132). Madeline’s censorship of the happenings in the clinic takes the form of insisting that doctors are mean, rather than concerned about girls’ health. Constructing doctors as mean provides the logic for and validation of Madeline’s resistance to treatment. If doctors’ motivation is malicious then girls cannot be expected to be compliant patients.

Claudia illuminates how the doctor/patient hierarchy works and provides several different examples of this in her interview. Because patients often have a long wait until the doctors present them with test results, Claudia secretly acquires the results by
using the staff computer when it is unattended. Claudia suggests that because of her position as patient, the only way she can “get what she wants” is to be covert in getting information. Claudia’s account reveals that although doctor patient hierarchies restrict patients in both physical and psychic ways, this hierarchy does not merely repress all girls. From her position as patient Claudia can obtain the information she requires and assert an appropriate subjectivity in the interview by claiming she is worried about her health.

These accounts do not reveal obedience as in most other accounts of doctor-patient relations but some different forms of resistance to doctors’ power. Resistance is not overt; it sometimes appears as compliance. However, compliance does not always signal passivity; an awareness of how to perform appropriately as a patient can be an act of agency, as one has the knowledge to behave as an appropriate patient in encounters with the doctor.

7.3.2. Struggles over honesty

Anorexics are constructed as dishonest in medical discourses about issues such as weight and eating (Garner & Garfinkel, 1997; see 5.1.2). In the clinic, girls are weighed three times a week. The weighing ritual is thus: in the early morning, girls are woken up and told to use the toilet and dress in hospital gowns without underwear, in order to make it difficult for girls to strap weights to any part of their bodies. Girls
who are under suspicion for artificially inflating their weight are required to urinate in bedpans, from which a sample is taken to test their urine concentration to ascertain whether they have waterloaded. Many girls were aware they were positioned as deceptive, because they had been accused of and engaged in hiding food, vomiting and exercise. Being and being positioned as honest was important in taking up a subjectivity as Other to anorexia. Some girls employed a binary between their own and others behaviours to claim that they were honest, and therefore not anorexic.

Maria

\[ \textit{a lot of the girls refused to drink their Ensures from the beginning and a lot of them weren’t eating, whereas I was showing them I was eating and I was showing them I was drinking and stuff, so I was being honest with them from the beginning.} \]

Maria construes herself as having always been honest with doctors “from the beginning.” However the phrase “showing them” insinuates a performance; perhaps she was not actually eating, but “showing” the doctors that she was. In performing as an honest subject, Maria seeks what Butler (1997b) terms recognition: “the sign of its own existence outside itself, in a discourse that is at once dominant and indifferent” (Butler, 1997b, p.20). Maria does what Butler theorises; Maria’s desire to exist as honest involves locating herself as “different,” as Other to the deceptive anorexic that lies to the doctors.
Antonia describes the other patients as “fully fledged anorexics” and is distressed at being diagnosed and assigned a public persona as anorexic. Antonia suggests that doctors are aware anorexics are intrinsically dishonest and relies on doctors knowledge of this construction of anorexics in claiming that doctors will realise she is not anorexic (and cannot be) because she is honest and compliant:

\[Antonia\]

I managed to get through the past week because I knew I was doing the right thing [eating, not exercising or vomiting]. It was (sob) enough belief in myself and I thought (sob) yeah well by next week I'll; I'm doing the right thing and I know by next week that they'll know it.

Despite Antonia’s best efforts, her identity as Other to the anorexic girls in the clinic is dependent on doctors’ recognition of Antonia as honest. Antonia realises she is emaciated but claims her honesty should assure doctors she is not anorexic or provide a release from her construction and designation as anorexic.

I pondered the issue of honesty in reflecting on some girls’ presentations in the interviews. During the doctors’ meetings I heard accounts of girls’ behaviour that differed from the narratives girls presented during the interviews. For instance, Maria’s claim that she was always honest with doctors was revealed as a \textit{performance} as evidenced in her second interview where she speaks about ‘using other ways to get back at them. In reflecting on Maria’s presentation of herself in her first interview it may mean that if she can speak herself into a more powerful position in the interview then this could have consequences for how she feels about herself and handled interactions.
with doctors. Lather and Smithies, (1997) in their study with women living with HIV/AIDS, suggested that the narratives offered by their participants were not necessarily factual truths but may have been a mechanism for coping with what confronts them on a daily basis. In relating Lather and Smithies (1997) reflections to my own work, I suggest that Maria and other girls were not intentionally trying to mislead me, but making use of the discursive space of the interview to speak themselves into more agentic positions.

Discourses of honesty were mobilised by girls for purposes other than negotiating with doctors. Elise asserts that she is honest because she always tells the nurses the truth, in particular by informing the nurses when she purges. Yet this identity as a truthful, virtuous subject is constantly in conflict with the inner obligation to purge.

*Elise:* I told them, I’m so honest that I told them I really want to stop but then I feel like it’s a duty that I have to purge [...] it’s ah, an obligation.

*Desiree:* And so the nurses and all that know you purged?

*Elise:* I tell them. So even, they don't even have to try and find out if I do it [vomiting] or not, I just tell them.

In what is positioned as an attempt to stop vomiting, Elise works at creating herself as an honest subject; perhaps because it is more appropriate to be seen as honest rather than telling the nurses she is unable to stop vomiting. Elise actively seeks the clinic’s control as a resource to control herself, deploying these controls to fit her desire to be a controlled subject. Elise’s agency arises from her subjectification; she assumes the
power exerted by the clinic to construct a subjectivity based on a moral position, in
that she is obligated to be honest with herself and her superiors.

In the clinic doctors have sovereign power because they have a monopoly on medical
knowledge and their title and position in the clinic affirms their status as experts- as
experts they have the authority to position the girls as anorexic and thus dishonest.
Being positioned as anorexic and also subordinate to doctors immediately erodes
girls’ status as honest subjects, but girls refuse their construction as always/already
dishonest and offer different readings of their subjectivity.

7.3.3. Psychologised subjects

In the clinics, the doctors assert that re-feeding the patient is the first step to recovery,
but also suggest that psychological therapies have an important place in the treatment
of anorexia. Psychological discourses organise anorexia into particular categories (see
4.2.2). Some clinical staff as Madeline suggested, constructed girls as in possession
of a submissive personality, suggesting that they were “people pleasers.”

Within a psychological culture of therapy and self-help, the subject who is committed
to therapy has to do work on the self in order to change (Featherstone, 1991). In the
treatment of anorexia, anorexia is positioned as masking the true self that can only be
uncovered by particular rituals that are offered by the therapist (Hayes, 2000). The
rational subject that is committed to change through therapy does what therapist
suggests, including re-storying their experience (Hayes, 2000). In the extract below Madeline explains how she initially felt hospitalisation was unnecessary at her current weight. Madeline discussed this conception of anorexia and treatment with her therapist. The therapist suggested Madeline’s theory was inappropriate and Madeline articulates an alternative story drawing on what she has taken from the consultation:

Madeline

I just didn't want help. I just didn't think there was a reason for me to be here because I hadn't gotten to 38 kilos (D: Mm) and I just thought that unless you got to a critical weight, it meant that you weren't sick. I sort of felt like I hadn't had a chance to get to that point and that I needed to get to that point to get better. But now [post therapy] I realise that [...] it would've just been harder to get better, if they'd let me get that far.

In taking up the therapist’s construction, Madeline construes her claim of 38 kilos as the ultimate signifier of chronic anorexia as irrational thinking and reworks her initial construct of herself so that she is an appropriate ‘sick’ subject. In therapeutic discourse, in order to ‘recover’ a person must first be positioned as legitimately sick. In the case of anorexia, the person must be either emaciated enough to be labelled anorexic or be in possession of some other signifier of anorexia, like irrational thinking.

Foucault (1973, p.108) suggested that: “[t]he clinical gaze has the paradoxical ability to hear a language as soon as it perceives a spectacle (italics in original). In the
clinic, what is manifested is what is originally spoken.” Foucault’s argument is relevant to Antonia’s account of her initial consultation with a psychiatrist. Families are always implicated in psychological constructions of anorexia, as evidenced in Antonia’s account below. As Antonia and her mother found out about the hospital through an Internet search, Antonia saw herself as choosing to go to the clinic and thus wanted freedom in decisions about her treatment, including not having to see a certain psychiatrist. In her first session with this psychiatrist Antonia claimed the psychiatrist contended her family had co-dependency issues because their names all started with the letter A:

Antonia: He reads into that, that shows like co-dependency issues and it’s- so and so

Desiree: And he said all this to you?

Antonia: Um, I'm very good at reading upside down (heh heh). And... sort of things I realised, like when he would make links like that meant this and its like no; if you listened to the rest of that sentence and what I was saying there, instead of just the first bit of that sentence, you would know that isn’t right.

In her interview, Antonia said she was angry about what she perceived as the doctor’s refusal to listen to the whole conversation. She suggests he noted parts of the conversation that he deemed relevant and made his judgements from these snippets. Antonia suggests the doctor assigned her an arbitrary label and excluded any information that might belie this diagnosis. In this account, Antonia positions herself as having agency, not by questioning the diagnosis itself, but according to how the
psychiatrist interacted with her in relation to medical discourse. Medicine operates with fixed categories of illness into which individuals are fitted, a practice that removes any responsibility or necessity for reading and understanding the individual through language other than what clinical discourse has produced as self-evident (also see Foucault, 1973). Antonia resists being categorised by the doctor, a resistance that is enacted in the interview by her reflection on his problematic attempts to position her.

Girls incorporate psychological discourses into their subjectivities in different ways as explicated in the two extracts reproduced here. For Madeline, psychology allows her to be sick, but Antonia rejects this particular psychological construction as having any power to position her, particularly because of the problematic way in which this discourse came into being when applied to her.

7.3.4. Child versus adult

The interviews revealed that some girls who had prior admissions to Clinic A felt they were treated differently in Clinic B because they were “older patients.” Sophie raised this issue in the interview, and was adamant that this was appropriate practice for both clinics. It annoyed her when some members of the team in Clinic B were not forthcoming with information about her treatment, because she believed it was her right to be informed because she was older. If she disagreed with a decision about treatment, Sophie always tried to negotiate with doctors.
Desiree: Is there room for negotiation or?

Sophie: Um, sometimes. Oh, well they always say that after the team decision’s been made there’s no going back but, I’ve disproved them about three times, heh, heh.

Desiree: Have you told them that or?

Sophie: Oh, well no like the time just last Wednesday we’re putting the tube in. No, last Monday they said, “We’re putting the tube in,” and I said, “No”. So I didn’t get the tube so and it was fair because I did well without the tube in the end, so. I think I think it’s fair that there’s a bit of room for negotiation ‘cause we’re not two, so. We’re like 16 sort of thing, heh.

In both clinics decisions are made by the treating team and then relayed back to girls. In explaining treatment decisions to patients and their parents, staff emphasise that the entire team was involved in the decision making process, so as to avoid girls demonising or attempting to influence one of the clinicians (see 5.1). While decisions are presented as absolute, Sophie tells a different story. To legitimate her questioning of treatment decisions, Sophie mobilises a discourse of adolescence. Discourses of adolescence emphasise that parents should give their children some autonomy which means freedom and responsibility to self govern and make their own decisions. Sophie takes up this discourse, holding that it is appropriate for her to take responsibility for treatment decisions.

In negotiating with doctors, girls also mobilised discourses of rationality and maturity. In the extract below Maria construes herself as a mature adult. In this construction
adulthood is taken to mean rationality. However, as revealed in the extract, Maria’s rationality was not visible to the doctors, or else the doctors choose to ignore how Maria constituted herself.

Maria

What really annoyed me the most was a lot of the girls who actually go to them [doctors] are in tears <and> they [girls] get their way. And a lot of them get their parents, and I dealt with it [having the nasogastric tube] in my own way and maturely and as an adult I went to them [doctors] and talked to them and spoke with them and nothing happened.

Maria claims she tried to have a mature discussion with the doctors about treatment instead of performing like an irrational child by enlisting the help of her parents when unhappy with treatment decisions. Speaking to the doctors from a position of adult is a strategy she deploys in the hope that doctors will negotiate with her. Her attempt at rationality failed however, because “nothing happened.” Because Maria did not perceive the doctors as treating her as a rational adult person it legitimated her agenetic take up of an alternative position, as apparent in the following extract.

Maria

I felt like I had to act like a kid to really get my own way [about treatment] um, and so I thought I may as well act like a kid and I ended up losing weight and getting a tube, heh heh. I didn’t lose weight but I hadn’t put on enough [weight] and they wanted me to put on more [.]. I used other ways of trying to get back at
them [...] instead of keeping to the way I was acting in the beginning and making sure about it, (heh heh) not very adult.

Maria takes up the position as child, a strategic move when she cannot get her way as an adult. Maria defines acting like a kid not as behaving immaturity as other patients do by crying and calling their parents. Instead, it seems to mean losing weight, or not putting it on. Maria does not want to put on weight, and is determined to achieve this whether it means acting like a child and losing weight through devious means, or as an adult and negotiating with doctors so as not to have a tube. Maria moves between constructing herself as a child and an adult according to what she recognises as possibilities for agency in either one of these positions. There is a contradiction that Maria does not acknowledge however, that the consequences in terms of treatment remain the same irrespective of the position she takes up.

The issue of responsibility is central to the workings of the clinic. Clinicians claim that they want girls to act responsibly by gaining weight. Yet the stringent nature of the clinical regimes means that taking responsibility for the self is almost impossible. The curious doubleness of the clinic is that the structure of clinical practices erase the opportunity for girls to take up these humanist constructions of responsibility that appear in the doctors’ discourses and are what clinic sets out to achieve. In positioning girls as rational beings, the clinic constructs girls as free to make choices and be autonomous as long as they gain the required weight. Yet the clinic removes any possibility for the girls to be ‘free’ in a humanist discourse. It is only possible to see agency and autonomy when reading the clinic in a poststructuralist frame.
As discussed above, traditional doctor patient relationships are one sided (Frank, 1999) meaning that it is presumed that patients unquestioningly accept the diagnosis and obey doctors’ instructions about treatment. However the nature of the illness does dictate the extent to which patients feel they can be active and negotiate with doctors in the medical encounter (Lupton, 2003). For example, Frank (1999) gives an account of his experiences as a patient with leukaemia. He writes about the silencing of the person as the illness becomes the patient’s identity in the hospital. Yet Frank (1999) is accepting of this positioning because he wants to be cured. Anorexia is different in that many patients do not see themselves as sick and in need of medical intervention. Many girls refused the position as patient in their interview conversations with me, but explained that they perform obedience and compliance so to be positioned as a good patient, so to have a shorter stay in the clinic.

Some girls construed themselves as continually at war with doctors, articulating these relationships through warlike metaphors. For instance, Renee suggests that the doctor-patient relationship is based around an ‘us versus them’ mentality. Despite her own contribution to this dynamic, Renee construes herself as surprised at the extent of the bitching about doctors, as she describes below:

_Renee_
There's a lot of- you know bitching from the girls that goes on about the; you know, staff and that sort of thing, um- [...] There is an ‘us versus them’ mentality though, like they want me to put on such and such by Wednesday and um I can’t believe, and you know. Yeah it's hard to explain but, there is a real I'll do it [gain weight] just to make them happy so that I can get home. Ah, rather than they think that it's best that I put on this amount of weight, and they know what they're doing because they're medical professionals, so I guess it is best for me.

This extract again signals Renee’s reflective awareness of hospital practices and the positions that doctors and patients occupy. Renee is aware of the controlling practices within the clinic and knows that girls perform simply to have a short stay in the clinic: “I’ll do it [gain weight] to make them happy so I can go home.” Renee seems to be suggesting this is not a useful strategy (despite employing it herself) because it serves only to deceive doctors and the self by creating an illusion that one is well and “over anorexia.”

In the clinic, girls actively perform so-called feminine behaviour, perhaps because they desire to be located by staff and their friends that visit them in the clinic as ‘normal’ adolescent girls rather than as anorexic patients. In social forums certain practices of male and female behaviour are normalised, become acceptable and are taken for granted (Davies, 1999). Girls code themselves as feminine subjects by using a multiplicity of strategies. In taking up the common notion that females enjoy pretty, dainty objects, girls colonise the hospital space through an implicit range of gendered behaviours such as furnishing their cubicles with posters, photos, candles and flowers. In entering the girls’ cubicles, doctors move into the girls’ domain rather than the
stark hospital space that is their familiar environment and the medical domain, and
doctors have to negotiate this new setting. When these signifiers of girls’ personhood
are visible, it can be harder for doctors to treat the girls just as an illness and perhaps
doctors’ sovereignty diminishes in these spaces of the clinic that are colonised by the
girls. The display of gendered identities can also be read a strategy for controlling a
particular territory. The feminising of these cubicles works as a mechanism for girls to
assert their power, as well as a persona and public identity that they are more than
anorexic patients.

Several girls made use of the limited resources available to them in negotiating with
doctors. Some of these are cleverly disguised under the rubric of female behaviour. At
one stage during the research process there were a number of patients who resisted
taking their medication. These girls complained that the medication made them tired.
At one of the clinical meetings it was discussed whether patients were deliberately
applying make up in such a way to make them look tired so that doctors would reduce
the medication dose. Because of the age difference between doctors and patients,
doctors were unsure whether it was currently fashionable to wear thick make up under
the eyes, as these girls were doing. In one reading this scenario resonates with one of
Davies’s (1999) explanations of agency; that subjects can see how they are subjected
in different discourses and use the meanings of one discourse to go beyond the other.
Girls consciously deploy one discourse (femininity) to go beyond another
(patienthood), exercising agency through the conflation of the discourses. As make up
is a feminine practice and it is deemed normal that adolescent girls wear make-up,
doctors could not simply berate girls for being non compliant. Girls’ complaints are
thus legitimated and girls obtain the right to speak and be heard about how medication affects their sleep.

Some girls deployed broader cultural practices by mobilising discourses of gender in negotiating with doctors. Traditional gender roles were played out; where males are positioned as the powerful figures and women are weak and obedient, using their femininity and physical fragility as a tool in negotiating with men. In the clinic male and female are sometimes pitted against each other, with men holding the power. The hierarchy in the clinic (see 7.3.1) is also reflected in the gender hierarchy, which girls and doctors have an awareness of.

In discussing their treatment, some girls flirted with doctors, laughing and tossing their hair about. Their flirting was not because they were attracted to the doctors but was for another purpose. Several girls also cried and refused to speak to the doctors. Crying and silent treatment are categorised as ‘normal’ female behaviour. Some girls suggested that being able to voice their opinions about treatment was more important than the strategy itself. Girls “didn’t care” if certain behaviours meant that doctors positioned them in a bad light, such as overly emotional. A few of the girls claimed they were aware of the effect that “crying like an idiot” had on one particular doctor and were prepared to cry if it meant a reduction in Ensure. Even if clinicians do not reverse a decision immediately they might explain why it was made, and explanations provide girls with an opportunity for further negotiation.
The clinic is a fluid context and the players within are continually taking up different positions and repositioning others. Relations between doctors and patients are continually shifting, which is a very different dynamic than suggested in some of the feminist arguments where the female patients are only subjugated under the medical gaze (Frank, 1999; Segal, 2003).

Knowledge of individual clinicians, including their ethnicity or age, provided girls with tools that were deployed to rupture doctors’ authoritative position. Sometimes girls seemed to mobilise strategies deliberately designed to confuse the doctor, such as the make-up incident. At other times the operation of parallel cultures (medical and
social practices of adolescence) worked to confuse the doctor. One example involved readings of a t-shirt from a popular adolescent clothing shop. The shirt was emblazoned: “The army needs men and so do I.” I overheard a discussion between several members of the clinical team about what the slogan might mean and the appropriateness of such a shirt. Yet it did not seem to occur to the clinicians that this shirt was being worn by many adolescent girls across Australia and New Zealand.

Some girls used a number of different strategies to go beyond their subjection as patients, such as deploying the difference between their own and the doctors’ cultures as a form of resistance. The operation of different cultures in the clinic means that particular incidents lend themselves to be read in multiple ways.

**7.3.6. Clinician as Other**

In society people frequently form themselves into collectives and exclude other people and groups from joining on the basis of various attributes. Through these practices, excluded groups are constructed as the Other “which is always lacking, lesser in some respect” (MacLure, 2003, p.10). Because the Other is often constituted through negative attributes, it is perhaps surprising that a doctor should be located as Other, especially by a female adolescent patient. In our most familiar discourses doctors are often constructed as next to God.
Girls are aware that there are certain practices that the doctors have to follow in compliance with medical ethics and other legalities. Some girls used their understanding of the medical system to question the doctor about their practice. I overheard one of the girls who was 15 years of age and about to turn 16 speaking to the doctor. “I’m 16 soon, and patient confidentiality means you can’t talk to my parents about my treatment, or anything like that anymore, doesn’t it?”

Girls used a number of different linguistic devices in constituting doctors as Other. At one point in Jessica’s interview she paused, and looked at me directly. “Will this information go to a Mr Gareth Parkes?” “No not with your name on it,” I assured her. Jessica was referring to one of the principal doctors in this question and in one reading, her use of Mr instead of Dr worked as a deliberate linguistic device intended to undermine the doctor’s status and credibility as a health professional.

Sophie’s competence in discourses of anorexia provided her with a means of constructing one particular doctor as Other. Her negative comment about a doctor’s age and experience is informed by a litany of medical consultations, a history that Sophie draws upon so that she does not simply appear as rude:

*Sophie*

he said he had a lot experience with eating disorders even though he looked about 10, heh, heh, no about 20 or something, like straight out of College sort
of thing. So I was, I was really sceptical about like how much experience [in treating anorexia] he’d had.

Throughout the course of Sophie’s anorexia she saw a number of different specialists. These included psychologists, doctors, counsellors and dieticians and Sophie found few of them to be helpful. Sophie suggests that a doctor’s experience is essential in treating anorexia and that those who helped her somewhat had this experience. Sophie’s claim is represented in a different guise in medical texts, which emphasise the importance of medical students learning by experience (Foucault 1973; Lupton, 2003). Sophie’s is the authoritative voice in this discourse, despite her position as patient. By evaluating the health workers on their practice she presents as being of a similar status to them, subverting the traditional doctor/patient binaries that usually configure such relationships.

The nurses have a stronger presence in the daily running of the ward than doctors. In these clinics the senior nurses were actively involved in making decisions about patients’ treatment plans. Despite the importance of the nurses’ role, some of the girls did not treat nurses with the same respect they accorded to doctors. For example, one girl refused to come back from her leave when a ward nurse rang her up, but when the doctor called the patient immediately returned accompanied by her parents and all of them were full of apologies for the doctor. While girls may present a veneer of compliance to doctors, nurses are treated differently:

Desiree: All- the nurses, do you think they don't have enough understanding of what it is?
Claudia: No, I don’t [...] They know what it is, but they don’t know all the truth, what people get up to, so; they don’t ever get educated about that.

Claudia suggests that nurses have a limited understanding of anorexia and are unaware of the devices that girls use in the clinic. Nurses may learn about the physical consequences of being underweight but they are “unaware of what people get up to.” Claudia appears paternalistic in her description of nurses; implicitly positioning nurses as lesser than doctors. In her construction, nurses cannot think beyond what they have been “educated” about.

Locating nurses as inferior legitimated girls’ disobedience to nurses’ instructions, such as Antonia eating off others’ trays (as discussed in 6.3). Positioning doctors as equal and nurses as inferior to the self provides these girls with room to take up positions in which they are not dominated by the doctor; which are the predominate accounts of patienthood in feminist and autobiographical accounts of anorexia.

7.4. Relations between patients

Relationships between patients with anorexia nervosa in the hospital context are generally positioned negatively and doctors and sufferers share the same anxieties (Segal, 2003; Way 1993; see 5.1.1), namely that the entirety of the interaction between patients is competition over weight- as to who weighs the least. This discussion illustrates that competition is a constant theme in the clinic, but that
competition is much more nuanced than suggested in the existing literature. Competition is part of the ways in which subjects become acceptable in Western society, by being better at certain things than other people. Although competition is discussed as a separate theme here, notions of competition were apparent throughout many of the girls’ discussions and are evident in the analysis. Engagement with other patients produces a multitude of different subject positions through which girls constitute themselves and others.

7.4.1. Fragmented friendships

Other patients influence girls’ subjectivity. Although many girls situate their story of anorexia as distinct from others, they also suggest it is helpful to associate with others who have anorexia to share their distress about the experiences of anorexia and hospitalisation. Some girls suggested that their friendships with others develop independent of the fact that they have both been diagnosed with anorexia. Sophie claimed to have made good friends with many of the other patients, for different reasons:

Sophie

a lot of the girls here I’ve become really close to because we’re so similar and we know what we’re talking about. Like we can understand each other, which is good. But, my friends at school, um they don’t know so- yeah.
Sophie suggests her school friends lack understanding of anorexia. Their lack of understanding may be partly because of how anorexia is presented in the classroom. Evans et al. (2002) are scathing about the depiction of eating disorders in school curricular: “the cultural over-evaluation of thinness…remains an enduring theme, especially in the popular media and among policy makers and teachers in the school” (Evans et al., 2002, p.199). The inconsistency and marked discrepancies between the syllabus and Sophie’s experiences of anorexia means her school friends may have little understanding of eating disorders or how Sophie conceptualises anorexia.

For Jamie, being with the other girls was a very different experience to Sophie’s:

Jamie

Last admission I didn’t like any of the girls. The second admission I was like best friends with one of the girls, we had a good friendship going and that's when I was being naughty and hiding things [food] as well and that was encouraged by the girls [,] (D: Mm) and I was doing wrong, and I should've been. They exchanged ideas and I picked up more things in here [,] than like in my last couple of admissions.

The survival of the fittest is an enduring discourse in contexts like boarding schools and prisons and is also pervasive in the hospital. In her third admission Jamie was constantly teased by the other patients, who played pranks on her, including taking her phone calls and telling her friend who had rung the ward “horrible things about her.” In this extract she relates how the other patients had taken dead flowers, ripped
off the petals and thrown the petals onto her bed along with salt and pepper. The mess was not discovered until midnight, when the nurses made Jamie pick up the flower petals:

_Jamie_

_The girls had left the room, like they wouldn't pick up anything, they walked out and I had to pick it [the petals and spices] up about 12 o'clock at night. The nurses didn't- I ran downstairs crying and um, I was down there for a while and the nurse decided to check if I was OK. I wouldn't go upstairs and they had to get someone to come down with a wheelchair and put me in the wheelchair and wheeled me up. Um [they] put me in the single room 'cause at that stage, I wasn't going to talk until my dad came in and talked to me and [.] then helped me explain._

To see Jamie’s agency requires more than reading her words in a rational frame. Many different accounts of this incident circulated within the clinic. The interview provided the discursive space for Jamie’s account of this incident. By producing a tale in which she is the injured party, Jamie construes herself as blameless, finding agency in this positioning.
There is a gang mentality in the clinic in that girls can hurt each other, but will band together against outsiders, including doctors (also see Segal, 2003). Samantha described the other patients, specifically one other girl “as very different to her.” Samantha suggests that the difference between her and the others is that they continually tried to deceive the doctors, whereas she did not. Yet Samantha is reluctant to exclude herself from an anorexic identity entirely. Butler (1997b) offers a theory that accounts for the ways in which belonging to a category guarantees a subject’s existence, although there is ambivalence about this subjection to this category. Samantha performs the ambivalence that Butler (1997b) describes. Samantha explains she could not “betray her friends.” This betrayal would position Samantha as different and therefore not (properly) anorexic. If Samantha told the doctors about the other girls’ behaviour this would put her identity as an anorexic patient in jeopardy.

This discussion has illustrated how many of the familiar scripts about young women’s interactions are played out in the clinic, including friendship, jealousy and locating oneself as part of a collective group who undergo similar experiences (Jackson, 2003). These different elements informed the experience of being hospitalised for anorexia.

7.4.2. Running the clinic: Competition and conscience

Discourses of competition circulate in the clinical context. Some girls suggested there was intense competition over food consumption, weight and the size of bodily parts. Other girls were not aware of these dynamics, and implied that competition was not a
factor in their relationships with other girls. Girls did not construe their relationships with other patients as one-dimensional, but as complex and mediated by a number of different factors. For example, Elise desires thinness but wants to be fair to others:

*Elise*

*I think it's unfair for those who are bigger than me, because; [...] I shouldn't do that [...] and I shouldn't compare myself to others as well; but that's just me and I compare myself to everyone. I count how many things they eat...I encourage them to eat more, heh, heh, and I think that's really wrong.*

Elise encourages both nurses and other patients to eat more. Sometimes she manages to do so, but her conscience intrudes “I shouldn’t do that...I think that’s really wrong.” Butler (1997b, p.5) argues that conscience works by “the psychic operation of regulatory norms.” Butler’s (1997b) theory has some parallels with Elise’s constitution, because Elise struggles with reconciling different norms that have become part of her psyche. She does not want to be fat but she is also located in a culture where concern for others is well regarded and struggles in trying to negotiate these two aims in the clinic, because encouraging others to eat (and get fat) does not constitute caring for people. Elise takes the only way out “that’s just me” construing herself as a failed subject, yet she is simultaneously successful as a competitive subject because she has the willpower to be the thinnest.

*Angela* has been labelled by doctors as an extremely chronic patient, and is ambivalent about this positioning. Angela’s account concords with Butler’s (1997b) notion of passionate attachment; that the subject has a sense of being coerced by
invisible and external forces into becoming subject to a power that the subject is ambivalent about. Angela both desires and hates anorexia and she explains how she hates that anorexia has to “take over everything.” Angela is particularly referring to a family trip to Europe and the fact that she will only be given medical clearance to fly if she gains 10 kilos. Angela really wants to go to Europe, yet she is afraid of having a “fat” body. Angela’s subjectivity is lodged in anorexia and she cannot ‘get better’ and risk her existence as “the best anorexic.” In the interview, Angela recounted her mother’s suggestion: “Instead of being the worst anorexic, why don’t you try to be the best at getting better?” Angela refuted this suggestion: “It doesn’t work that way.” Her refutation implies an investment in anorexia and a reluctance to relinquish this attachment, despite the restrictions anorexia places on other areas of her life.

In Carrie’s account the clinic seems to produce better anorexics. Carrie explains how she never used to vomit during her earlier admissions. It was not till one of the other patients showed her an easy way to vomit by putting her hand down her throat that she began throwing up in earnest on a regular basis. At the time, Carrie was grateful for the tip but now regrets it, not just because she has permanent scars across her knuckles from the vomiting. It is because vomiting always functions as temptation, an easy means of losing weight, an option Carrie has to balance against the dangerous physical consequences like electrolyte imbalance and dental problems. Carrie’s story has parallels with Foucault’s argument in Discipline and Punish that prisons “do not distinguish the crime rate: they can be extended, multiplied and transformed, the quantity of crime and criminals remains stable, or worse, increases” (Foucault, 1977, p.265). In the clinic girls have the opportunity to talk to other patients and to refine their methods of weight loss. This is construed as a quasi-criminal form of behaviour
in the clinic and will have an effect of increasing some girls’ resistance to the
governing practices of the clinic. The staff are aware of this dynamic (see 5.1.2) and
expressed concern about the effect girls’ non-compliance has on other patients. On
one occasion during the time I was researching, I heard a conversation between two
staff members, one of whom was concerned about the effect of having one patient in
a group situation, because she was seen as a bad influence on other patients.

The clinic can be observed to produce superior anorexies rather than helping the girls
recover. The clinic replicates other social practices where female adolescents are set
up to compete with each other, such as to be the thinnest or prettiest girl (Jackson,
2003), so it is perhaps inevitable that competition should be a feature of the clinic.

7.4.3. Responsibility, roles and rules

Performing as a responsible patient involved caring for other girls, for instance by
telling them they were not to hide food or utilise other means of losing weight. Maria
advised Karen not to lose any more weight, as described in the extract below:

Maria
I was talking to one of the girls who was actually leaving in the next 2 days, she was getting discharged. And um, she was about 15, she was a beautiful girl [Karen] and she was like saying how she wanted to lose weight when she got out and I sort of snapped her out of it and said it’s not the right thing to do, to be.

The irony of this comment is that Maria spoke to Karen when she was first admitted to hospital. At the time, Maria was medically compromised with a low body temperature and was in a worse physical state than Karen. In light of her physical state it is odd that she took up a physician’s role in talking to Karen. Furthermore, Maria’s claim that she “snapped Karen out of it” does not appear credible; anorexics rarely make an instant change for the better. Yet it is possible to read this exchange in another way using Butler's (1997a) work. Butler (1997a) argues that the very act of going beyond what is permitted for a subject of a certain status means that the act has legitimacy. When I questioned Maria about the believability of her words, Maria claimed her advice to Karen had a legitimacy that is absent in medicine, namely because she had lived with anorexia and the doctors had not. Thus, Maria believed her words would ring true for Karen. Here is an instance of the agency that is written about in poststructural theory, where the subject speaks in ways that are disruptive of traditional positionings, and thus creates new subject positions that are not defined by age or gender (Davies, 1999, 2000).

The common construction of ‘old timers,’ those who have long been subjected to a particular practice, such as a lengthy prison term resonates with girls’ constructions of
new and old patients. Madeline talks about keeping knowledge of anorexic behaviours from the newer patients. She claims that when girls are first admitted they are desperate to lose weight, and “older” patients’ should not help them to lose.

**Madeline**

*Yeah, it's an unwritten rule. It's kind of just sort of a protection thing. Like [,] we don't want them to [,] 'cause when, when some girls come in, they're really, they're really sick, like and they'll do- they're desperate, they'll do anything, so any ideas that they get, they'll follow through on so we just try and keep it all under wraps, a bit, all the mischief.*

Madeline suggests a censor operates through “unwritten rules” in the clinic. This censor: “circumscribes the social parameters of speakable discourse, of what will and will not be admissible” (Butler, 1997a, p.132). In the clinical context, the governing practices of the clinic censor what girls can and should say. For instance, what is acceptable to tell a new patient seems based on an existing patient’s conception of how sick the new patient is at that time. There are a number of ways to read Madeline’s positioning. Madeline’s attempt to protect other girls is in stark contrast to accounts where anorexics compete against each other over weight (Segal, 2003). Madeline constructs a subjectivity that is based on a moral position, holding that she has a duty of care to censor the knowledge available to new patients, so to protect these girls from becoming sicker than they already are. However there is a dimension of competition in taking up the role of censor. In this position, Madeline construes herself as superior to others.
Hannah construed herself as not as sick as the other patients and found their conversations at meals depressing. Hannah wished to be separated from the other girls at meal times, explaining she was tired of the frequent discussion of the calorie content in the food served at meals.

_Hannah_

_I kind of wish there was a way they could separate me from the other girls a bit more though, but I know I’m kind of the exception up here. Like a lot of most people come up here, probably 99 per cent of people that come up here have come up here with anorexia, and I’ve come up here <just with> malnutrition I guess._

Hannah constitutes herself as malnourished, a position that distinguishes her from the other patients (also see 8.2.2). Hannah’s account reveals an instance of how discourses are taken up in constituting subjectivity and that discourses have different effects on the subjects they inscribe. Hannah constitutes her subjectivity through discourses of anorexia, but rejects the psychological aspects as irrelevant to her stage of anorexia, whilst maintaining these psychological aspects are still pertinent to the other girls. Such a position can be maintained in the clinic because the focus is largely on re-feeding and Hannah can appear to be compliant with treatment.

Some girls noted that weigh days created a competitive environment. Claudia suggests that the fattest girl feels really bad because she is the fattest in the clinic. In an attempt to make the girl feel better, Claudia claims that she says: “you’re not the
fattest one, even if they are.” In reflecting on Claudia’s attempts to be responsible or kind, Butler’s discussion of embodiment is relevant. Butler writes that bodies can “exceed [their] interpellation, and remain uncontained by any of its acts of speech” (Butler, 1997b, p.155). Butler’s (1997b) contention is that language assigns particular labels to bodies, and she is referring to how heterosexual bodies are labelled as appropriate. However, I am referring to the girls attempts to name their own and other bodies, specifically Claudia’s suggestion that her body is fatter than some other girls. At the time of Claudia’s interview, she was among the thinnest in the ward, her emaciation undisguised by her baggy tracksuit. Claudia’s body exceeds its speech act; her words are rendered void by the physicality of her body.

Girls constituted bodily fluids as important in producing different subjectivities. It is relevant to consider Grosz’s (1994) argument about how specific bodily fluids produce particular responses from others, citing an example that vomiting invokes disgust. How the girls constitute the act of vomiting differs from what Grosz (1994) theorises, as apparent on one occasion when the girls were upset someone was vomiting in the communal bathroom. It was not the vomiting per se that disgusted the girls, but where the patient was vomiting. The girls show each other ‘better’ ways to vomit (see Carry 7.4.3) and condone this behaviour as long as one vomits downstairs in the public toilets, so that others are not exposed to this. It seems there are a set of governing practices and protocols in the clinic that are established and preserved by the girls and these operate independently of official regimes. The girls have established their own cultural practices that dictate the extent or social acceptability of practices of resistance within this subculture. Thus, vomiting is permissible as long as others do not have to see it. In the context
of inpatient treatment for anorexia vomiting is part of the sub-culture of practices
developed by these girls to sustain an identity in the clinic and includes sharing what
is appropriate anorexic (and social) behaviour.

In the clinic girls struggle with the eating habits and anorexic practices of themselves,
particularly as to how these measure against the behaviours of others. Constructions
of anorexia as informed by clinical regimes are a factor in their friendships with other
girls. The balance between friendship and anorexic subjectivity is sometimes difficult
to negotiate. For example, putting effort into being the best anorexic could be
positioned in a number of ways, as competition but also as concern, not wanting
another to get ‘sicker.’

7.5. (In) conclusion

In the clinic patienthood is construed differently than traditional accounts of doctor
patient relationships (Frank, 1999; Johnstone, 1993). Rather than the patient passively
responding to the doctor, relationships between doctor and patient involve multiple
negotiations between and re-positionings of different players. The clinic is a complex
space because while one, dominant (medical) discourse is constantly in operation, a
number of counter discourses that work in opposition to medicine converge at this site
and are taken up by many of the girls.
Girls are confined to the clinic because of their emaciated state, but by gaining knowledge of certain regimes girls can devise different strategies of troubling clinical practices and find alternative subject positions. Foucault (1977), in discussing how subjects are rendered obedient; notes that “the agent of punishment must exercise a total power, which no third party can disturb; the individual to be corrected must be entirely enveloped in the power that is exercised over him” (1977, p.129). If this argument is applied to the production of docile bodies in the clinical context it means that for treatment to work, doctors must have total control over subjects. But the clinic does not work this way. Rather girls perform compliance. They do not actually comply but present a performance of docility.

Many girls contest doctors’ power and the truths offered by doctors. Subjection to medical discourses does not mean that that all girls will take up the discourses in the same way; discourses are incorporated into subjectivity in different ways. Girls were actively involved in Othering the doctor by performing in other ways than is generally permissible for patients. Troubling traditional doctor patient dynamics becomes possible by being competent in discourses of anorexia and in drawing on other discourses such as popular culture, adolescence and femininity.

The relations between those diagnosed as anorexic differ from the relationships between patients with other illnesses in an inpatient context. In my visits to see family and friends who have been hospitalised for other conditions, there is often a dialogue between patients that is not of a medical nature, and traverses a range of issues like
current events, news, weather and sharing newspapers and magazines. Different to other illnesses, in the instance of anorexia relations between patients play a central role in producing anorexic subjectivities or Other to anorexia. Girls have created an enduring subculture of resistance to the clinic, which they share with others even after they have been discharged by leaving diaries and pictures in their cubicles. This subculture appears a means of resistance to being positioned as passive patients.

Similar to Foucault’s (1977) discussion of prisons, hospitals can produce better anorexics rather than recovered patients. Competition over weight is multi-layered and is perhaps a momentary take up of authority as a mechanism for girls to step out of their position of oppression. Discourses of competition are not one-dimensional, but complex and involve a number of different positionings. Many of the intricacies of adolescent relationships are played out, including peer pressure and competition (Gilligan, Rogers, & Tolman, 1991) and girls conflate such constructions onto discourses of anorexia and patienthood. The over-arching theme is that relationships between patients are multiple; girls do not simply compete with each other over weight.

It is evident that the clinic’s attempt at nurturing autonomy is problematic, because the nature of the regimes erodes any possibility of autonomy. What happens in the clinic is not overt non-compliance however. Girls are aware they are positioned as irrational and if they blatantly refuse treatment they will be subjected to more stringent models, like being sectioned under the mental health act. Therefore, many of the girls constitute themselves through medical discourses, finding agency in this
subjection by troubling certain discourses and how they are positioned within such discourses, to create subjectivities other than anorexic patients.

The following chapter extends this analysis by exploring the shifting constitution of the anorexic subject in the clinic. Constructions of anorexia, mental illness and the stigma attached to those who inhabit psychiatric hospitals are powerful signifiers in informing subjectivity. Yet these discourses are not fixed but amenable to reconstitution and change.

Chapter Eight

Shifting Subjectivities

8.1. Introduction

Chapter Eight explores different constructions of anorexia, mental illness and psychiatric institutions and the array of subjectivities through which girls are constituted and constitute themselves. The chapter is comprised of three parts. Part One examines how girls constitute doctors’ attempts to externalise anorexia, as
subjection by troubling certain discourses and how they are positioned within such discourses, to create subjectivities other than anorexic patients.

The following chapter extends this analysis by exploring the shifting constitution of the anorexic subject in the clinic. Constructions of anorexia, mental illness and the stigma attached to those who inhabit psychiatric hospitals are powerful signifiers in informing subjectivity. Yet these discourses are not fixed but amenable to re-constitution and change.

Chapter Eight

Shifting Subjectivities

8.1. Introduction

Chapter Eight explores different constructions of anorexia, mental illness and psychiatric institutions and the array of subjectivities through which girls are constituted and constitute themselves. The chapter is comprised of three parts. Part One examines how girls constitute doctors’ attempts to externalise anorexia, as
evident in the comments made by doctors such as “that’s the anorexia talking.” Part Two examines girls’ take up of different, opposing and multiple subject positions. For instance the positions girls were allocated in particular medical discourses were sometimes at odds with how they constituted themselves. Part Three examines constructions of psychiatry in which anorexia is located in both medical and popular discourse. The constructions of psychiatry that were mobilised in interviews borrow from fact and fiction, such as popular films, and these knowledges inform how girls and others construe anorexia and inpatient treatment for anorexia.

8.2. Negotiating narratives: Separate or subject?

To contextualise this part of the chapter, some background about the use of externalisation in the clinic is useful. Externalisation is a rhetorical device developed by Narrative Therapy. Many components of narrative approaches are not utilised in the clinic so are not described here. For a discussion of Narrative Approaches see Hepworth (1999), Monk et al. (1997) and Morgan (1999). Briefly, externalisation involves the linguistic separation of the illness and the person, as it is suggested that while the illness can affect the person, the individual is not the illness (A. Lock, Epston, & Maisel, 2004). The doctors in the clinic use a version of externalisation that they have modified for their specific purposes. On one occasion, for instance, following the appointment of a new psychologist, the consultant explained that as a clinical team they separate the anorexia and the girl. Doctors attribute behaviours like lying, cheating and stealing to anorexia, thus removing responsibility for these behaviours from the girls. The doctors tell the girls and their parents that girls have to constantly fight against anorexia’s influence. It is important to note that doctors’ use of externalisation is different to narrative therapy. Narrative therapists emphasise that
the person needs to take charge of their own lives, which can be done by finding stories that fit with their experiences (Monk et al., 1997), whereas the doctors assume the girl and anorexia are separate entities.

8.2.1. Various voices of anorexia

The extract below is taken from a longer commentary where Abby describes her attempts to negotiate with doctors about her treatment. In complaining that she is being made to eat too much, doctors ask Abby whether she or anorexia is speaking:

Abby: the doctors. That's why they classify us as- like is that the anorexic mind talking or is that you talking? It's like we're only one person.

Desiree: yeah.

Abby: so that's pretty degrading. So I honestly don't think I'm anorexic, °but° [.I'm in here [the clinic] so [. ] that just muddles me up. Here I am, I've got a [nasogastric] tube down my (heh) neck

Abby construes doctors' conception of her as in possession of two “minds” as degrading. Abby struggles in calling herself anorexic, believing she is not thin enough to be anorexic or be in the clinic. Yet as Abby explained, she could reconcile “being anorexic” if doctors did not insist on splitting her into “two people.” Elsewhere in the interview Abby constructs her personhood through defined roles: daughter, friend and chef, each of which allocates her a social position and identity in particular contexts. In contrast, in the clinic Abby is construed as “two people at once.” It seems that
Abby needs a unitary identity in order to be in a context. In the clinic doctors construe her as two persons and as a consequence she cannot exist comfortably in this space.

Sophie re-counted how many others had continually endeavoured to separate the anorexia from her. Her parents spoke about Sophie as separate from anorexia, following the suggestion of her psychologist. This psychologist, in Sophie’s words: “painted a lovely bleak picture of her life,” claiming that Sophie had to attempt to externalise the anorexia so as to “have a life.” Sophie disagreed vehemently with this idea. “I still manage to do OK at school and I have friends and I’m not completely stupid.” Sophie sees the psychologist “as just trying to scare me or whatever.” Sophie explained that having “control issues” is why she “got anorexia” and why “getting better” is difficult. In understanding Sophie’s construction, Probyn’s (1987) conception of anorexia is useful. Probyn (1987) construes anorexia as a strategy for negotiating the different discourses that attempt to appropriate (anorexic) bodies.

Different medical discourses conceptualise anorexia in particular ways and a powerful psychological construct that has developed from medicine is that anorexia is caused by a pathological need to control one’s life. In other words, control issues are long enshrined as a central trait in discourses of anorexia (see 4.2.2). Sophie troubles this discourse, holding that control does not only signify anorexia, rather Sophie construes control as central to her identity: “a part of my personality.” Thus, Sophie sees therapeutic attempts trying to get her to channel control ‘appropriately’ are redundant, because she is “very controlled…it’s not just the anorexia.”
In the extract below Claudia explains how doctors perceive her complaints about meat:

*Claudia*

*Like I don't eat red meat because I don't like the taste of it and I tell them [doctors] that. They're like, “oh, you must think there's fat in it” or something, and I don't. I know that red meat is good for you and everything, I just hate the taste of it, and so they [doctors] always assume that your thoughts have to do with eating disorder things."

Claudia suggests her claim of disliking red meat is not legitimated because the doctors attribute it to the anorexia rather than Claudia’s personal preference. Doctors tell Claudia she must overcome anorexia and she should demonstrate to the doctors that she has control over her anorexic behaviours by eating meat. The doctors punish Claudia (for instance by reducing her leave) if she does not eat meat. Paradoxically doctors do not blame her for refusing meat because they “always assume your thoughts have to do with eating disorder things.”

Madeline resisted doctors’ attempts to separate the anorexia from her. When doctors spoke about the separation, Madeline conjured up an image of an angel with a devil hovering beyond its shoulder. Madeline never got further than this image in trying to understand where doctors “were coming from.” What she found more helpful were the sessions with her counsellor, whom she “made a connection with.” Madeline suggested the therapy sessions helped to identify the cause of anorexia, realising “I need to find myself, to do things for me…rather than what my parents want.”
Madeline positions anorexia as means of demonstrating her refusal to obey her parents, as she had done prior to therapy. Madeline construes anorexia as an agenetic act: “a success of mine, in a sort of sick way.” Madeline sees the separation of herself from anorexia as negating the very aim of her starvation.

It is evident that doctors’ attempts to use externalisation, a strategy intended by narrative therapists to ‘empower’ clients, fails when it is unequivocally applied without first consulting or acting in collaboration with the clients. Doctors’ practices of externalisation angered and confused several girls, who troubled the doctors’ attempts to construe them as split beings.

8.2.2. Anorexia as metaphorically locked up

As some of the girls had encountered narrative approaches before admission to these clinics, it is perhaps unusual that few alternatives to illness narratives emerged in the interviews, given that this is the aim of narrative therapy:

It is crucial to tease out these individual stories as landscapes within which effective counter narratives can be constructed, counter narratives that bring into being the possibility of sustained “acts of resistance” to anorexia, a resistance that is otherwise easily co-opted or overwhelmed (A. Lock et al., 2004).
In interviews girls recounted ‘therapeutic’ conversations with doctors, psychologists and social workers. Some girls claimed that they were treated as “anorexic statistics” by the clinicians. Girls felt they were immediately positioned as dishonest (see 7.3.2). The girls’ experiences may make visible the extent to which the clinics rely on a model of anorexia as pathology despite doctors’ contrary assertions and attempts to utilise narrative approaches. This is an important issue, but it is not the focus of the study and will not be pursued further here. Instead, the narrative Hannah produced in the interview is examined as Hannah was the only participant that attempted an alternative story. What follows is a summary and analysis of how Hannah narrated her story of anorexia.

Hannah lost a lot of weight on a five-week overseas school trip, so much that when her parents came to pick her up from the airport they walked straight past her, not recognising her because of her immense weight loss. Hannah was taken to her General Practitioner who diagnosed anorexia and attempted to monitor her weight, but Hannah continued losing weight so the General Practitioner made a referral for her admission to hospital. It was a few days before admission that Hannah could “see it wasn’t me and that there was a way to get better, and yeah I realised that I did have anorexia.” Hannah was able to separate anorexia from her because she “could see that it was there, because it was me for a while.” On initially externalising anorexia, Hannah named anorexia “It” and later “That Bitch.” Around the same time, prompted by Internet research and talking to others who had experience with anorexia, both her parents and Hannah’s brother began referring to “It” as separate from Hannah. Hannah describes herself as coming into the clinic with “only malnutrition.” Hannah explained how she and her family believed anorexia was left at home, locked in the
garden shed and her father and brother would frequently give the anorexia a kick, to ensure it was well and truly dead. In the extract below Hannah explains how in the clinic she sometimes “got affected” when other girls discussed weight and calories. In responding, I inquired whether she could ask the girls not to talk about those issues in her hearing:

_Hannah_

_No (heh). Because <it's kind of like>; it's [anorexia] them [girls] at the moment and [...] they might, not that they'd get hurt but; um, [...] it’s- I'm not talking to the real them I'm talking to the anorexic them and so they wouldn’t really understand and they might get angry or whatever._

Hannah suggests anorexia currently acts as a mask for the “real self,” which has some parallels with how the doctors conceptualise anorexia. Implicit in the extract is that the “real” self will prevail eventually, a construction reminiscent of the popular dictum ‘the truth will prevail.’ The real self will become visible when girls can constitute their identity as other than anorexia, as Hannah has done.

Hannah’s central narrative is that she has overcome anorexia, but during her interview she reflected on why she may have “become anorexic.” This extract is a report of conversation between Hannah and her brother Luke, who has diabetes:

_Hannah_

_I said [to Luke] “I think one of the reasons I got sick was because I wanted to experience what you were feeling with your diabetes.” And um, “I wanted to
know what you were going through and I would rather be diabetic for you any day.”

Hannah construes herself as actively taking up anorexia to share Luke’s pain. In this construction anorexia is located outside the control of medicine and other institutional discourses. Rather Hannah mobilises anorexia as a means of sharing Luke’s experience of illness; anorexia is Hannah’s attempt to empathise with her brother. Constructions of anorexia as something one deliberately takes on have worked in perpetuating negative constructions of anorexics. Those who self-starve have been constructed variously throughout history as witches, liars, vain and foolish woman (Brumberg, 1988; Malson, 1998; Vandereycken & van Deth, 1993). In contrast, Hannah positions her deliberate starvation as appropriate and acceptable in a cultural context where caring for family members is well regarded. Doctors would construe Hannah’s behaviour differently if she revealed this explanation to them and might suggest that Hannah has a distorted perception of her brother’s illness and her place in his care. Because girls are located in the clinic their actions are always subject to doctors’ scrutiny and interpretation.

Although Hannah constructed an identity independent of the anorexia before she came into the clinic, her account is still indebted to medicine. Hannah can separate psychological notions of anorexia as pathology and claim she came into hospital only with malnutrition, thus constructing a binary between her and the other patients; yet she is still treated as an anorexic patient and doctors are likely to question her story. Hannah’s account reveals the extent to which medical discourses dominate in
constructions of anorexia, despite her own and her family’s attempt at constructing Hannah as “beating” anorexia.

8.3. A conflation of subjectivities

Various constructions of anorexia produce different subject positions, which some girls engage with in discursively negotiating anorexia. At times, girls constitute anorexia as a desirable identity, as part of the self, separate from the self and in conflict with the self. Malson (1998) also analysed how anorexic identities are construed in relation to the self, contending that “the discursive and physical management of the thin/anorexic body and the discursive struggle over its meanings can thus be understood as a management of identity” (Malson, 1998, p.42). Malson’s analysis does not focus on the relationship between anorexia and identity in the space of inpatient treatment and I extend Malson’s analysis in exploring how anorexic subjectivities are managed in the clinic where struggles over identity are arguably more difficult to negotiate as girls are affixed medicalised identities.

8.3.1. Desiring anorexic subjectivity

Butler (1997b), in explaining investment, argues that a subject takes up a position within the discourse to ensure continuity of the discourse. Butler’s argument has some parallels with girls’ construction of anorexia as a desirable subject position. In the clinic medical technologies create particular ways of being. Because of their clinical location, taking up anorexia meant these girls had to incorporate medicalisation to perform as a legitimate subject in these discourses.
Elise seemed to want to be anorexic, an attachment that is recognised by her doctor who recounted to me that Elise walked into his outpatient clinic and announced: “I’ve got anorexia nervosa purging type.” For Elise, being anorexic requires recognition by self and others that she “has a problem.”

Elise: I don't know I'm just really, I'm obsessed with wanting to be anorexic.

Desiree: How do you mean, obsessed?

Elise: I still want to be thin, yeah. I really want someone to notice me, that I have a problem and that I need help.

Elise takes up the term anorexia as desirable subject position and this subjectivity requires both thinness and the medical gaze to affirm her emaciation. Medicalisation conflates with thinness: Elise needs to be visibly thin so that she can be noticed by others and helped, possibly by medicine. Elise walks a paradoxical line between being thin and medicalised as to be given help as an anorexic means being re-fed which may mean relinquishing her identity as anorexic. Those who desire the label anorexic and the medical gaze may attempt to negotiate the sick/well duality as Jamie does:

Jamie

I didn’t want to be fattened up…but wanted help to deal with the thoughts.

Jamie wants to be allowed to retain her thin body whilst receiving medical help with her anorexic thoughts of feeling fat, uncomfortable and depressed. The value Jamie places on thinness is evident in the extract, as are traces of psychological discourses.
of anorexics as having an underlying psychological problem that needs to be addressed (see 4.2.2). Butler's (1997b) explanation of how subjects are invested in particular subjectivities illuminates how investment is not just physical, but also psychic. Psychic investment means that girls take up aspects of anorexia that are confronting and painful despite attempts to relinquish these. When asked about possible recovery, Jamie replied:

*Jamie*

*I feel like I’m falling down a bottomless pit, never getting out [...] I don’t think
I’ll ever be able to.*

In Butler’s (1997b) terms Jamie is not free in choosing her attachment to anorexia. The term “bottomless pit” is used elsewhere in her interview to describe her life of anorexia, self-harm, depression and many failed treatments. Anorexia gives Jamie a social position to which she is attached and is unable to renounce. It seems that although *being anorexic* is painful, Jamie has lodged her identity in anorexia and she does not want to relinquish this identity.

Maria polices anorexic subjectivity by demarcating what a (real) anorexic does, both physically and mentally. Maria constructs an anorexic as one who mentally struggles with putting on weight, especially putting on weight fast. In the extract below Maria construes herself as anorexic, because she has experienced this anorexic thinking:

*Maria*
Some of the girls don’t [mentally struggle with putting on weight] they just start putting on weight like automatically and one day I actually just stood back and went, nah there’s something wrong with that [the speed that one girl put on weight]. She’s gonna put on all the weight too fast, she’s gonna freak out and then wanna to lose it. But so far she’s proven me wrong ‘cause she’s dealt with it.

Maria construes those who can deal with putting on weight at speed as Other and not anorexic. In making this claim Maria draws on biomedical discourse- that anorexics can only cope with gaining a kilo per week for both mental and physical reasons such as risking falling prey to re-feeding syndrome. Thus, Maria employs medical discourse to construct (her) norms about what is appropriate and inappropriate behaviour for an anorexic.

Carrie had been discharged six months prior to her interview. In arranging the interview, Carrie said she found going to the outpatient consultations particularly distressing at the time because she felt fat and did not want to make herself feel worse by seeing “other anorexic girls.” We thus arranged for the interview to take place at the university. In the interview, it quickly became evident Carrie was very uncomfortable with her body, and she explained it was the biggest she had been in five years. Carrie’s negative feelings about her body prompted her to have a consultation with Jenny Craig, a popular weight-loss company.

*Carrie:  Like sometimes I feel like I just can’t stop eating, like all I'm doing is eating, the total opposite to what- like I'm not bingeing, like I'm eating <all the
time> and I just, I get really depressed over it and I cry a lot. °yeah. ° I went to Jenny Craig (heh).

Desiree: Oh okay.

Carrie: I didn’t sign up, I just went there to see how much weight she thought I could lose, she said I could lose 6 or 7 kilos.

Throughout her five years of treatment, Carrie rejected the label anorexia because she believed she was not thin enough. She wanted to be thin, hence the consultation with Jenny Craig, but rejected the medical label anorexic. Carrie occupies an ambivalent position; psychically she feels fat and being diagnosed and treated as anorexic has not convinced her that anorexia is an appropriate label for her. However her long history as an anorexic patient seemed to have a presence in her interview. I read Carrie as uncertain about my connection with the doctors: she may have aligned me with them. The doctors were still monitoring Carrie in outpatient consults, thus admitting to going to Jenny Craig places her in a dangerous position with the clinicians (which may have included me) as visible in her qualifier “I didn’t sign up.” Doctors’ would treat Carrie’s claim of “just checking out” Jenny Craig with suspicion, believing that this was a sign of relapse. Butler writes that the “rules that constrain the intelligibility of the subject continue to structure the subject throughout his or her life” (Butler, 1997b). In relation to Carrie, her construction suggests she will recognise and be recognised by others as anorexic “throughout her life.”

Carrie’s boyfriend Joe continued to position her as anorexic, although she had been out of the clinic for six months and she was no longer emaciated. Carrie said she was
annoyed with Joe because they had only been dating for a few months; yet her body and what she ate were a constant source of tension in the relationship.

Carrie

*Like I have a boyfriend [Joe] now and he knows that I was in hospital and what I was in hospital for. He doesn’t really understand it. (D: Mm) not that he tries too. But now that I’m going out with him he’s like [when Carrie refuses to eat fast food] don’t be so selfish, don’t do it to yourself and, don’t do it to me, and I’m like, I’m not going to get sick again. I’m just watching my weight and he thought no, eat something.*

Joe rejects Carrie’s statement that she is “just watching her weight” and her assurance that she will not take it to extremes. There are a number of ways to read Joe’s monitoring of Carrie. Joe perhaps defines the non-eating as something that Carrie chooses but that also harms him and therefore she should consider his point of view. However, Carrie constructs Joe as having a lack of understanding of how she feels, particularly because he does not offer any other support besides forcing her to eat. Carrie wishes Joe would simply trust her not to get “sick” again. Another possible reading is that in encouraging Carrie to eat Joe takes up a paternal role that perhaps resembles a doctor. Carrie was an outpatient at the time of her interview but the medical gaze appears in another guise through Joe’s surveillance. Joe watches Carrie to detect whether there are any signs that she may relapse into anorexia, which annoys Carrie.
Angela suggests that she initially hated the principal doctor involved in her treatment, Dr P, but now loves him because “he’s done so much for me.” One reading of Angela’s pronouncement, informed by medico-cognitive theory (see 6.5), would be that Angela hated Dr. P while underweight and once she was re-nourished, she could accept that Dr P. was trying to help her. Another reading is possible, drawing on Butler’s (1997b, p.20) theorisation of subjectification. Butler argues that “there is no formation of a subject without a passionate attachment to those by whom he or she is subordinated.” Using Butler to understand Angela’s account, it may be that Angela has a passionate attachment to the doctor because she desires anorexia and Dr P provides the conditions of possibility by which Angela can be recognised as anorexic. Dr P.’s constant utterances of dismay that Angela frequently starves herself to a low weight reinforce her physicality and visibility as thin. Yet Dr. P is also responsible for her numerous admissions and Angela hates the clinic as she is thin when she sees Dr. P on admission but is quickly “fattened up.” Angela is ambivalent about anorexia and much of this ambivalence converges at the site of Dr. P. Angela’s ambivalence can also be read as an act of agency because she disrupts binary positionings of good and bad patients (see 6.7). Medicine positions bad patients as resistant to treatment and doctors, and good patients as compliant (Lupton, 2003). Angela simultaneously occupies positions within both these discourses, thereby prohibiting medicine from controlling her identity.
The desire for medicalisation often goes unrecognised in both medical and feminist texts. When girls’ investment in anorexia is recognised by clinicians, it is generally attributed simply to the desire to be thin, without any further exploration (see 4.2.4). Yet this discussion illustrates that investment in anorexia can be more ambiguous and includes many different aspects of anorexia, such as medicalisation, thinness and
social positioning. Some of these positions are paradoxical, however; in being medicalised one will be admitted to hospital, re-fed and thus lose the thin body.

8.3.2. Anorexia as prohibitive and productive

Constructions of anorexia as both a positive and negative identity was a common theme across many of the interviews (also see Malson, 1998). In girls’ accounts different aspects of anorexic subjectivity were construed as having particular effects on the self.

Elise explains that she learnt about anorexia by writing a report for a school assignment. After reading the article, Elise “confessed” to her mother that she had anorexia:

Elise

I confessed to her [Mum] I had anorexia like; I was really thin and I didn't want to get any more thinner in case I would die.

Despite the entry of the term confession into popular discourse, confession still retains its original Catholic connotations of asking for forgiveness and help about to how to right a wrong. In positioning herself as confessing to her mother, Elise construes herself as needing help to overcome anorexia. However Elise’s desire for anorexia is evident throughout her interview, and can be read in her claim of being “thin enough to die,” as she suggests elsewhere that this is the body she desires (see 8.3.4). Elise continually works to remain dominated by anorexia, as “I feel like I have to do it [.]
It's not a matter of I'm happy or not.” Elise attaches ambivalently to anorexia, suggesting anorexia has both positive and negative effects on her.

In the extract below, Renee ponders anorexia’s effect on her and her relationships with others:

_Renee_

*Um, so I guess it's had a big effect on me in that way [.]. and the way that I sort of analyse other people as well [.]. um, it's made me more aware of people's reactions to things and <emotions> I guess. But um there's parts of it that I don't want to be part of me anymore; parts of the eating disorder that I do definitely want to get rid of [.]. um, just the parts that [.]. um, just make it really uncomfortable socially <and emotionally> on myself as well.*

Renee constitutes anorexia as informing who she has become; a person that is “more aware of people’s emotions.” Anorexia is positioned as the grounds for “the way Renee is” and from which her interest in helping others is derived. This subjectivity is both productive and negative: “parts that make it really uncomfortable socially.”

Madeline also construes herself as sensitive. Differently to Renee, anorexia did not *make* Madeline sensitive; rather, anorexia gave Madeline an *awareness* of her sensitivity:

_Madeline_
Um, I think it was getting to, this- like I didn't, I don't think I've ever really
known the way I am. I think I've always sort of been [...] what other people
[parents] >want me to be< so having the eating disorder has helped me realise
that I need to find myself, (D: Mm) which is what I am doing in here now. Like
with my support meetings and stuff, discovering who I am and what I actually
like doing.

Madeline claimed she was always going to get anorexia because her parents put a lot
of pressure on her and she had not yet “found herself.” There are two entwined
discourses evident in this extract. The first is a humanist construction, that one has a
single identity that can be revealed through appropriate therapy to produce rational
action and thought. Such a construction is in concert with the medical imperative to
isolate a single cause as the agent of anorexia. The second construction in this extract
is parental blaming, specifically that the anorexic daughter is submissive to her over-
controlling parents (see 4.2.5). Madeline’s counsellor “helps her realise she needs to
find herself.” The problem with Madeline’s take up of the discourse offered by the
therapist is that her capacity to act is that of a flawed subject.

Amanda claimed she could separate anorexia from herself, yet anorexic thoughts had
also become a part of her thinking. Amanda construes anorexia as making her
obsessive about eating and also about cleaning, time management and scholarly
achievements. Anorexia has infiltrated Amanda’s way of thinking, not allowing her to
“ever think a certain way anymore.” While there were many negative aspects to
possessing anorexic thoughts, Amanda construed discipline as central to anorexia and
suggested that this discipline can be harnessed as a positive attribute. Amanda saw
discipline as helping her to achieve in sporting and academic arenas and she wanted to preserve it as a defining attribute of herself.

Different to Amanda, Karen sees anorexia as hindering her participation in activities like Art and Music:

Karen

Um, I was always into Art and Music, (D: Mm) but- like- when you get really sick you give up your interests to concentrate [. ] on the illness (D: Yip) [. ] yeah.

Karen articulates her identity through different roles: art, music and anorexia. She was “into art and music” until she became sick. Locating anorexia as a disease that affects individuals, as evident in the earlier part of the quote, runs counter to Karen’s latter claim that she must “concentrate on the illness.”

8.3.3. Discursive struggles: Self versus anorexia

In the extracts reproduced here, girls construct an aspect of the self as opposing the other part of the self that is anorexia. Some girls constructed anorexia as part of their identity but also as Other to whom they desired be.

Maria reports that it is a struggle between anorexia and her “own mind” at meal times. Maria described how she would eat some of her food, like half a sandwich, and then the anorexia would “tell her” not to eat the other half. In the extract below Maria
illuminates some of the interactions that take place between anorexia and her “own mind” when eating a meal of rice:

Maria

Another thing that anorexia does it takes over by trying to trick- [...] and in that way it tricks your own mind. It’s like I said before you might want to finish that whole rice or whatever and it will trick you and say no you don’t, you don’t want to finish it, you might put on weight if you finish all that, sort of thing, little tricks like that. But it doesn’t actually talk to you, (heh, heh) but in that way in the same thing, it puts little ideas into your head and you really don’t think that way, so.

Anorexia tries to “take over” Maria to “trick her own mind” in order to make her think as anorexia. Maria constitutes herself as being “tricked” by anorexia, yet she has developed a reflective capacity to distinguish between anorexia and her “own mind” and can use this to resist being entirely taken over by anorexia. Maria’s construction is a more nuanced positioning than feminist and empirical accounts where anorexia is presented as a paradox of control. In discourses of control the anorexic is positioned as believing they are in control of their food intake and weight but they are actually becoming out of control because the eating disorder is increasing its grip on the person (see 4.2.2). Maria illuminates how anorexia tries to “take her over” yet she can distinguish between it and herself and listen to her own mind. Although some girls criticised the doctors’ deployment of the split between anorexia and the individual, their construction is consistent with Maria’s positioning in relation to anorexia.
Claudia was more ambivalent than Maria about her attachment to anorexia. She spoke of engagement in “anorexic behaviours and having anorexic thoughts.” I asked whether she saw these thoughts and behaviours as part of or separate from the self. This is her answer:

Claudia

*I think [...] it’s a bit of both; like I have thoughts, but [...] They’re probably caused by anorexia because, [...] I have it, but [...] I can control my behaviours. Like say [...] I look at some food and I don’t want to eat it because it’s got so many calories in it, (D: Mm) but then I think, I want to get out of hospital, so I’m just going to eat it anyway.*

Claudia is both subjected to and has made anorexia part of her own subjectivity. In other words, Claudia is controlled by anorexic thoughts, but she can control her anorexic behaviours because these adhere to her own aims. Claudia eats enough to be discharged although “having anorexia,” means that she is uncomfortable with the calories she has consumed.

Rita spoke about being able to easily lose weight by vomiting whenever she wanted. Constant vomiting meant her potassium levels were often low which resulted in several admissions through emergency. Doctors had warned Rita of the consequences of low potassium, but their warnings did not stop her from vomiting. Rita seemed to desire thinness more than her health and she claimed that anorexia “is a huge part of my personality.” Yet in Rita’s accounts of interactions with friends she took up a different subject position. Rita was adamant about not discussing any aspect of
anorexia or treatment with her friends. It was on a school camp that Rita once attempted to eat and not vomit for a week. In thinking about her presentations in the different contexts, I asked the following question:

Desiree: So do you see yourself as kind of separate from the anorexia?

Rita: No. It's like; it controls my life [it is] all that I am basically.

Despite construing anorexia as controlling “all I am,” Rita configures her subjectivity differently in different contexts. In the clinic she constitutes herself as anorexic, and in social circles she simply wants to be “a mate.” One reading of this dynamic is that the clinic provides the space to be anorexic and when anorexia is not offered as a possible site for self, girls lodge their identity elsewhere.

8.3.4. Anorexia as multiple: Brains, bodies and beauty

In some accounts anorexia is discursively produced as having multiple meanings. Anorexia “affects” different parts of the subject which are sometimes in conflict with each other, yet they are all anorexia, or adhere to anorexia (also see Malson, 1998). The connection between the different anorexics and their relationship to the subject is somewhat ambiguous. Anorexia can also act on the subject as is articulated in terms of “anorexia makes me feel…”

Maria suggests that when anorexia becomes deeply ingrained there are affects on the brain, as illuminated in this extract:
Maria

Yeah, cause a lot of people have an- anorexia and it’s a lot in the brain, it’s what the brain is telling them, like it has full control over them and they don’t want to get better and things like that. Like they want to stay thin and they want to get thinner (D: Mm) and I just had a little bit of it, it hasn’t been too bad. I think it’s also because my parents have brought me up and I’ve always had really strong; strong beliefs and when I believe something I don’t ever turn back on it, (D: Yeah). Like I believe in never making myself vomit.

Maria proclaims that she only had “a little bit of anorexia” in contrast to the other patients who are far more controlled by anorexia than Maria is. In Maria’s construction, her strong resolve means she will not allow herself to be possessed by and can overcome anorexia. Maria’s recognition of and ability to articulate a counter story makes it easier for her to take up a legitimate subject position. Maria suggests that when the self and anorexia blur, a unified identity is harder to negotiate.

Marina sees herself as three: Marina at 15, Marina at 40 and anorexia. As the descriptions of Marina now, Marina at 40 and the anorexia were somewhat similar, I asked Marina how she or others differentiated the three people. Marina replied that all three “sort of tie in together, at some point.” In understanding Marina’s anguish about being three entities that give her contradictory messages, it is useful to look to the context in which Marina is situated. In counselling a therapist may ask a person what they would be if the illness was not such a constant presence. This construction relies on a notion of a singular identity that does not shift in different settings and that a
person is free to act as they please independent of the context. Furthermore, as some girls’ accounts illuminated, they do not lose every defining feature when they ‘become anorexic,’ and in recovery be ‘restored’ to the same person. Marina and other girls are located in particular social/cultural and historical contexts where girls are positioned by others and take up different positions in constituting themselves. For instance, Marina’s brother suggested she was behaving as if she was 40, thus verbalising his belief about how Marina should behave. Her brother’s words have consequences for Marina, as she has to negotiate another persona in trying to be in the clinic and the wider social world.

Elise also construed anorexia as having multiple meanings. A competitive dimension is visible in Elise’s description as she articulates a desire for “just a muscle there and kind of bone.” Elise seems to want to go beyond what is attractive and physically possible. Elise’s construction is suggestive of a desire for extreme emaciation, a body that would be medically compromised. When I asked “what does having anorexia mean to you?” Elise responded:

\textit{Elise}

\textit{Looking sexy, looking great (D: Yeah) […] wanting to strive harder, to be the best at everything.}

Elise’s construction of anorexia as “sexy” and “great” borrows from media depictions of supermodels whose bodies Elise desires. Magazines offer a discursive space in which many female celebrities are at some stage labelled as having eating or body image problems (Boughtwood, 2005). For instance, in 2003, the front page of a \textit{Cleo}
magazine portrayed Holly Valance as “Not engaged, not anorexic!” (Cleo, 2003). When I suggested that some people might disagree with her description of anorexia, Elise replied that those people who do not recognise anorexics as sexy are crazy.

Another construction of anorexia is visible in Elise’s account of “striving harder.” In psychological discourse her striving would be labelled perfectionism (see 4.2.2). Elise’s efforts extend beyond the body “being the best at everything.” Elise construes thinness and “striving harder” as her rules, as evident in the extract below:

*Elise*

*It's like in my quotes or in the rules that Elise has to be, so and so, ah careful.*

*[…] It's not like if I put on a kilo, like I've broken any rules, it's not like I'd be dead or killed or hurt, or anything.*

While Elise recognises that non-adherence to her rules has no legal or deathly (total) implications, the consequences are nevertheless almost as dire. One way of keeping to these rules is by using external controls, because Elise suggested she lacked inner control. Elise re-counted how at one time in her life she managed to control herself by working in her mother’s restaurant every afternoon and on weekends; the lack of free time meant she only ate small amounts a few times a day. However, her mother sold the restaurant and Elise had to try to self-control but failed. Elise construes herself as craving the control the restaurant imposed and suggested the clinic enforced a similar control on her eating and behaviour. In the following extract, Elise explains that she will try to recreate some of this control once she is discharged from the clinic and returns home:
Elise

Yeah, I'm making a rule that I can only eat at home or school, (D: Mm) places where I'm kind of restricted. I have to try and lose now and the time I put on weight was already over. It was when I was in hospital. Now is the time for losing.

Elise takes up the governing practices of the clinic, particularly the use of mechanisms like set eating times to try to maintain her weight. Elise’s construction has some parallels with Foucault’s (1980b: 155) argument about subjectivity: “The disciplined subject becomes so accustomed to the constant surveillance of his/her overseer, the ‘inspecting gaze’ that s/he will end up by interiorising (the gaze) to such a point that she is her own overseer, each individual thus exercising surveillance over, and against him/herself.” Elise takes up clinical controls, but her constitution departs with what Foucault theorises because she takes up clinical controls for a different purpose than intended by the clinic, namely to lose more weight. Her unhappiness about her fat body is visible in the comment “now’s the time for losing.” Elise describes herself as requiring external controls and takes up the external controls of the clinic as an internal constraint on the self so as to be an agentic subject in the clinic.

Elise constructs herself as requiring external and internal disciplinary measures. It is only by implementing strict controls that she can contain this uncontrolled Other self that threatens her anorexic identity. Once she gained weight, however, the threat takes a different turn:
Elise: I'm back to a healthy weight, so I'm not really that anorexic, but mentally I'm still really anorexic.

Desiree: Yeah. In that you think about food and weight and that all the time?

Elise: It's dominating my life. So [...] it's not even anorexia; I don't know what I've got, but I've got to get it away from me.

Anorexia is produced here as dominating Elise. Yet “it is not even anorexia” because Elise’s body is not thin enough to signify anorexia. To be anorexic Elise requires the emaciated body that is the object of medicine and evokes revulsion, admiration and envy from others. Without this body Elise is excluded from this subjectivity and persona- is a failed anorexic. Yet Elise still retains the thoughts of an anorexic and these torment her: “I’ve got to get it away from me,” as if these thoughts are the essence of anorexia.

The multiple positionings that Elise articulated throughout her interview illustrate her constitution through and subjection to anorexia. “Sexy and great” locates anorexia as immensely desirable. In Foucauldian (1977) terms, where the soul is positioned as a prison for the body, the development of an anorexic soul is a necessity in the clinical context as one is being refed, and the soul must be retained so that the anorexic body can be recreated upon discharge. However, this soul becomes torturous when it is retained without an appropriate body and some girls become uncomfortable and ambivalent about their embodiment.
8.3.5. Public and private subjectivities

Once out of the clinic, girls are often subjected to the comments of friends and family about their weight. These comments may be well intentioned, but girls may be distressed by these comments and construe themselves as fat. For some girls the loss of aspects of anorexic subjectivity was more ambiguous, not simply determined by weight and sometimes involving a negotiation over, as Carrie explains, “tiny little things."

Carrie explained how feeling uncomfortable about eating with others was a problem when going out with friends: “because it’s pretty normal eating, like everywhere you go people are eating.” Carrie suggests what she found difficult was not the fear of gaining weight “but the little habits that it’s hard to get out of” that made her able to eat comfortably. These included checking the fat content, size of food portions and taking her time to eat. Out eating with friends, Carrie noted the carelessness and speed with which they ate, which made her uncomfortable, particularly if her friends became impatient with Carrie and tried to rush her. Carrie articulates ambivalence about hanging onto her behaviours of checking the contents of the food. She realises that they mark her as anorexic. Yet these behaviours also provide the space for her to appear ‘normal.’ With the checking, she can eat in public like everyone else.

In the excerpt below Renee draws on an idea she has taken from Dr Phil. Dr Phil originally appeared as a guest on Oprah Winifrey (a popular US talk show). Dr Phil now has his own show (McGraw, 2003) which is of similar format to Oprah’s; he
brings people onto the show and helps them sort out their problems about family relationships, career and appearance. On this particular episode, Dr Phil was not discussing eating disorders but body image. Renee remembers Dr Phil’s definition of body image “bodily feeling, how one sees their body.” Renee considers Dr Phil’s definition, relating it to her experience of anorexia:

Renee

*With eating disorders is that they're like; your physical appearance and your mental appearance are just constant to the one thing. Like the way you see yourself, in your head, you know, both like mentally and physically is the same, (D: Mm) and so if you're feeling; [...] it's hard to say. You know, like feeling fat, you might not look fat to other people, but you look fat to yourself because that's the feelings, you know, you're feeling that way inside and so you see that on yourself."

Renee’s account is informed by Dr Phil’s argument that being fat or thin is a mental feeling that exceeds the binaries of inner feelings and outer bodies. The popular dictum of ‘it’s what’s inside a person that counts’ does not apply to Renee’s situation. For Renee “feeling fat” is all encompassing: “feeling that way inside and so you see that on yourself.” Renee’s account illuminates how the social infiltrates the psyche in ways that cannot be easily erased in the clinic.

Maria spoke about the loss of the nasogastric tube as she had “become attached to it,” despite her distress when the tube was originally inserted. Butler’s (1997b) argument about passionate attachment is useful in reading Maria’s ambivalence. Butler’s
(1997b) point about the desire for social existence is important, because Maria never positions the tube as part of a socially desirable existence at any point. The tube is not a marker of desirable aspects of anorexia, such as thin and beautiful. The tube is physically uncomfortable, visually awful, marking the person as anorexic and it functions to fatten the body. Maria’s attachment to the tube is not something she can explain; she “misses it” but cannot explain the feeling of loss when the tube was removed. Her ambivalence about the tube is part of a desire that cannot be rationally explained, perhaps rooted in some sort of attachment to being an anorexic patient.

As a category of illness and of person, anorexia is construed as having a multiplicity of effects on and relationships to the self. Some girls constructed the self as trying to resist anorexia through construing an aspect of the self as stronger than anorexia—however some aspects of anorexia were positioned as positive and desirable and the girls expressed a wish to retain these subjectivities. Taking up an identity as anorexic or as Other to anorexia involves negotiating a number of different constructions of anorexia and the relationship of these constructions to subjectivity and identity.

8.4. Portrayals of psychiatry: Mad, bad and sad

In biomedical discourse anorexia is classified as a psychiatric illness and some of the myths, mysteries and stigma about psychiatry and its patients are conflated with constructions of anorexia. The following discussion explores how various knowledges of psychiatry inform how girls and their friends and family constitute anorexia and inpatient treatment for anorexia nervosa.
Asylums were established in the 12th century and these functioned as repositories for mentally ill to remove them from mainstream society. No rehabilitation was provided, in effect asylums served as jails (Shorter, 1997). In Australia the first closure of an asylum was in 1985, the last in 1993 (Mullen, 2005). Despite the out-phasing of asylums, resonances of 19th century asylums linger and mediate constructions of psychiatric institutions and their patients (Shorter, 1997). Both girls and parents expressed extreme distress at the stigma associated with being hospitalised. Some girls, often prompted by their parents’ reactions, suggested they would never be seen as normal again. For instance Elise told me that her parents believed being in a “mental hospital” meant a permanent black mark on her record and would prevent her from getting jobs later in life.

The depiction of the clinic as stigmatising and frightening was a major theme of Abby’s interview.

Abby

all my friends told me [...] like you eat or you’ll; I’d end up in hospital and all they do is make you fat and force feed you and stuff like that. But I also thought of it as the film, um, Girl Interruptus-Interrupted, have you seen that?
Abby reiterates several times in her interview how her friends were concerned that she was not eating and told her that she needed to eat or she would be hospitalised. To Abby, her friends’ descriptions of hospital sounded like *Girl Interrupted*, a book that was made into a film in 1999. Set in America in the 1960s, the main character Susanna is depressed and psychotic and attempts to commit suicide by taking a combination of vodka and aspirin and ends up in a psychiatric institution. In both the book and film Susanna and the other patients are variously depicted as unwell/mad, bad and rude, because they cause havoc by upsetting the other patients and staff yet are unrepentant about their behaviour (Kaysen, 1993). In turn, the patients construe themselves as misunderstood and so badly treated by staff that many make elaborate plans to escape. In invoking *Girl Interrupted* Abby explicitly locates hospital as a place for the mad. Such madness is not enabling or positive, but “ever subject to diagnosis which bears the formidable stamp of ‘authenticity’ declared in the name of medicine” (Martin, 1987, p.15).

In explaining her experience of the clinic Abby draws a comparison with her aunty, who was hospitalised for anorexia some twenty years before Abby was. Abby’s interpretation of herself in relation to anorexia is relevant to her commentary in the extract below. Elsewhere in the interview Abby describes how she saw her situation before coming into hospital: “I just think I was trying to lose weight to a certain extent and I just went overboard, because I don’t look anorexic, I don’t feel it, my head’s normal.” Abby suggests that anorexia was virtually unheard of twenty years ago:

*Abby*
Abby construes anorexia and other mental health problems as developing by being in a “bad” environment, validating her claim by drawing on her aunt’s experience of inpatient treatment. Abby’s construction of psychiatry resonates with the writings of Janet Frame, a popular New Zealand author who wrote about psychiatric hospitals. Frame argued whether patients were really ill on admission to the institutions, or responded to their physical and psychological location as mentally ill (Frame, 1980).

Other girls echoed Abby’s claim, suggesting the clinic created and refined their identity as anorexic. One girl told me about how she did not attempt to eat anymore; she was constantly on a 100 percent meal replacement that she took through the tube. It was easier to put on weight, she explained, if she did not have to think about eating. This seems to be another instance of the clinic enabling an anorexic identity—providing the means for girls to eat in ‘abnormal’ ways.

London’s first psychiatric institution, Bethlem Royal Hospital, was founded in 1247. It became famous for its harsh treatment regimes such as strapping patients to the floor and shaving their heads (Shorter, 1997). The media interest in psychiatry (A. McDonald & Walter, 2001) and anorexia (Ramsay, 2000) suggests that contemporary
Western society has a similar fascination with psychiatric phenomena. This fascination was perhaps evident at the opening of a research centre in the hospital. Among speeches from the several politicians and doctors, two girls from the ward had a role in the proceedings. Dressed up, they wore skirts and had their hair done nicely, despite having come from the ward. That these girls were inpatients was apparent to everyone in the audience, because one girl had her nasogastric tube intact. The girls’ role was to cut the celebration cake. The cake itself was enormous, with dark chocolate icing and cream. The audience consisted mainly of health professionals, politicians, important members of the community and academics. The irony of the girls and the cake was not lost on the audience, as evident in the proliferation of comments that were articulated in murmured tones while the cake cutting took place; including; “why anorexics and a cake…the stupidity of bureaucracy…they must be embarrassed…isn’t that one thin…that one has thinner arms…show ponies…how does that tube work…do you think they keep it in?” Examples like this suggest that while doctors now treat their patients with more humanity and respect than the 18th century (Rosen, Walter, Politis, & Shortland, 1996), medicine may inadvertently perpetuate the stigmatisation of those they label mentally ill by displays like these.

Maria, the girl with the tube, commented on “the look” of the tube in this context, meaning how other people might see her. She explained that I should not see it as causing her embarrassment, because it was for “the cause,” helping people understand what anorexia “is like.” I agreed with her that there was a lack of public understanding of anorexia, but I also wondered about what I saw as her take up of a medicalised identity. Maria seemed to advocate her participation in the spectacle of illness because it was for a (good) “cause.” Foucault (1973, p.84) suggested that the
doctor, upon entering the clinic “undergoes a decisive moral experience that circumscribes his otherwise limited practice by a closed system of duty.” In other words, the doctor has a moral obligation to cure illness by his knowledge. In one reading Maria construes herself as occupying a similar role to the doctor, as she positions herself as having a duty or moral obligation to provide knowledge of anorexia to the public, by displaying the tube for all to see.

Foucault (1977) argues that the prison system, through control and surveillance, created criminal subjectivities. Although disciplinary practices are perhaps more pronounced in the prison system, these were replicated in other institutions and are visible in contemporary sites, including the clinic. A description of the hospital in a published account of anorexia suggested that: “hospital, graduate school, prison; it’s becoming increasingly difficult to tell the difference…At least here the rent is paid” (Shute, 1992, p.19). At one stage during the research there was a prisoner in the hospital. He was in a single room, constantly watched by two security guards and his room was located close to Clinic B. The nature of his crime was not revealed and nothing untoward occurred, however several parents were concerned about having a prisoner in such close proximity to their daughters. I was informed of this by one of the girls and I asked her whether she shared her parents concern. She laughed and replied. “No, we’re all prisoners anyway.” This statement perhaps reveals an awareness of how girls are positioned in the clinic; as prisoners on many levels. These girls are restricted physically by their location in the clinic and constituted as unable to cope in wider society as they are seen as unable to manage their bodies.
The organisation of space in the clinic functions to reinforce particular constructions of anorexic patients, such as dishonest (see 7.3.2). Sophie’s reflective awareness of the clinic and the subjectivities it aims to create was evident in a conversation we had outside the interview. Sophie had just been readmitted and had taken up residence in a cubicle previously occupied by another patient who drew a lot during her time in the clinic. The girl had left some of her art taped onto the wall and we were looking at her drawings. One picture contained women in different poses, and the background was a series of swirls, some of which merged with the figures. Pointing to one of the figures, I made the comment “she looks like she’s got a nasogastric tube.” Sophie laughed at me: “now you’ve got that on the brain. We have, being in here, now you have too.” Her comments suggest that in being in the clinic as a patient, doctor or even researcher, one comes to read everything through the lens of anorexia, becoming the docile body that Foucault (1977) wrote about. Yet some girls develop a reflective awareness of how they are positioned in the clinic, which creates possibilities for girls to rupture existing discourses and relations of power.

8.4.2. Lunatics and anorexics

As alluded to above, many negative and stigmatising myths about psychiatric patients abound and these are disseminated by media texts, particularly popular films. Media conceptualisations of mental illness borrow from medical fact and fiction (A.McDonald & Walter, 2001). A discourse that frequently appears in films is that those with mental illness are mad (Rosen & Walter, 2000). Often no distinction is made between different diagnoses and the nature of the symptoms. For instance, in the 1996 film *Cosi*, the head nurse comments: “the patients are on varying degrees of
medication...don’t let that worry you—just worry about the one’s who aren’t” (Rosen et al. 1996). Representations of mentally ill patients as requiring heavy sedation reinforced the notion that patients are mad (Rosen & Walter, 2000). These films have a considerable impact in informing public conceptions of mental illness (Rosen & Walter, 2000; see Abby’s description above), as do many of the historical discourses, such as referring to patients as lunatics until the 17th century (Minnesota Psychiatric Society, 2005). These media representations and historical discourses inform how the anorexic is constituted by the girls and others.

In her interview Natalie described anorexia as ‘like schizophrenia.’ In making this claim Natalie draws on a popular myth about people with schizophrenia as having split personalities. This construction was introduced and reinforced by the 2000 film *Me, Myself and Irene*, which starred Jim Carrey and Renee Zowellger (Rosen & Walter, 2000). In the film, the protagonist Carrey is described as having “advanced delusionary schizophrenia with involuntary narcissistic rage.” The film received widespread criticism for its misrepresentation of schizophrenia from many mental health organisations (Byrne, 2000). In the film Carrey, the protagonist, is represented as struggling against himself in different contexts as a result of his delusions. Natalie gives a similar description of herself in explaining how anorexia makes her behave strangely in some contexts. For instance, Natalie described how when she was in the city people would accidentally bump into her, as often happens on crowded streets, but Natalie yelled at them because she felt so tired and weak- even though she knew this was odd behaviour. Natalie attributed this behaviour to the anorexia, explaining that anorexia was the reason for her “weird, annoying” behaviour.
In the extract below, Angela explains how her brother’s friend George believed Angela should be dealt with:

*Angela*

*Like, I remember when I was in hospital in ‘99 for a year like this guy [George] was saying to my brother, why don’t you just pin her down and shove food in her mouth and all that.*

In this extract George is constituted as impatient with anorexia. George appears to position anorexia as a superficial (feminine) condition that he is not prepared to tolerate. George seems to give voice to a common public perception of anorexia, that it is superficial and self-induced (Bemis-Vitousek, 2000) and women should be forced to eat. This treatment has a long history in feminist writings on women’s madness. “The female lunatic is less easily tolerated…women’s madness is being constantly closed down by the ubiquitous presence of hysteria” (Martin, 1987, p.14-15).

Feminists suggest that medical discourse categorically positioned women as mad, as out of control and requiring force to contain her, but little care and attention is paid to the specificity of the women’s symptoms (de ras & Grace, 1997). Such a description resonates with how George is positioned as treating Angela.

Karen categorises anorexia as one of a number of psychiatric illnesses. Karen claims that many of her friends suffered from anxiety and depression and they could empathise with Karen because they know “what it’s all about.” Feminists have been critical of this conflation of anorexia with other psychiatric illnesses and counter medicine’s claims by reiterating the large numbers of so-called normal women who
frequently engage in excessive dieting and exercise (Bordo, 2004; Way 1995; see 4.3.6). Taking a different position to these authors; Karen does not construe a psychiatric diagnosis negatively. Karen situates anorexia as a mental illness and therefore part of a group identity although, as she explains elsewhere, both she and her friends often become simultaneously distressed and make each other feel worse, not better. Yet as Butler (1997b) argues, membership of a social group, despite ambivalence about this belonging, is more desirable than no life at all. Butler’s (1997b) argument resonates with how Karen positions herself: as part of a group of friends who all have mental illnesses, although this is undeniably a painful identity for herself and others.

Other girls found the conflation of anorexia and mental illness to be a negative positioning. Renee spoke about having to lie to her old classmates about coming to the clinic, because of the nature of her condition. “Having a mental problem…it’s not the kind of thing you can tell people.”

Amanda claimed that people did not understand how “horrible” it was to have anorexia, particularly because people “don’t know you get OCD from anorexia.” Amanda reported how her OCD took different forms, such as extreme exercise and excessive cleaning. Amanda firmly believed that her OCD came through having anorexia, although this is disputed in the medical literature (see 4.2.1). Amanda’s construction of OCD is not a report of what doctors have told her, she extrapolates it from her own experiences and feels very distressed about her condition.
Appropriating anorexia as a mental illness is a means of refusing reductionist explanations for anorexia; such as that girls develop anorexia because they want to be thin (Boughtwood, 2003; see 4.2.6). This particular construction angered Amanda, particularly as it informed how anorexia is conceptualised in school curriculums (see 7.4.1). Amanda said she had asked if she could leave class for the few periods when anorexia was discussed, because she “found it too hard to take.” Other girls were also anxious to be recognised as ill, not just thin, such as Angela:

\[
\text{Desiree: why did they (doctors) get sick of you, was it?}
\]

\[
\text{Angela: Because I wasn’t getting any better and I was getting worse if anything, and I don’t think I was being a too good influence on the girls, so I think they just got fed up with me and put me in the psych ward.}
\]

Angela explains that the reason she was moved to the psychiatric ward was that “doctors got sick of her.” In Angela’s construction, she was not a bad patient but her illness was too hard for doctors to handle. Angela claimed she was getting worse, not better and being a bad influence on the other patients and the doctors “got fed up.” In making this claim, Angela creates a hierarchy between herself and the other patients, she is more ill than they are and should not be allowed to influence them by remaining in the ward. Her use of “psych” (psychiatry) instead of adult ward is perhaps an intentional linguistic strategy employed here to reinforce her position as more unwell than other patients, as psychiatry carries connotations of serious illness. However, in her descriptions of the psychiatric ward she takes the opposite position, construing the other patients as more unwell than her. The extract below is an account of Angela’s experience with a female patient who had schizophrenia:
Angela

All the other patients as well, [...] like a lot of them have like mental illnesses and they’re scary. Last year I was in there for a week. We had a woman who was trying to take all my things from my room and I was like; “No, they’re mine” and she just like kept trying to take them away and then [...] all just stuff like this-I don’t belong in here.

Angela evokes a distinction between anorexics and other psychiatric patients: “a lot of them have mental illnesses.” In Angela’s construction, anorexics are not mentally ill; which means that anorexics are not scary; nor do they steal. Anorexics are normal. Employing this distinction between anorexics and other patients enables Angela to construct herself as not belonging in a psychiatric ward. Similarly, Sophie drew a distinction between anorexia and other mental illnesses:

Sophie

Like I, I don’t respond that well to people [doctors] asking me if I’ll kill myself and have voices in my head so, I don’t really like that.

Sophie suggests she becomes angry when asked about suicide and other questions that make up a standard psychiatric evaluation. Upon a patient’s admission to hospital, the assessing team always asks about suicide because it is an immediate and pressing concern to psychiatrists. Sophie’s description “voices in the head” are a medical construct of schizophrenia and this knowledge has infiltrated popular contexts such as films, again particularly Me, Myself and Irene (see 8.4.2). Sophie considers that being
asked about these two issues always/already interpellates her as a psychiatric patient, a position she refuses, and she responds angrily.

The ambivalence of anorexia lends itself to be constantly (re)configured and reconstituted as evident in the diverse responses to the actions of Melbourne based anorexic twins, Clare and Rachel Wallmeyer. Clare and Rachel, now 34, have struggled with anorexia for over twenty years. In an effort to cope with their pain and to lose more weight they use amphetamines, and have engaged in petty theft to support this habit. The variation in public opinion about whether the twins should be convicted (Gaitz & Clearly, 2004) makes visible the uncertainty about the nature of anorexia. There is contestation as to whether anorexia is a mental illness, despite the dominance of medicine in explaining and treating anorexia. Most girls are aware that anorexia is and is seen as a complex category, which enables them to continuously constitute themselves through different, often enabling subject positions.

8.4.3. Sickness or superficial stories: Contestations of anorexia as illness

In the interviews girls described how the diagnosis of anorexia and admission to hospital provoked some negative reactions from family and friends and these echoed girls concerns about treatment, including the stigmatisation of being treated for a psychiatric illness. These negative constitutions borrowed from discourses of psychiatric illness, social and familial expectations and what was construed as properly sick. Because anorexia is assumed to be able to be ‘fixed’ by eating some girls were labelled “sad and weird” by their friends and family, rather than sick.
Carrie interpreted people’s questions about her condition to mean that she was too fat to have anorexia, and operating from their assumption that there was no reason, she invented various explanations about why she was in the clinic:

Carrie

*I never saw myself as being thin; I was like how can you have anorexia if you're fat? That’s what I always just thought [...] so, like and I was always embarrassed if people asked me why I was in hospital, I used to make up other reasons for why I was in the Children's Hospital.*

Carrie desires emaciation and works hard at being anorexic but claims that she fails to achieve this, and interprets others questions about why she was in hospital as further recognition of her failure to appropriately embody anorexia.

Girls who believed they were not “really sick” were also concerned about the implications of being in the clinic:

Abby

*I'm hoping they still think of me as the same girl 'cause [cough] in one way that's why I want to start over completely with new friends, new life and everything so I don't get recognised as that girl [with anorexia].*

Abby suggests that diagnosis and hospitalisation has marked her so irretrievably that she may need to “start over completely…with a new life.” Such a claim is constant
with Abby’s construal of the clinic as like the film *Girl Interrupted* (see 8.4.1). Abby is afraid she will always be positioned as mad and has to fashion a whole new identity to cast off the stigma of anorexia. A somewhat radical means of avoiding stigmatisation is to claim she was given the wrong diagnosis:

> Abby

> I don’t think [...] ’cause I reckon to be anorexic you’ve got to be that stick figure look as well. There’s no way I’m a stick figure look. And my aunt supposedly was like 34 kilos or something and I was never 34 (heh) kilos.

Abby draws a comparison between herself and her aunt, who was hospitalised for anorexia in a psychiatric clinic in the same city. Abby suggests that anorexics, including her aunt, embody a stick figure look that she does not have. Abby has a stake in proposing emaciation is necessary to be anorexic because it means it is unnecessary for her to be in the clinic. In claiming doctors got it wrong she can claim misdiagnoses rather than mental illness.

The reactions of her family and friends to the diagnosis of anorexia upset Angela. Angela told me that she wished to be seen as “normal,” although this claim contradicted other storylines in her interview. Her family formed part of a close-knit school community who provided support throughout Angela’s illness. However, Angela’s perception was that some of this community “judged her” for being admitted
to a psychiatric hospital. Angela was upset by people’s suggestions that she was mad and out of control. Other people expressed sympathy for her, which she did not want either. Others’ constructions of Angela’s “problem” contradicted how she positioned herself. Angela acknowledged that she needed to gain weight but she saw this as completely different to being psychotic.

In opposition to how Angela was positioned; Rita’s friend Albert suggested Rita could help herself:

*Rita*

*He’s like, [...] I don’t know; it’s weird with him [Albert] because he hates the fact that I’m in here, he thinks it’s my fault.*

Rita reads anorexia as affecting her friendship with Albert, who blames Rita for “having anorexia.” The construction of anorexia as something deliberately taken up has a long history in medical and popular discourses which construct anorexia as prompted by and a result of women’s vanity and foolishness (Brumberg, 1988; see 8.2.2). Media portrayals of celebrities with anorexia such as Cherry Boone O’Neill, the daughter of singer Pat Boone, Karen Carpenter and more recently Princess Diana have worked to frame anorexia in this way (Way, 1995). In media reports and thus in public perceptions anorexia is constructed as a “yuppie sort of illness– a phase that mainly affluent young women go through and grow out of” (Touyz in D. Williams, 2001, p.58). Rita suggests that Albert blamed her for having anorexia. In Rita’s reconstruction of how Albert feels, Albert is construed as being angry about Rita’s
‘illness.’ Albert hates that Rita is in a psychiatric clinic and thinks it is the wrong place for her, yet paradoxically sees it as her fault that she is in the clinic. Rita explains elsewhere in the interview that Albert holds the view that Rita would not be in the clinic if she was not overly concerned about her physical appearance. Albert’s construction of Rita positions her within two opposing discourses—she is construed as vain, and this construction invariably implicates sociocultural prescriptions of thinness. Yet Rita is also held accountable for her vanity, although this vanity is a product of the culture in which she is located. Rita’s account suggests this contradiction has perhaps not yet permeated popular understandings of anorexia.

There is a lack of public understanding of anorexia (Beumont, 2003; Boughtwood, 2005) but it is not confined to the general public; even some nurses show little sympathy for anorexia, as Carrie experienced first hand:

_Carrie_

there’s two nurses that are like look, don’t you feel bad, because you know such and such has got cancer and they can’t help that, you know, you’ve just got to eat [...] and it’s just, you know, you feel like the bad person.

In this extract anorexia is again construed as intentional and Carrie is foolish, labelled a “bad person” because she has a superficial condition that could be fixed so easily, simply by eating. A binary is evident in reactions to physical (such as cancer) and mental illness. If the illness can be seen and understood, the patient is construed as sick. The mentally ill, on the other hand, invoke anger, frustration and fear because they are seen to refuse the treatment offered, and get worse. This stigmatisation of
mental illness is deeply ingrained in social circles, yet Carrie’s comments suggest it has also permeated medicine, as echoed in the clinical literature. “Nurses begrudge caring for people who appear to have self inflicted problems because they utilise valuable resources and are somehow seen as less deserving” (Franko & Rolfe in Marks, 2000, p.119).

The discussion has illustrated the convergence of discourses of anorexia, mental illness and normality in both talk and text. Girls’ accounts make visible the lack of understanding of anorexia and this positioning has a number of consequences for girls in many different contexts.

8.4.4. Blame and shame: Anorexia as bad behaviour

Some girls suggested that because their family and friends could not understand anorexia, they categorised anorexia as strange, bad or deviant behaviour. These constructions sometimes distressed the girls, who explained they were ashamed about things they had done, like expressing uncontrollable anger toward their families, but felt unable to do anything about it.

Renee’s friends responded sympathetically to her admission, but still found it “shocking.”

 Renee
They were all pretty upset about it but at that age [13] it wasn't something we'd discussed, really, like I was just in hospital, there wasn't really any in depth discussion about it.

Renee remembers her friends all being upset about her being in the clinic “but it was not something we discussed at that age.” Hospital is represented as frightening and mysterious, requiring age, a familiar cultural marker of wisdom, to understand the significance of being hospitalised.

Christabel’s family also reacted strongly to her admission. She mentioned this several times in the interview, concluding that her family now saw her as “weird and scary.”

Christabel

Yeah. I think it hospital just scared them. They don't go to such extremes- like I don't think (sob) yeah. I don't think they thought I'd do that. And I think they, they found that a bit weird, bit hard to cope with.

Christabel considers that her family saw her as “going to extremes…which [the family] found weird, a bit hard to cope with.” In this account, the clinic is construed as a discursive and material location that marks Christabel as different from the rest of her family. Christabel remembers her mother believing her daughter would never be normal:
I had another boyfriend before my boyfriend now and yeah, my mum was just really happy. She's like; I did never think you'd be like a normal child again and I was like, oh thanks mum. [Laughter] She's like no, you know what I mean.

In this extract, having heterosexual relationships during adolescence is construed as a mother’s proof that their child is normal. Yet this construction is not simply imposed on Christabel by her mother. Christabel also articulates a desire for normality and she feels that she has failed at being normal for much of her life, commenting: “I feel really stupid because you don’t know…having missed out on all the phases when you’re in year ten and stuff.”

There are longstanding consequences to being located as Other than normal as Christabel elaborates elsewhere in the interview. Although it has been six months since her last admission, her sisters still refuse to talk to her, along with many of her friends:

Christabel

Just because I know that like- something like this happens, like you go into hospital or something and you- you do realise that 99% of your friends you just don't speak to again.

Christabel claims that her friends turned away from her without her really knowing why and she assumed it must have to do with her admission to the clinic. The reaction of her friends saddened Christabel and she struggled to come to terms with it.
Christabel explains elsewhere that her friends became angry with her when she was losing weight, not understanding why she would not eat. Their confusion intensified more when Christabel was admitted to hospital under the auspices of psychiatry and they eventually stopped contacting her because they were at a loss about how to deal with her non-eating, anger and irritation.

Jamie re-constructed an account of her mother’s reaction when she was first diagnosed:

Desiree: Why is she [mother] unhappy about having a daughter with anorexia?

Jamie: I’m not sure. <I think she likes me to be perfect. Cute and perfect.>

It’s really hard.

Throughout Jamie’s illness, she saw many health professionals with different qualifications who attempted to help her understand why she had anorexia. Jamie and several of the other girls found the therapists’ search for one cause of anorexia to be problematic and confusing. As the therapist seemed to require girls to pinpoint one reason, some girls felt they needed to invent a plausible explanation as to why they had anorexia but because they did not have one reason they grasped what the therapist offered. Among other explanations offered in therapy Jamie learnt that women aspire to be thin and anorexics take this too far (see 4.2.6). Taking up this discourse, Jamie suggests elsewhere in her interview that she may have reduced her weight in an attempt to become cute and perfect, as her mother desired. However Jamie reduced her weight too much and ended up in the clinic. Jamie suggests she failed herself and
her mother in her elusive search to have the perfect body, which she finds “really hard.”

Several girls perceived that their mothers’ desired to have ‘normal’ daughters. In girls’ constructions of how their mother’s perceived ‘normal’ behaviour, ‘normal’ is translated as slim but not too thin, cute enough to attract a boyfriend and enjoying their social and schooling life. However the idealised discourses about stages of appropriate development for adolescents and the place of the daughter in the family do not account for a daughter having anorexia. Elise suggests that she has failed in her older sister role:

*Elise*

*Like he’s my little brother, I should be a good role model, not like- not <talk to him> about everything bad I do, he just makes it as an excuse for his own badness.*

In berating herself for the way her brother behaves, Elise draws upon a familiar, traditional familial discourse, that the older siblings should be a role model for the younger. In Elise’s construction, anorexia is construed as bad behaviour. Elise does not lie or steal as some anorexics do when they become desperate (Sheridan & Collins, 1983); her “being bad” is a reference to her eating habits, such as refusing to eat family meals. Elise construes her conduct as shaping her brother’s behaviour “he makes it as an excuse for his own badness.” Elise takes up the regime of truth about the older child’s role to mean that she should do something about the way she believes anorexia is making her behave.
This part of the chapter shows how myths about psychiatric patients as bad and badly behaved are visible in contemporary construals of anorexia and mental illness. These positionings evidently caused girls much distress. Girls can articulate counter discourses by troubling the meanings of particular labels and by claiming family and friends do not understand anorexia.

8.5. In summary…

Anorexic subjectivity is constructed by power-knowledge that regulates constructions of anorexia. One construction of anorexia that is becoming more pronounced in therapeutic circles is the construction of a split between the girl and anorexia, which is how the doctors in this study conceived of the girls. Some girls took up the externalisation as offered by clinicians, while others vehemently rejected this construction. However, some girls seemed unable to take up anorexia or a position outside it without first being inserted in medical discourse, which is perhaps because of the girls’ clinical location where they confront anorexia only as mental illness.

The chapter illuminates the contested nature of anorexia. These different discourses about anorexia inform some girls’ subjectivity. Anorexia is constructed as becoming entangled with identity, which was constructed as both productive and oppressive to the subject. The self was construed as opposing anorexia, although anorexia was also located as part of the self (also see Malson, 1998). Anorexia was construed as having a multiplicity of different effects on the subject. In possessing a bigger body, girls found that their anorexic identity was subject to renewal and their discursive struggles
illuminated the difficulties in trying to negotiate an appropriate private and social identity.

Various subject positions are produced by the conflation of constructions of anorexia, mental illness and psychiatric hospitals. There are a number of different constructions of mental illness and psychiatry and some of these can be traced historically and are represented in the media. Historically, mentally ill people have been labelled as mad, seen as badly behaved lunatics who require locking up but are also deserving of sympathy (Goffman, 1968; Shorter, 1997). These discourses appear in contemporary constructions of mental illness, particularly in media representations. Popular representations of psychiatry informed how girls and their family and friends constituted the clinic and girls location within, positioning girls as mad, bad and sad.

In girls’ reports of their own and others conversations, anorexia and mental illness were merged or categorised as separate conditions. For instance, some girls realised that less bizarre mental illnesses (as opposed to illnesses like schizophrenia) were socially acceptable and conflated anorexia with conditions like depression to produce anorexia as socially legitimate, more ‘normal.’ Alternatively, girls took up positionings of being abnormal and bad in having anorexia because of their non-conformity to social and familial discourses about ‘correct’ behaviour. Girls were distressed at how family and friends constructed them, particularly as there were long-term impacts on their relationships with different people.
I have argued that categories of anorexia, mental illness and patient-hood are shifting and contested. As the examples from films have shown, knowledge of these conditions is not ‘owned’ by medicine but has become part of the social fabric. Drawing on this array of knowledges, girls take up various subject positions in negotiating inpatient treatment for anorexia and thus subvert the dominant discourses of mental illness.

The analysis in Chapters Six, Seven and Eight, although intended for other purposes, has revealed some of the problems in inpatient treatment for anorexia nervosa. Some suggestions for how inpatient regimes could operate differently are included in Chapter Nine, along with a summary of the central arguments posited in the thesis and a discussion of how my work contributes to understandings of anorexia.
Chapter Nine

Summaries and Shifting Stories

This conclusion is in three parts. Part One summarises and draws together the different threads of the thesis to illuminate the overall argument. Part Two considers the practical implications of my research, suggesting some ways in which inpatient treatment could work differently. Part Three elaborates on how this thesis contributes to understandings of anorexia nervosa.

9.1. Overview of thesis

The thesis has argued that girls are simultaneously subjugated and brought into being by medical discourses and relations in the clinic are shifting and contested. Constructing the clinic as a discursive space in which girls are continually negotiating different positions does not mean that inpatient treatment for anorexia is not a distressing experience. It is precisely because of the anguish girls and their families...
experience when told by doctors that hospitalisation is necessary to save a life that a reflective analysis of the clinical context is necessary.

Chapter Two elaborated on the complexities of conducting research and working in the clinic. My interviews took place over a 14-month period during which I was witness to and involved in many complex situations with girls and doctors. Like other feminist researchers, I have shown that interviewing is an intricate process involving continual negotiation with different players. An openness to engage with all the players in a context is a necessary part of ethical research practice.

Poststructural theory informed the analysis of the interviews and a detailed discussion of poststructuralism and discourse analysis is outlined in Chapter Three. In this chapter the specific arguments of the five different theorists whose work I have utilised in this thesis were illuminated, specifically: Michel Foucault, Elizabeth Grosz, Judith Butler, Elspeth Probyn and Deborah Lupton. These authors offer theoretical and conceptual possibilities and insights that informed my work, but I have also extended and diverged from these writings as evidenced in Chapters Six to Nine.

Medical discourse claims anorexia nervosa as its remit, yet other disciplines have contributed to understandings of anorexia, often drawing on or responding to medicine (Hepworth, 1999). Chapter Four examined medical constructions of anorexia, focusing largely on 20th century literature about causal factors of anorexia. Among other constructions, anorexia has been conceptualised as: an embodied defect, a desire for perfectionism, a perpetual distortion, a drive for thinness, an effect of
family dynamics and a response to images of thin women in contemporary Western societies. Feminist scholars made the first foray into analysing the sociocultural contributions to eating disorders (Lelwica, 1999). Once a contested factor in this field, sociocultural issues are now firmly established as a contributing cause of anorexia in medical literature (Nasser & Katzman, 2003). There has been a recent move in medical circles to combine all conceptualisations of anorexia, in attempts to produce a ‘fuller’ picture of anorexia, which is profoundly problematic as it brings about a number of conceptual and epistemological problems (Hepworth, 1999; Malson, 1998). Also examined in this chapter were four qualitative studies on anorexia nervosa and treatment. I focus on these studies to highlight the differences between my work and these studies and to show how different perspectives add to understandings of anorexia nervosa and inpatient treatment.

The complexity of anorexia is reflected in the lack of successful treatments (Ben-Tovim, 2003). Chapter Five described inpatient treatment for anorexia nervosa and provided an overview of some of the medical and feminist arguments about treatment practices. Paralleling other feminist critiques of the medical encounter, feminist writings on anorexia have criticised hospital regimes and individual doctors for focusing on the body, rather than the person (Sesan, 1994). However, the divide between feminists and clinicians is no longer as pervasive as it once was (Katzman & Lee, 1997). The problems of inpatient treatment, as pinpointed in both clinical and feminist work (see 5.1.3 & 5.1.4) revealed more similarities than differences in their critiques of these systems. Also attended to in this chapter was a description of the specificities of the clinics in which the research was conducted, including: the organisation of the clinics, qualifications and roles of staff, goals for treatment and
other therapies and activities that are integrated with hospitalisation. The intention of mapping this terrain was to contextualise girls’ talk about anorexia within the clinic.

Clinical and wider social discourses of embodiment are sharply opposed to clinical discourses and girls have to negotiate this dissonance in the clinic (Chapter Six). Medical and wider social discourses deploy different measures in gauging the body’s physicality. Specifically, medicine uses numbers to measure bodies, such as weight and BMI, and society evaluates bodies by outward appearance. Girls have to manage these different technologies both within and outside the clinic and reconciling the two is a bodily struggle. The different discourses of embodiment play into different and opposing constructions of the meaning and purpose of food. The analysis echoes the work of Lupton (1996) and Probyn (2000), revealing that people deploy food to take up certain subject positions. The categorising of foods in specific ways is not exclusive to the talk of anorexic girls but appears in the rhetoric of men and women outside the clinic (Lupton, 1996).

In the clinic, weight gain becomes the sole function of food, which contrasts with the place and meanings of food in wider society, such as its place in celebrations and in asserting a feminine or masculine subjectivity (Lupton 1996, Probyn 2000). While it would be a misrepresentation to say that all patients wanted to eat, some girls articulated a desire to eat and reported hunger pangs. Yet clinical regimes seem to work against the desire to eat by requiring girls to eat large amounts of bland and sometimes unpalatable food in a tense environment of continual surveillance.
Foucault (1977) and others such as Goffman (1968) who have written about institutionalisation illuminate how institutions physically and psychologically removed people from their social worlds. However, my analysis suggests that although hospitalisation physically removes girls from society, social discourses infiltrate the clinic and are deployed by several girls to construct a public persona or identity and to inform their relationships with others in the clinic. Girls illuminated as to how ‘anorexic practices’ such as healthism discourses, dieting rituals and eating regimes are pervasive in wider society. Girls mobilised these social discourses and applied the gender divide of wider society to food by categorising food as masculine and feminine. Food was constituted through binary oppositions of good/bad and healthy/unhealthy. Some girls attached moral meanings to restrained eating, constituting themselves as knowledgable and disciplined subjects.

Grosz (1994) writes about how bodily fluids shape subjectivity. My analysis illuminated how some girls fragment their bodies by speaking of their body in individual parts, arms, breasts and stomach so as to negotiate a biologically possible body. In girls accounts biology constrains bodies. For instance, having sufficient body fat to have breasts means that one will also get periods and while menstruation was construed as unwelcome it had to be tolerated if one wanted breasts.

Drawing on quasi-medical and popular knowledges, girls construed their bodies as individual entities, holding that their bodily functions are unique to them. Grosz’s (1994) writings on the individuality of bodies informed my analysis of the ways in which girls constructed their bodies as unique. Some girls wanted to be anorexic and
even though they did not possess particular anorexic attributes, such as thin arms, they still asserted that their body was *uniquely* anorexic because medical measures of anorexic bodies did not apply to them for multiple and different reasons.

The legacy of Cartesian dualism is evident in treatment regimes for anorexia nervosa. In the clinic the body is positioned as the important entity, as girls are malnourished and thus irrational. Clinicians emphasise the necessity of refeeding girls to a biologically healthy weight (see Chapter Five). As a response to treatment regimes, some girls asserted their mind would remain anorexic despite what the doctors forced upon their bodies. Thus, girls engaged with treatment regimes in ways in that were opposed or contrary to doctors’ intentions, as a means of retaining anorexic subjectivity. However, other girls became very distressed about possessing a fatter body whilst retaining anorexic thoughts. Grosz’s argument that Cartesian dualism is not philosophically or psychologically useful (see 3.6) helps illuminate why treatment does not work. Anorexia is a condition that is deeply and subjectively embodied, but treatment regimes seem to ignore the complexity of anorexia and its entwinement with the social. As a consequence, the allegedly ‘neutral’ clinical regimes are detached from girls’ subjective experience of anorexia.

The clinic seems to work on the premise that renourishment will enable girls to become rational and autonomous and assume responsibility for their recovery. However girls’ constructions of the clinic suggest that clinical regimes actually constrain any autonomy. Chapter Seven illuminates how medical discourses of anorexia both subjugate girls and provide the possibilities for various acts of agency.
Subjects are inserted in the clinical context as mentally ill but take up the clinical discourses to create different ways of being. Here, I employed Butler’s (1997b) theorisation of agency, contending that girls are both subjugated and brought into being through medical discourses of anorexia nervosa.

Foucault (1973) explicated how medicine developed a precise system of categorisation into which ‘diseased’ individuals were fitted. In the interviews, girls described the effects of being assigned a diagnosis of anorexia nervosa, which meant they were always/already positioned as deceptive. However, Foucault’s proposition in *Birth of the Clinic* (1973), an argument which is explored further in his later work *Discipline and Punish* (1977), as to how bodies and subjectivities are produced by the governing practices of institutions, is different to how some girls constituted subjectivity into the clinic. In these clinics, some girls *performed* as good patients by gaining the appropriate weight at the pace that doctors required of them, but this was for a different agenda than intended by doctors. Several girls gained weight to produce a credible performance of patienthood and if girls are successful in this performance and gain the required weight, their stay in the clinic will be very short. However, girls’ *performance* of docility reveals girls’ resistance to being *positioned* as docile patients. That girls can produce plausible performances, both by waterloading and also by eating high calorie foods to quickly gain weight but not ‘recover,’ reveals how easy it is to make a mockery of treatment. This dynamic is perhaps in contrast to the prisoners Foucault (1977) wrote about who had a longer incarceration and were unable to do anything about the duration of prison sentence, notwithstanding slightly shorter sentences for good behaviour.
Butler (1997a) writes about how a censor shapes what can be said about particular events and shapes ‘normal’ and appropriate behaviour for subjects in various contexts. Going against the censor, such as by constructing an alternative explanation for particular events can be an act of agency (Butler, 1997a). In the clinic, girls took up a position as censor, and narrated events in particular ways, such as positioning doctors as mean and unfair rather than concerned about girls’ health.

Girls took up a position as the “worst anorexic” (the sickest and/or the thinnest) as a glorified and desired status in the clinic, by interpellating the other patients in particular ways. Being constituted as “the worst anorexic” or working to constitute oneself as “the worst” involves positioning oneself and others in precise ways in particular discourses. However, girls are also ambivalent about their subjection to the category anorexic. Butler (1997b) describes the subject as becoming passionately attached to the laws which subject it, and in relation to anorexic subjectivity in the clinic, this notion helps generate an understanding of the distress girls undergo in the processes of subjectification to anorexia and patienthood.

Many girls took up anorexia as a subjectivity and identity, or as Other to anorexia. Several girls described their elaborate discussions with doctors to try to convince them that they were honest and not anorexic and thus deserved to be listened to. Discourses of sexuality were deployed as a tool in girls’ negotiations with doctors. Girls used the differences in gender and age between the doctors to their advantage, to engage in performances designed to confuse the doctors. Girls knew that doctors would be uncertain about how to read their actions as it was possible to see girls
behaviour as non compliance with treatment or an aspect of youth culture. Doctors’ uncertainty meant that they had to listen to girls’ complaints about treatment. These different strategies were deployed to go beyond girls’ subjection as patients.

This analysis builds on Gremillion’s (2002) and Lupton’s (1997, 2003) arguments that the medical encounter is complex and shifting. The clinic is a transitory space where the positions that players take up are not only defined by their status as doctors and patients. Rather, different positionings are continually being negotiated. The theoretical frame employed to analyse this context has illuminated these different subject positions, and it is evident that in this context “medical dominance is an inappropriate term and it is neither possible nor desirable to specify who is subjecting or dominating whom” (Fisher, 1991 in Lupton, 2003, p.120).

Butler’s (1997b) contention that a subject needs the Other(s) to guarantee their existence is important in understanding girls’ constructions of interactions with other patients in the clinic. Existing medical and autobiographical literature has little to say on the relations between anorexic patients, save for concern over the competition between patients (see 5.1.1 & 5.1.2). However in the clinic, relationships with others were central to girls’ subjectivities. Other patients had an influence on girls, which girls attributed to the shared experience of ‘being anorexic’ and also to other girls’ personal qualities.

Competition over eating and weighing the least without being detected by doctors was a feature of interactions between girls in the clinic. Like Foucault’s (1977) argument
about prisons producing better criminals, the clinic seems to work to produce better anorexics. Yet competition over ‘being anorexic’ does not take place in isolation from other values and desires. This is another instance of the curious doubleness that seems intrinsic to the workings of the clinic. It is apparent that preserving anorexic subjectivity is an ongoing struggle, as there is tension between being competitive and wanting to constitute oneself as in possession of moral values. For instance, some girls positioned themselves as having a duty to look out for the new patients; advising these girls that they should not lose more weight, which could be read as competition and was designed to subjugate others and also as concern for other girls’ well being and recovery. Although thinness is central to anorexic subjectivity, many girls do not seem to be able to pursue thinness to the exclusion of everything else, as being an appropriate subject in the clinic requires caring, or being seen as caring for others.

A marked feature of the interviews was the difference between girls’ appearance and the ways in which they spoke about themselves. Some of the girls who were very thin spoke of themselves differently, claiming that they were fat. Medical discourse may read girls’ constitution of their bodies as a perpetual defect (see 4.2.3). An alternate reading is that fatness is the dominant language of anorexia and as this is not called into question in the clinic, girls persist in constructing themselves as fat despite the size of their bodies. Butler (1997a) has suggested that bodies can exceed their speech acts (see 3.5), an argument that resonates with how I understood girls’ attempts to constitute their bodies as different from how I and others (doctors) read their physicality. Girls’ bodies belied the labels they inscribed to them and rendered their words invalid.
Grosz (1994) has attended to the corporeality of the body, contending that different bodily fluids produce particular responses from other people. Grosz (1994) suggested that vomit is a particularly contentious fluid that invokes others’ disgust. Yet in the clinic girls response to others vomiting is not straightforward disgust. Vomiting is construed as a legitimate aspect of being anorexic that is condoned by other patients, and the girls share with others these and other details of weight loss behaviours, that are construed as necessary to maintain an anorexic body and anorexic subjectivity. Girls only expressed disgust if they could smell other girls vomit and thus girls imposed sanctions about where vomiting was permissible. In sum, Chapter Seven has illuminated the multiple ways through which girls trouble how they are constituted and supposed to behave in the clinic. Girls take up the medical discourses through which they are positioned, such as dishonest and competitive over weight thus deploying treatment regimes to create other subjectivities.

Chapter Eight examined some of the different constructions of anorexia, mental illness and psychiatric institutions that constitute and play into the subjectification of anorexic teenage girls. Anorexia and mental illness are not unitary categories but can be troubled and contested. Doctors’ attempts to externalise anorexia from girls had a multiplicity of effects on girls’ identities and how they constructed themselves in relation to discourses of anorexia.

As Butler (1997b) illuminates, subjects take up positions within particular discourses in which they are invested, so to ensure the continuity of these discourses. Girls revealed that they were invested in particular aspects of anorexia. While the outward
signifiers of anorexia are immediately observable, such as emaciation and peculiar eating behaviours, anorexia was constituted as having a multiplicity of psychic effects on subjects that were invisible to other people.

Girls attempted to take up what they positioned as the desirable aspects of treatment regimes. For instance, one girl attempted to take up the external controls of the clinic as an internal constraint on the self so as to be a controlled (anorexic) subject. This construction has some parallels with Foucault’s (1977) explanation of self-surveillance that has been taken up by feminist scholars such as Bartky (1988), who explained how women participate in self-surveillance by internalising norms of femininity and engage in weight loss behaviours and beauty regimes like waxing to maintain thin, hairless bodies. However, this analysis diverged from Foucault’s contention (1977) and feminist extenders of his work, as the girls took up the governing practices of the clinic differently than intended by the doctors. Both as patients and upon discharge from the clinic girls deployed what they had learnt from the clinic, so-called normal eating behaviours such as eating at set times, so as to lose more weight.

Girls constituted themselves as trying to resist what they construed as negative aspects of anorexic identity and retain the positive and desirable aspects, such as thinness and a persona as controlled and disciplined. Yet in girls’ constructions, these aspects do not exist in binary opposition to each other; for example control was construed as both prohibitive and productive.
The thesis supports Probyn’s (1987) argument that anorexia is a strategy for negotiating the discourses that attempt to appropriate and categorise bodies. The girls drew upon both contemporary and historical knowledges in discursively constructing anorexia. Although these clinics operate through the discourses of current Western medicine, girls mobilised constructions such as ‘thin is beautiful’ discourses and ‘historical’ constructions of mentally ill people as mad and requiring locking up (see Chapter Eight) to trouble how they were constituted in various encounters and discourses.

The variety of stigmatising discourses about psychiatric illness informed how some girls and their friends and family constituted anorexia. These girls reported how their friends and family expressed exasperation at their refusal to eat, suggesting that they were sad, sick, vain, abnormal and selfish. However, girls intervened in such discourses, refusing to be constituted in this way and not allowing negative constructions to shape their identities and subjectivities. For instance, some girls traced a distinction between anorexia and other mental illnesses. Those girls had been hospitalised in general psychiatric wards described their interactions with patients who had illnesses like schizophrenia, drawing on these experiences to constitute themselves as Other than mentally ill. Other girls saw the alignment of anorexia and mental illness as more of a positive positioning and merged anorexia with conditions like depression to produce themselves as legitimate subjects and as part of a larger group. The confusion and ambivalence about the nature of anorexia in both medical and social circles (see Chapter Four) has provided space for girls to produce themselves through multiple, sometimes contradictory discourses.
The discourses of anorexia and the governing regimes of the clinic carry much discursive power. These authoritative scripts and material practices subjugate girls, positioning them as anorexic patients by establishing norms of what an anorexic patient should do and be. Some girls are ambivalent about their subjection to aspects of anorexia, and use these same discourses to generate other subjectivities.

9.2. Implications for hospital practices

This section considers some of the implications of my analysis for treatment regimes. There has been some debate as to whether theoretical work can have practical implications. For instance, Butler has been criticised for the lack of political implications and definitive answers in her work (Nussbaum, 1999). One of the strongest attacks on her work is by feminist author Nussbaum (1999). Nussbaum (1999) contends that Butler’s work is a “virtually complete turning away from the material side of life, towards a type of verbal and symbolic politics that makes only the flimsiest connections with the real situation of real women” (1999, p.2). In contrast to Nussbaum’s criticisms, I suggest that Butler’s work can be used to analyse particular forms of power that operate within a context and subjugate players in particular ways and to various ends. This theoretical analysis can be deployed in offering suggestions as to how the site might operate differently.

The interviews revealed girls’ pain, distress, embarrassment and ambivalence about treatment. There are some problems with the ways in which anorexia is currently being treated in these clinics. Based on this research, the suggestions outlined here are
related to certain components of treatment routines and relations between doctors and patients.

Chapter Six highlighted the gap between clinical regimes and social notions of appropriate physicality. Wooley and Wooley (1982), in discussing The Beverley Hills Diet, which they term The Beverley Hills Eating Disorder, include a message for doctors. “That training in anorexic psychopathology is selling so well holds a message…And it reveals a degree of desperation heretofore unknown…no price is too high for thinness, including health (Wooley & Wooley, 1982, p.65). The only food consumed on The Beverley Hills Diet regime is fruit, which works as a natural laxative. The authors pinpointed how these anorexic behaviours are now embraced enthusiastically by the general public and urge clinicians to consider that in the outside world, the pursuit of thinness through exercise and semi-starvation diets is the norm, particularly for women.

Social values are in opposition to embodiment in the clinic. Here, the girls are learning to eat in ways that will put on weight. The required weight gain is made explicit to them, as girls are told they need to gain one kilo a week, which girls (and other ‘normal’ people) would see as a frightening prospect if it were taken on as an everyday eating regime. The paradox is that girls are not going to survive in the outside world without a will to live; however they will not survive in the clinic either. Girls resist the life force that is being offered by the clinic (re-feeding) as this opposes the body that girls’ are attempting to create.
The dilemma that doctors and the clinics confront is that there is tension between attending to the physical side effects of malnutrition and helping girls manage their own lives. It is important that girls find a balance in eating, exercise and other facets of their lives, rather than making weight loss and gain the sole focus.

Currently, girls’ forced engagement with the re-feeding regimes of the clinic means they experience difficulties in negotiating eating in the outside world (see 6.3). Informed by an understanding of the dissonance between social and clinical constructions of food, I contend that if food was presented in a more balanced and varied way in the clinic, then girls may be more encouraged to eat (also see Probyn, 2005). Instituting more usual eating practices such as a variation in the foods served and times that meals are eaten could serve to reduce the ‘release anxiety,’ to borrow a term from Goffman (1968), that girls experience in being discharged and having to eat in a ‘normal,’ less structured environment. Some clinicians have begun to integrate some spontaneity and choice into their practices around food, including a meal in a restaurant during inpatient treatment (Beumont, Russell, & Touyz, 1993) which seems to work well (personal communication, M. Boughtwood, 2003). I argue that one of the reasons for the apparent success of Maudsley Family Therapy (see 5.2) is that it incorporates ‘normal’ eating practices, as girls have to eat in the family context, eating the same meals as the rest of their family members. However, MFT is implemented in the home, which means that food is still medicalised for the duration of girls’ stay in hospital. Other possibilities for presenting food differently in hospital include employing people who are independent from the hospital to work with these girls, a nutritionist who could run cooking classes (Probyn, 2005), a life style coach.
and exercise therapist. These people are not constrained by medical discourse and could offer alternate discourses to girls.

Changing the construction of food in the clinic opens up the possibilities of dissolving the binary between social and medical constructions of food. Making the social formally part of treatment regimes, rather than these discourses incidentally or accidentally infiltrating the clinic as is currently the case, could help girls to manage and perhaps even enjoy food.

A paradoxical feature of clinical life is that doctors do not seem to question or challenge the discourses about weight and food that the girls are using, for example, 50 kilos as obese. The point is not whether girls should be informed of or need to put on weight. Rather, I suggest it is important for clinicians to question the language of anorexia, and this should happen in daily conversations between clinical staff and patients. The authoritative figures (doctors) have an important role in helping girls find a balance as doctors are in a position to offer a counter discourse to the current rhetoric of anorexic-speak, by troubling girls constitution of themselves as fat.

In considering doctor-patient relations, it is important that girls are treated with respect. It is important that clinicians acknowledge their patients as people, not only as anorexic patients. Treating patients with respect would include girls being privy to discussions of their treatment and providing explanations of the reasons for particular procedures. If these practices were implemented there may be fewer attempts by girls to sabotage treatment, trick the doctor and thus hurt themselves (Sesan, 1994).
The logic behind food refusal is complex and contradictory and differs widely between girls. For this reason, doctors need to attend to the subjective meanings of an individual’s food refusal. For example, if girls are using starvation as a means of expressing some pain or conflict that they are experiencing, then it is not helpful to sufferers, their families and the therapists working with the girls for this behaviour to be interpreted only as faulty (B. Thompson, 1994). A relational manoeuvre, so that the therapeutic relationship is reconfigured in a more positive and ethical way could help facilitate ‘recovery.’ For instance, if clinicians recognise that some girls are invested in being anorexic and this investment is ambiguous and not merely about being thin (Bemis Vitousek, 2000) this could have positive implications for therapeutic relationships.

Many writers have questioned anorexia’s status as a psychiatric illness on the grounds that some of the clinical signs of anorexia are similar to allegedly normal eating and dieting behaviours (Gordon, 2000; Malson, 1998). Anorexia is also construed as desirable in popular discourse and people frequently make comments that they wish they could catch “a bit” of it (Brumberg, 1988). A comparison between anorexia and schizophrenia was briefly discussed in Chapter Four to highlight the inappropriateness of constituting anorexia as similar to other psychiatric diagnoses. The differences in the symptomatology of these illnesses are apparent even to a layperson, and it seems incongruous that patients with anorexia are treated in general psychiatric wards. It is difficult to see how either group of patients would benefit from an integrated ward. Chapter Eight contained some of the negative descriptions that anorexic girls articulated about patients with schizophrenia. The girls who had admissions in the
general psychiatric unit suggested it was frightening and disorientating to be hospitalised with other mentally ill people, a claim that is echoed by the biographical accounts of anorexia (Loewenthal, 1996). While economic factors may be one reason for the integration of patients, the reorganisation of wards to clearly demarcate patients from one another would be helpful for patients with both diagnoses.

The literature suggests that relationships between anorexic patients are based on competition and there is little acknowledgment of any other dynamic (Segal, 2003; Hornbacher, 1998). Clinicians position girls as colluding with one another, particularly sharing knowledge about how to covertly dispose of food. The analysis revealed that girls were aware of this generalisation, because they defended their friendships with other patients in the interviews. Based on the analysis presented in the thesis, it would be more strategic and desirable for clinicians to acknowledge there are other commonalities and bonds between girls than the shared experience of anorexia and hospitalisation.

Currently, a binary seems to structure the debate on hospitalisation. Some commentators, including feminist therapists and sufferers have argued that hospitalisation should be abandoned and proposed a number of different treatments as an alternative to hospital. Others, particularly doctors, take the view that these girls are difficult patients and need harsh treatment both to force them to behave rationally and to prevent them from dying (see Chapter Five). There is a multitude of vested interests in continuity of hospitalisation, such as the power of medical and psychological discourses in informing how anorexics are understood and treated.
Furthermore, families and clinicians experience many ethical and moral tensions when faced with needing and wanting to save girls from starving to death. Perhaps a more useful strategy is to take a middle ground, by using other understandings of anorexia to revise current treatment practices. Hepworth (1999, p.130) makes an important point. “No one discourse or discipline can provide the total framework for formulating future directions for the prevention and treatment of anorexia. A range of knowledge must inform the prevention and response.” In particular, this would include incorporating some of the understandings offered by sociocultural explorations of anorexia nervosa into hospital treatment regimes. If young women are repeatedly institutionalised they will lose any sense of their own bodies and how to manage these in re-entering society.

9.3. (In) conclusion

This thesis attends to the perspectives and experiences of adolescent girls whose voices, with few exceptions, are smothered in discussions and debates about anorexia. The stories and subjectivities of anorexic teenage girls are brought into the foreground in this thesis which offers one reading of how girls negotiate the diagnosis of and inpatient treatment for anorexia nervosa.

The thesis has argued that engagements with clinical regimes are more complex than suggested in some medical, feminist and autobiographical accounts of hospitalisation (as discussed in Chapter Five). (In) concluding the thesis it is perhaps relevant to return to how the thesis was conceived. I have had a long and varied engagement with
anorexia. In my multitude of engagements with anorexia I constantly heard similar comments about inpatient treatment regimes: “Isn’t the hospital a depressing place…patients become institutionalised…fattened up like cows…psychiatric patients are so scary.” These comments were usually articulated in social circles and in autobiographical accounts but as I moved into academia, I heard many of them reproduced, albeit in scholarly terms, in the literature on anorexia. Initially I was seduced by the apparently transparent logic of these commentaries. During the research for this project, in interviewing girls and generally being in the clinic, I became intrigued by the complexity of girls’ engagement with anorexia and clinical regimes. Girls generated a variety of explanations for why they wanted to be thin and/or anorexic, borrowing (often unwittingly) from various knowledges of anorexia, and discourses about femininity, bodies and mental illness. The analysis has illuminated how girls negotiate and enact resistance to treatment to construct themselves as other than anorexic patients. Although being medicalised is distressing on many levels, girls can go beyond how they are subjected in these discourses, using these discourses to generate other subjectivities and thus troubling culturally entrenched notions of patients as only passive subjects. I suggest that further research into the medical encounter should explore how subjects deploy and reconfigure clinical discourses to constitute other ways of being.


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Appendices

Appendix One

*Interview Questions*

1. Can you tell me a bit about you…your family, interests and passions?

2. Tell me from the beginning about the history of your eating disorder?

   Significant events? Turning points?

   a) When did you suspect a problem?

   b) When did others suspect a problem?

   c) What lead to you to treatment?

   d) When were you diagnosed?

   e) What do you think were the contributing causes?

3. How has Anorexia affected your daily life? How did you feel about this?

   a) Has Anorexia affected your schooling? How?

   b) Has Anorexia affected your relationships with peers, both girls and boys? How?

   c) Has Anorexia affected you physically or emotionally? How?

   d) Has Anorexia affected the sorts of activities you do and your interests? How?

   e) How would you say Anorexia has affected the public face you present to the outside world?
f) How has Anorexia affected the inner, private you that you keep hidden from most of the world (trust, secrets, fantasies, moods etc)?

4. In what ways has Anorexia affected your relationship with members of your family and the way your family functions?
   a) Do you think Anorexia has affected members of your family? How?
   b) Has Anorexia affected your relationship with members of your family, or their relationship with you? How?
   c) Has Anorexia affected your family’s daily routines and activities? How?

5. What treatment have you received and how did you feel about it?
   a) How did you feel about being diagnosed as having Anorexia Nervosa?
      (disbelieving? surprised? indifferent? Did it change the way you saw yourself or your illness?)
   b) Can you tell me about some of your different treatments you have been involved in? What was helpful? How did it affect you? How did you feel about it at the time? What do you think about that now?
   c) Who or what has helped and supported you through the experience of Anorexia Nervosa? (How did they support you? In what way did you find that supportive?)
   d) Can you think of any support that you did not receive that might have helped you? How would it have helped?
5. Can you think of any deliberate things you did to cover up your illness or to stop people from interfering with what you were doing? (Why did you do that? Did it work? How do you feel about that now?)

6. What things did you do to help yourself? (Why did you think that would help? Did it help?)

7. How do you think the experience of Anorexia Nervosa will affect your future?

8. Is there anything else you would like to mention so people understand what Living with Anorexia Nervosa is like? Are there any questions I should ask people in the future?
Appendix Two

Transcription System

°/I know it, ° ‘degree’ signs enclose obviously quieter speech (i.e., hearably produced-as quieter, not just someone distant).

CAPITALS mark speech that is obviously louder than surrounding speech (often occurs when speakers are hearably competing for the floor, raised volume rather than doing contrastive emphasis).

Underlining signals vocal emphasis; used in sentences where the reader would not necessarily expect the emphasis on a particular word or when the emphasis determines meaning.

[...] square brackets enclosing dots indicate pause and length of pause. [. ] is a very short pause [...] is a medium sized pause and [……] is a long pause.

[sighs] Non-verbal sounds described in square brackets.

But: Semi-colon indicates that the speaker has broken off speech in the middle of a sentence or word.

>he said< ‘greater than’ and ‘lesser than’ signs enclose noticeably speeded-up talk. Can be used the other way round for slower talk.

heh heh Voiced laughter.

um Any similar sounding speech-filler regardless of the exact noise

sto(h)p i(h)t Laughter within speech is signalled by h’s in round brackets.
[R: that's right] Brief interjection by one speaker within the speech of another.
Interviews and field notes and interviews are the two primary sources of data for the Living with Anorexia Project. Field notes provide the contextual descriptions (physical, emotional, atmospheric etc) for positioning and interpreting data, for elaborating on the epistemological frame, and for informing analyses, particularly when humanist (e.g., grounded theory, symbolic interactionism, interpretive post-modernism) or critical approaches (eg, critical realism, post-structuralism) are employed.

1. Contact Notes (CN)

Details about interview date, time and duration, need for follow-up interview, arrangements for further meetings, keenness to participate in other stages of the research etc.

2. Observational Notes (ON)

These are concrete detailed and accurate renditions of what the researcher sees; feels; hears; tastes and experiences. They should include

- physical location of the interview;
- description of the physical setting and context including background noises, interruptions etc
• physical description of participants and any other people who the researcher had contact with eg, siblings in the background, boyfriends wandering around etc
• overall impression of the interview atmosphere (eg, tense, relaxed etc) any changes in the atmosphere during the course of the interview and tentative explanations for this)
• memorable incidents during the interview eg, question where the participant was uncomfortable, enthusiastic, etc.

3. Methodological Notes (MN)

These are notes about the process of data collection. This is the section for noting when and for what reason issues arise with aspects of the methodology. For instance interview questions not addressed or that worked particularly well and why; tape recorder didn’t work and how this has been addressed; instruments that did not work or that participants did not complete and why, etc.

4. Theoretical Notes (TN)

This is the section where initial post-interview interpretations are recorded, including hypotheses, hunches and critiques of the epistemological frame of the researcher.

5. Personal Notes (PN)

These is where the research notes his/her feelings about the research, the people she is talking to and her feelings about the process, as well as any doubts, anxieties, pleasures. This section does not involve censor. Rather, it is the place for articulating and documenting how the researcher’s feelings and emotional responses might impinge on how the interview is conducted and the data interpreted, and affects what/how the researcher lays claim to knowing.
Appendix Four

Notification of Ethics Approval to Chief Investigators

1. Westmead Hospital
2. Children’s Hospital Westmead
3. University of Western Sydney