Chapter One

The Power Of Critical, Feminist Psychology Theorisation:
What Is It? Why Use It? How Can It Work?

1.1 Introduction

The power of critical, feminist psychology theorisation opens out a way of considering eating disorders, hospital based therapeutisation of eating disorder patients, and nurses who care for eating disorder patients as embedded in culture. It is a theoretical framework in which the patients and the nurses can be viewed in terms of a rise and fall and rise again of agency and subjectification and in which psychology is conceptualised as the intersubjective, as ‘a something’ located squarely within soft contours of the discursively constructed individuals.

This first chapter of this thesis is offered over three sections. The first section of this chapter discusses the philosophical and theoretical tenets that underpin this study in the following theoretical overview of this study as a project of feminist, critical psychology. The following discussion differentiates a feminist, critical psychology ontology and epistemology from a ‘positivist’ ontology and epistemology, with the latter theoretical approach recognised as underpinning contemporary conventional psychology. The second section of this chapter offers a literature review in which I consider the background to eating disorders by outlining the scope and significance of eating disorders, the aetiology of eating disorders, current approaches to the treatment of eating disorders, and the issues of nurses are related to those treatments. The third section of this chapter discusses how the aims of this study relate to the qualitative, discourse analytic, interview-based methodology adopted for this study.

1.1 Theoretical overview: What is a critical, feminist psychology theorisation?

The wider ground of understanding in which this research project is situated - put simply - is that we largely live in worlds of ‘meanings’ (Hall, 1997; Efran et al.,
1990). As such, this project explores "the extent and quality ... the particularity" (Figilio, 1982, p. 174) of a certain niche of 'meanings' - a locale of 'meanings' and power relations embedded therein where nurses care for patients with eating disorders. This exploration is a discourse analysis of the nurses' accounts of caring for patients with eating disorders.

The following discussion offers a brief overview of the ontological and epistemological differences between the feminist, critical psychology framework adopted for this study and that of contemporary mainstream psychology. An epistemology is a theory of knowledge (Harding, 1987, p. 3) and ontology consists of claims about what exists - a 'reality' theory ascribing 'existence' in a way that cannot be eliminated or analysed out by reduction (Scruton, 1996, p. 142). This discussion is intended to clarify the research direction and intentions of this project. Following the ontological and epistemological overview the terms of this report are defined. These terms include, as just mentioned above, 'discourse' as well as 'subjectivity' and 'culture'. The purpose of defining these terms is to indicate what work they do in this report, rather than offer definitive definitions.

1.2.1 Epistemology and Ontology

The following consideration of the 'ontological' and 'epistemological' differences between a feminist, critical psychology perspective, and a 'positivist' orientated contemporary, conventional psychology perspective is intended to establish this study's theoretical perspective. It is from this feminist, critical psychology perspective that the literature in the next section of this chapter is reviewed, and on which the methodology adopted for this study is predicated. 'Ontology' and 'epistemology' can be regarded as the latitude and longitude of any research work, directing what kind of research questions can be asked, and what sort of knowledge is valued (Blaikie, 1993; Unger, 1983 & 1996). The terms 'ontology' and 'epistemology' function as types of assumptions understood differently from within different methodological and theoretical approaches (see Blaikie, 1993). As Efran et
al., (1990, p.21) suggest, different methodological and theoretical approaches reflect the “thorny questions of epistemology and ontology – what we know and what we are”. Feminist critical psychology and conventional, mainstream psychology differ in their respective philosophical underpinnings. The following discussion defines ‘positivism’ as a philosophical orientation that underpins conventional contemporary psychology against which a feminist, critical psychology theoretical framework can be understood.

Positivism or a positivist approach, represented in much of contemporary science by the hypothetico-deductive methodology, and “presented as the dominant paradigm in psychology” (Malson, 1998, p. 35), is also known as logical positivism (Bullock et al, 1988 pp. 486-487, 669), or verificationalism (Scruton, 1996 pp 25-32). Logical positivism has a long philosophical history, and was formulated by the Vienna circle in the early 1920’s. It “assumes an objective, knowable reality and is based in the empiricist epistemology that ‘true’ knowledge must be grounded in experience and observations” (Malson, 1998, p. 35). Thus Blaikie, among others, asserts that a positivist ontology entails an assumption of

an ordered universe made up of atomistic, discrete and observable events …

[and that] this order can be represented by universal propositions. Social reality is viewed as a complex of causal relations between events, which are depicted as an emerging patchwork of relations between variables. … [and in positivism’s] epistemology, knowledge is derived from sensory experience by means of experimental or comparative analysis [with] a correspondence posited between sensory experiences, and the objects of those experiences, and between observation statements and theoretical statements. [For positivism] scientific laws are identical to empirical regularities. (Blaikie, 1993, p. 94)

The ‘positivist’ theoretical orientation of conventional psychology is predicated on the above assumptions. Importantly these assumptions underpin the usually
unquestioned notion that language functions as a transparent and neutral medium to faithfully represent an "empirical world of free standing phenomena" (Unger, 1996). Conventional psychology assumes that ‘reality’ naturally occurs, and that this one ‘reality’ is independent of the processes of investigation and language (see Unger, 1983, 1996).

One critique of ‘positivism’ argues from a feminist perspective for the need to "counter the fact that the dominant forms of science [and hence dominant methodologies] have been constructed from a male point of view, by focusing on women’s constructions of the world” (Blaikie, 1993, pp. 100 – 101). Whilst there are a variety of feminist perspectives in the social sciences, a feminist ontology can be said to claim, in opposition to that of positivism,

that both the natural and the social worlds are social constructions, and that these worlds are constructed differently by people who, in different social locations, have different life experiences (e.g. men and women). Hence, multiple realities are possible (Blaikie, 1993, p. 100).

Further in the same explication Blaikie says a ‘feminist’ epistemology “substitutes women’s experiences for men’s experiences as the basis of knowledge … traditional views of objectivity and rationality are [thus challenged]”.

This study adopts a ‘feminist’ epistemology as a move away from ‘positivism’ in that construals of ‘reality’ are considered here to be a product of both individual and cultural construction in that

the existence of such constructive processes suggests that bias is inevitable [and that] people with different epistemological positions will seek evidence to support their different explanations and these explanations will influence their solutions for various social dilemmas (Unger, 1996).
It is very much these 'different explanations' that are sought in taking up a feminist, critical psychology position in this study. In taking a feminist, critical psychology position this study therefore contests the 'positivist' orientation in conventional psychology as "an innocent source of knowledge" (Flax, 1991, p. 10). The ontological position that this study's critical perspective assumes is that

the world is not a universe of facts which exists independently of the observer; theoretical statements do not describe reality, they depend on assumptions embedded in theoretical constructs and commonsense thinking (Blaikie, 1993, pp. 97 - 98).

And similarly this study's 'critical' epistemology considers that "objective observation is impossible in both natural and social sciences due to assumptions held by the observer" (Blaikie, 1993, pp. 97 - 98).

1.2.2 A Post-structuralist Feminist Approach

Whilst the above 'feminist' perspective on 'positivism' makes brief but important points concerning the differences between 'feminist' and 'positivist' epistemologies and ontologies, Blakie's (1993) critique is 'styled' as a more or less a 'generic' feminist position suggestive of an 'intrinsically feminist' research method. His critique thus belies the diversity and range of feminist critiques (see Malson, 1998; Weatherall, 2002a). The array of feminist critiques of both science and contemporary conventional psychology points to the breadth of feminist concerns, differing emphases and varying political interests. For example, 'feminist' scholarship instances critiques of the androcentrism in conventional psychology methodology (Harding, 1987) that results in a 'male-as-norm' principle. And this 'male-as-norm' orientation in conventional psychology methodology that inevitably marginalises and pathologises women has been exactingly explicated (see Malson 1998, see also Ussher, 1991). Similarly, the construction and regulation of gender (Davies, 1989) and "oppressive gender relations [in] an allegedly value-free science" (Malson, 1998
p. 37; Flax, 1991) has been challenged by feminist theorists. Feminist theorists have, in particular, critiqued the constructions of masculinity and femininity as ‘naturalised’ (see Malson 1998, see also Ussher, 1991), and have challenged, for example, the ways in which women are dominantly constructed as less intelligent (Walkerdine, 1993), as mentally unstable (Ussher, 1991; Russell, 1995), and as ‘naturally’ suited to domesticity and ‘mothering’ (see Malson 1998; Malson & Swann, 2003).

Further and importantly, this study assumes a post-structural feminist position. This position ensues, in part, from the understanding (as mentioned above) that language is not a transparent medium through which we view the world. It stands in contrast to a ‘positivist’ paradigm in which language is assumed to have a direct correspondence to a fixed and external reality (see Burman & Parker, 1993; see also Malson, 1998). Rather this study’s post-structuralist position considers that language mediates our representations and hence our understandings of ‘reality’, and so is “constitutive of reality” (Malson, 1998, p. 38). From this post-structuralist position language is theorised as intimately related to discourse (discussed further below). Thus, this study makes extensive use of Foucault’s (1986) theorisation of discourse as cultural regulation (see Malson, 1998; see also Laws & Davies, 2000). The significance also of taking up a post-structuralist position in this study is that the categorisations of ‘femininity’ and ‘masculinity’ - which are taken as ‘givens’ in conventional psychology and function as pre-given, inherent and natural - are problematised. A feminist post-structuralist approach instead specifically focuses on

gendered subjectification, [with subjectification meaning] the historically specific processes whereby one is subjected to the discursive regimes and regulatory frameworks through which gendered individuals and their social contexts are also, and through the same processes, constructed (Davies & Gannon, 2004, p. 1).

A feminist poststructuralist position also challenges and problematises the “notion of an authentic feminine or female experience, identity or desire repressed by
patriarchy” found in some feminist psychology theorisation (Malson, 1998, p. 39). Instead post-structuralism opens up the possibility of “seeing the self as continually constituted through multiple and contradictory discourses that one takes up as one’s own in become a speaking subject” (Davies, 1992, p. 57). This study takes up the position that, as Helen Malson says,

there can be no quasi-natural feminine/ female experience outside of patriarchy or essentially different from male experience. Rather, women’s or men’s subjectivities, experiences and desires are ‘always/already’ constituted in and regulated by discourses and discursive practices … Feminist post-structuralist research is therefore concerned not with an exploration or reclamation of an authentic female experience but with analysing the ways in which women’s subjectivities, experiences and desires are discursively constituted and regulated and with elucidating of the socio-historical specificities of gender power/ knowledge (Malson, 1998, p. 39)

Hence, this study intends to show how

gender … or any structured inequality in each interlocking specific instance gets built into the world – i.e. not ‘gender’ … as attribute[s] or as propert[y], but … as a practice that builds worlds and objects in some ways rather than others, that gets built into objects and practices and exists in no other way. (Haraway, 1994, p. 67).

Thus, in challenging the tenets of conventional psychology from a feminist, poststructuralist, critical psychology perspective, this study asserts

_not a set of analytic propositions that remain … unpolluted by praxis as an integral part of the network of inclusions and exclusions known as culture … [where] the theorist is a passive subject who assumes scientific objectivity and neutrality, but [that the researcher is] permeated by the same social
contradictions that inform the object of [their] study. Subject and object are part of the same network of powers and counter powers from which they cannot escape (Castro-Gómez, 2001, p. 141).

In the above quote Castro-Gómez situates ‘the subject’ and ‘the object’ of investigation in a ‘network of powers and counter powers’ drawing substantively on Foucault’s (1986, 1995) theorisation of the ‘micro-physics’ of power, where knowledge and power are conceptualised as co-constructed in discourse. As indicated above, Foucault’s theorisation (1986, 1995) of ‘discourse’ and hence ‘power’ is a decisive aspect of this study’s feminist, critical psychology perspective. A discussion of these concepts, and of how ‘language’ and ‘discourse’ are related is offered below in section 1.2.4 of this chapter. But, prior to this overview of discourse and language, a brief discussion of the terms ‘subjectivities’ and ‘subject’ and ‘cultural’ is offered.

1.2.3 Subjectivity & Culture

The psychology of personhood has been bedeviled by the ambiguity of the concept of ‘self’, a concept that has played a leading role in psychological discourses of personhood. This is a deep ambiguity of the question ‘Who am I?’ Human beings are characterised both by continuous personal identity and by discontinuous diversity and by discontinuous personal diversity. It is one and the same person who is variously positioned in conversation. Yet as variously positioned we may want to say that the very same person experiences and displays aspects of self that are involved in the continuity of a multiplicity of selves. (Davies & Harré, 1999, p. 36)

Davies and Harré’s careful consideration above opens out the terrain of ‘self’, subject’ and ‘subjectivities’ as unquestionably complex terms. They expose a temporal-spatial architecture where what is continuous and discontinuous, variable and constant; where what is the same and different is lived, and from which - in the explication of this lived complexity - a vocabulary of ‘self’ as plural can arise. Davies
and Harré's above consideration interestingly parallels part of a commentary on Kathleen Petyarre's major works exhibited at the Museum of Contemporary Art (Sydney), where the authors of the commentary say, that in

Anmatyerr [Petyarre's Aboriginal tribe/ place of origin] all living creatures, including human beings, are depicted as predominantly spatial rather than psychological beings, interacting in natural and cultural landscapes that occupy space over time (Nicholls & North 2001, p. 10).

In our Western culture we are used to seeing and experiencing each other and ourselves as separate, unified and as having a psychology that is intrinsic to ourselves and uniquely 'us'. This is not right or wrong. Nor importantly is it suggested here that there is a 'real' structure anterior to what we see and experience (Harré, 1992). Rather, it is to assert that, as Efran et al (1990, p. 31) say, "our semantic space and our perceptual space are ...intricately related".

The following definition of the terms 'subjectivity' and 'culture' is intended to show how these terms are used in this study rather than offer definitive definitions of these complex concepts. The terms 'self', 'subject' and 'subjectivities' have closely associated meanings yet these meanings are not necessarily interchangeable. For the purposes of this study the following definition of 'subjectivity' and the plural 'subjectivities' is adopted. Nick Mansfield writes that the word 'self'

does not capture the sense of social and cultural entanglement that is implicit in the word 'subject': the way our immediate daily life is always already caught up in complex political, social, and philosophical - that is, shared - concerns. .... 'Subjectivity' refers ... to an abstract or general principle that defies our separation into distinct selves and that encourages us to imagine that ... our interior lives inevitably seem to involve other people ... the subject is always linked to something outside of it – an idea, a principle or the society of other subjects. It is this linkage that the word subject insists upon. ... The
word subject ... presupposes that the self is not a separate and isolated entity, 
but one that operates at the intersection of general truths and shared 
principles. (Mansfield, 2000, pp. 1 – 3) 

The ‘subject’ in Mansfield’s above definition is very different from the ‘subject’ 
presented in conventional psychological research. For conventional psychology ‘the 
subject’ is ‘originatory’ and ‘unitary’ (see Henriques et al, 1984). That is, from this 
perspective, individuals are the source and the cause of (and therefore usually morally 
accountable for) their own behaviours – from the most discreet to the most 
rudimentary of behaviours. This conventional perspective assumes that ‘the subject’ 
is an individual “fully endowed with consciousness; an autonomous and stable entity; 
the ‘core’ of the self, and the independent, authentic source of action and meaning.” 
(Hall, 1997, p. 79). In positivist oriented research projects ‘subjects’ are extracted 
from their social and historical contexts and become object-like subjects; they are 
investigated within an ideological framework that defines the relationship between 
researcher and this subject as ‘impersonal’, and this framework becomes solely 
concerned with “discovering knowledge of universal truths of which there are 
privileged knowers of this reality” (Unger, 1996). The ‘hypothetico-deductive 
methodology’ of conventional psychology therefore produces knowledge about this 
bounded human being that can be generalised to other ‘originatory’ and ‘unitary’ 
individuals in a social and cultural vacuum (Apfelbaum et al., 1999; Bayer, 2002). 

For poststructural feminism, as for critical psychology, the structuration of 
‘subjectivities’ is ‘culture-bound’ (see Malson, 1998; Henriques et al., 1984). The 
term ‘cultural’ is derived from ‘culture’, which Raymond Williams says “is one of the 
two or three most complicated words in the English language [with cultural] its 
important adjective” (Williams, 1980, p. 76). Likewise Stuart Hall (1997, p. 2) says 
“[c]ulture is one of the most difficult concepts in the human and social sciences and 
there are many ways of defining it”. The term ‘culture’, like the terms ‘subject’ and 
‘subjectivities’ discussed above, and ‘discourse’ yet to be discussed, is 
‘embarrassingly overloaded’ (see Cousins & Hussian, 1984). The use of the term
‘culture’ in this study does not refer specifically to nationalities, race, social etiquette, refinements or art, but rather to possible ‘contexts of culture’. These ‘contexts of culture’ may or may not include nationalities or race or social etiquette, refinements, or art. For the purposes of this study the participants’ accounts are considered to be set in, arise out of, and sustain a ‘context of culture’. And, further, this ‘context of culture’ is considered to be a “complexity of sense and reference that alludes to the activities, relationships and processes” (Williams, 1980, p. 81) of the socio-cultural worlds we each, and all inhabit.

Moreover, in referring to ‘culture’ as a ‘context of culture’ - ‘context’ becomes a type of ‘sub-term’. While both terms ‘culture’ and ‘context’ resist definitive definition this study takes up Burke’s (2000, pp. 172 - 175) support of ‘imprecision and multiplicity’ where ‘context’ can be thought of as plural in “referring to phenomena just out of focus” at a given time. So that, “there is no one correct context”, and further, that it is useful “to place a narrower context with a wider and wider contexts” to create concentric contexts or “nested contexts”.

What is crucially important about the interpretation of the terms ‘culture’ and ‘context’ for this study is the implications of this theorisation of ‘contexts of culture’ for understanding the contextual located-ness of subjectivity. This view of subjectivity in culture contrasts markedly with a conventional positivist psychological perspective since a positivist ontology views “social reality as a complex of causal relations between events, which are depicted as an emerging patchwork of relations between variables” (Blaikie, 1993, p. 94), wherein, for example, psychiatry and psychology regard “humans as biology plus society ... as genes topped up with culture” (Littlewood, 1991, p.700). This positivist perspective is a “bucket-theory of context, which is contrasted with the view of context as a project and a product of interaction” (Slemrouck, 2003, p. 40). Another way of saying this is that a ‘positivist’ approach to the ‘context of culture’ involves seeing individuals abstracted from their environment as separate bodies (see Smail, 2001), with culture being how individuals are joined together. From this positivist perspective ‘culture’ constitutes a
‘joined-separateness-es’ that allows the examination of ‘the individual’ as a separate unit, much as ‘leggo’ pieces which together build a structure can be studied separately. However, in contrast, by viewing context as a project and a product of interaction, the context of culture can be understood as something that happens all at once where what is taken as ‘individual’ is also at one and the same time the institutions, social practices and conventions that we all share (see Smail, 2001). And this includes how we are imbedded in ways of thinking and talking about our commonality (see Weatherall, 2002a).

1.2.4 Discourse and Language

‘Subjectivity’, ‘subjectification’ and ‘culture’ are inextricably imbricated in the process of discourse and language. The term ‘discourse’ remains highly ambiguous and has become virtually synonymous with ‘practice’. ‘Discourse’ absorbs earlier meanings concern language without necessarily making the distinctions and convergences clear (see Hall 1997, 2001). For this study ‘discourse’ encompasses written and spoken language but is also more than language. As Foucault says when talking about discourse:

in analysing discourses themselves one sees … the emergence of a group of rules proper to discursive practice. These rules do not define the dumb existence of a reality, nor the canonical use of a vocabulary, but the ordering of objects. ‘Words and things’ an entirely serious title of a problem; it is the ironic title of a work that modifies its own form, displaces its own data, and reveals, at the end of the day, a quite different task. A task that consists of not – of no longer treating discourses as groups of signs (signifying elements referring to contents or representations) but as practices that systematically form the objects of which they speak. Of course, discourses are composed of signs; but what they do is more than use the signs to designate things. It is this more that renders them irreducible to the language (langue) and to speech. (Foucault, 1986, pp. 48 – 49)
Foucault, according to Mills (1997, pp. 1 – 76), offers a range of three meanings of what constitutes ‘discourse’. First, that discourse is broadly “the general domain of all statements”. Second, that discourse concerns an “individualisable group of statements”. And, thirdly, that discourse is “a regulated practice which account for a number of statements”. While all three of these definitions involve language – discourse, as Foucault (1986) says, is not reducible to language. Rather, the concept of ‘discourse’ concerns notions that “every social configuration is meaningful” and importantly that discourse is “where meaning comes from” (Hall, 1997, p. 72).

In understanding the relationship between discourse and language, language can be regarded as something we ‘do’ in a fundamental task of giving ‘voice to meaning’ (see Halliday, 1994). The ‘doing-ness’ of language, both its expression and content, serve social and affective functions (see Halliday, 1994, see also Hodge & Kress, 1991); language being the ‘code’ that links content and expression in what is articulated (see Finegan et al., 1992). Very clearly this study’s analysis examines what the participants say in their accounts. That is, the participants’ ‘language’ their experiences, understandings and perceptions of caring for eating disorder patients. The participants, like us all, deploy language as

a network of systems, or interrelated sets of options for making meaning.
[such] options are not defined by reference to structure; they are purely abstract features, and structure comes in as the means whereby they are put into effect, or ‘realised’ … (Halliday, 1994, xiii-xiv).

A linguistic analysis of the ‘text’ of the participants’ accounts would therefore yield a very rich, ‘text’ based analysis of how the participants construct what they say. Significantly, however, a linguistic analysis may not explicate the possible socio-cultural, political meaning/s that their accounts may hold. Nor, importantly, would a linguistic analysis explicate the relations of power that produce the positions from which the participants speak. For this study explication of meaning refers to
considerations of the ‘work’ that discourse does rather than to how the language has
structured the representation of the text. That is, a discourse analysis within this
feminist (poststructuralist) critical psychology perspective can, for example, question
what power relations occur in the ways the participants talk; in the ways gender is
talked about and not talked about, and in the ‘positions’ that the participants take up
in their accounts in making sense both of their work and the patients they nurse. This
means that ‘gender’, for example, is rejected as an ‘absolute truth’ - as part of
objectivity-established knowledge (Weatherall, 2002a, p. 88). Rather, a discourse
analysis, theorised within a feminist (poststructuralist) critical psychology
perspective, carefully pursues the recovery of “the structure of the conceptual model
which I [as the analyst] make use of in recognising that that is what it is” (Smith,
1990, p. 16). In other words, discourse analysis from this study’s theoretical
framework is an ‘inside job’: the ‘objects of discourse’ as they are revealed are taken
as detailing the relations of power that both produce them and hold them in place vis-
à-vis ‘gender’. Discourse is therefore ‘languaged’, but discourse is not language per
se. Discourse, as Foucault (1970, p. 233) states, is “what [is] enunciated itself: its
meaning, its form, its object and its relation to what it referred to.” In this way
therefore language is not synonymous with discourse and yet both are intimately
imbricated in semo-genesis - in meaning making.

Discourse for this study is therefore pre- eminent in shaping our lives, so that
what counts as human … is not given by definition, but only by relation, by
engagement in situated worldly encounters, where boundaries take shape and
categories sediment ….. agencies and actors are never preformed,
prediscursive, just out there, substantial, concrete, neatly bounded before
anything happened, only waiting for the veil to be lifted and ‘land ho!’ to be
pronounced. Human and nonhuman, all entities take shape in encounters, in
practices. (Haraway 1994, p. 65)
Thus, ‘discourse’ occasions ‘discursive practices’ wherein Haraway’s “entities take shape”. Discursive practices refer to the dynamic processes and conditions of production of ‘objects of knowledge’. As Foucault states, ‘objects of knowledge’ exist under the positive conditions of a complex group of relations. These relations are established between institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, modes of characterisation, … these relations are not present in the object … but are what enables it to appear, to juxtapose itself with other objects, to situate itself in relation to them, to define its difference, its irreducibility … to be placed in a field of exteriority. (Foucault, 1986, p. 45)

Discourses are produced through what is spoken and written and ‘sutured’ into social practices. A discursively produced object may initially emerge as patchy and provisional fragments, but over time, the ensuing coalescence of meanings shapes our understandings of ourselves, of objects and of the world through these finely woven interrelations to produce these ‘objects of knowledge’ (see Malson, 1998). Accordingly, I understand discourse to be

a multidimensional process … [and] a ‘text’ which is a product of that process, [for this study the participants’ accounts are ‘text’] …[It] is not a mere reflection of what lies beyond; it is an active partner in the reality-making, reality-changing processes. (Halliday, 1994, p.339).

I therefore contend within a critical psychology framework that “our lives mainly take place in a world of meanings” (Efran et al, 1990, p. xv), such that meaning is “a production of practice, not a reflection of the real” (Tseelon, 1991). It is within these understandings that this study’s feminist, critical psychology perspective privileges the concept that language functions constitutively (Burman & Parker, 1995) that language does not access the ‘true’ underlying nature of the ‘subject’ (see Malson,
1998; Fraser, 2003), and that ‘discourse’ is understood to construct rather than reflect the ‘subject’.

That discourse constructs ‘the subject’ is a far-reaching concept. Hall (1997, p. 80) writes “all discourses … construct subject-positions, from which they alone make sense”. Further, as Davies & Harré suggest,

[a ] subject position is made available within discourse [such that] a subject position incorporates a conceptual repertoire and a location for persons within the structure of right and duties for those who use that repertoire. … Positioning is the discursive process whereby people are located in conversation as observably and subjectively coherent participants in jointly produced storylines. (Davies & Harré, 1999, pp. 35 - 43)

It is at this nexus where discourse constructs both ‘the subject’ in ‘subject-positions’, and where these subject positions either are or are not available, and where individuals either do or do not take up these positions, that effects of discourse - the constitutive power of discourse - can be understood in terms of the “factors of truth, power and knowledge” that are elements of discourse (Mills, 1997, p. 18 – 22).

A Foucaultian approach to discourse and language considers that knowledge and power are co-constructed in discourse (Foucault, 1995). Foucault theorised that while power can be repressive power principally exists as a knowledge/power relation in the discursive regulation of culture, where individuals constituted in discourse are “seen as an effect of power” (Mills, 1997, p. 21 – 23). Power, for Foucault, is not attached to specific individuals or interests but “is incorporated into numerous practices” such that “power is not necessarily adversarial but ‘heterogeneous’ power can therefore be understood as ‘product’ in the power/knowledge relation not necessarily as purely repressive” (Sarup, 1996, pp. 75-93). As such, “power is implicated in the questions of whether and in what circumstances knowledge is to be applied or not” (Hall, 1997, p. 76).
Foucault’s theory of ‘power/knowledge’ has implications for understanding discourse and the ways in which discourse informs “social practices ... over questions of truth and authority” (Mills, 1997, p. 19). Within this theoretical framework science and research can thus be understood as social practices, not as explorations of an external and fixed and independent reality. This study therefore challenges the allegedly politically neutral position, the ‘independent role’ and ‘innocence’ of knowledge of ‘the expert’ in conventional psychological research. The feminist, critical psychology researcher is thus positioned to read and write against “the traditional detachment required of positivistic examination” (Squire, 2003, p.59; Davies & Gannon, 2004). And she does so with “a certain kind of ‘negativity’ ... to show that the established order is not necessary, nor perhaps even ‘real’ ...” (Haraway, 1994, p. 63). Hence, one of this study’s tasks is to analyse the ‘real’ in terms of taken for granted assumptions in the participants’ accounts that constitute what is accepted as ‘normal’ and ‘ordinary’. For, as Henriques et al. (1984, p. 22) contend,

 certain norms have become so much a part of our common-sense view of reality that we are able to forget that they are the result of a production: that they have become naturalised as indisputably biological or social.

This project sets out to investigate what is taken-for-granted in the participants’ accounts, where the appearance of what is termed ‘common sense’, ‘normal’ and ‘ordinary’ and ‘natural’ concealing both the practices and the power structure that authorise it (see Bourdieu & Wacquant, 1999)

Further, this study explores the ‘non unity’ of subjectivity through the consideration of the plurality of ‘subjectivities’ and ‘gender’ as interwoven and closely regulated within the overall power structures in society (Malson & Ussher, 1997). A power structure that is arguable, by and large, still patriarchal. In deploying a Foucaultian notion of ‘power’, the discursive constitution of ‘power’ in the participants’ accounts is one of the themes taken up in the analysis in chapters two, three and four. Similarly
the relations of power entailed in the ‘gendering’ of both eating disorder patients and nurses is also a principal theme in the following analysis.

1.2.5 Conclusion

The above discussion of this study’s theoretical framework demonstrates how a feminist, critical psychology perspective enables ‘eating disorders’, ‘patients’, ‘nurses’ and ‘nursing’ to be conceptualised as multiply produced ‘objects of discourse’ that are fully culturally, historically and politically contextualised (see Malson, 1998). It is a framework which enables the gendering of ‘the nurse’ and ‘the eating disorder patient’ to be understood as complex cultural phenomena with no *à priori* existence. This theorisation is in clear contradiction with the tenets of conventional, mainstream psychology (see Weatherall, 2002a) where individuals are viewed as “unified rational subjects who have a core self that dons roles” (Weatherall, 2002a, p. 141), and where individuals are theorised as carrying their psychology within them somewhere like soggy sacks of dysfunction. In contrast with such a view, this thesis, in exploring the field of nursing eating disorder patients, views that field as discursively constituted and regulated, as a field in ‘eating disorders’, ‘patients’, ‘nurses’ and ‘nursing’ are constituted and regulated in various ways. The following literature review discusses the difficulties and confusions that emerge in understanding eating disorders, their therapeutisation/s and the research into treatment outcomes. It highlights the lack of research that investigates nursing of eating disorder patients and discusses why a feminist, critical psychology perspective can be considered as invaluable to current research.
1.3 Literature Review: Why Use A Critical, Feminist Psychology Theorisation?

The previous section of this chapter introduced this study’s feminist, critical psychology theoretical framework, differentiating this framework from a ‘positivist’ orientated conventional mainstream psychological approach. In addition, it also defined the study’s feminist perspective as post-structuralist drawing extensively on Foucaultian theorisation. This theoretical perspective allows different conceptualisations of eating disorders, patients and nurses than conventional psychology allows and therefore enables different questions to be asked of this field. This section of this chapter section offers a literature review discussing research and theory in the field of eating disorders. This review discusses definitions of ‘eating disorders’, research into their prevalence, research and theory on the aetiologies of eating disorders, research into the current approaches to the treatment of eating disorders, and a discussion of research considering nurses’ involvement in treatment programmes.

1.3.1 Background: Nature And Scope Of The Problem

It is widely accepted that eating disorders are complex and serious problems. Eating disorders are considered to constitute major health care problems (Becker et al, 1999; Crisp & McClelland, 1996) that particularly affect girls and young women (Cockey, 1999; Emans, 2000; Laurie & Mitan, 2002; Smith, 2002; Steinberg, 2003; Rosen, 2003; Treasure, & Schmidt, 2001) in Western societies, including Australia (Baggs et al, 1999; Rolland et al, 1998; Steiner & Lock, 1998). In addition, eating disorders are increasingly being diagnosed in Westernised societies (Nasser, 1997) from where many Australians also originate. For this study the consideration of eating disorders is confined to anorexia nervosa (anorexia) and bulimia nervosa (bulimia). Anorexia has been described as one of the most common chronic illnesses among teenage girls (Touyz & Beumont, 2001), and is often associated with life-threatening complications (Touyz & Beumont, 2001; Gaskill & Sanders, 2000; Crisp & McClelland, 1996), significant psychological problems (Fennig et al, 2002) including direct and indirect self harm (Favaro & Santonastaso, 2002; Woolfolk, 2003). It is
associated with significant morbidity and mortality (Panagiotopoulos et al., 2000; Robinson, 2000; Touyz and Beumont, 2001), with deaths due to malnutrition (Crisp et al., 1992; Crisp & McClelland, 1996) or suicide (Bulik et al., 1999; Favaro & Santonastaso, 2002).

Contemporary psychology defines anorexia and bulimia medically according to the Diagnostic and Statistical Manual of Mental Disorders - IV (hereafter DSM-IV), (DSM IV 1994, pp. 539 – 550). The DSM-IV states that eating disorders are Axis I clinical syndromes with the principal diagnostic criteria for anorexia being

(a) refusal to maintain body weight or above a minimal body weight for age to height ... (b) intense fear of gaining weight or becoming fat ... (c) disturbance in the way in which one’s body weight or shape is experienced ...(d) in post-menarcheal females, amenorrhoea - not menstruated in the last three months (DSM IV 1994, pp. 544 – 555).

The diagnostic criteria for bulimia are

(a) recurrent episodes of binge eating ...(b) recurrent inappropriate compensatory behaviour in order to prevent weight gain ... (c) binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months ... (d) self evaluation is unduly influenced by body shape and weight ... (e) the disturbance does not occur exclusively during episodes of anorexia nervosa (DSM IV 1994, pp. 549- 550).

The above diagnostic criteria provide a useful ‘starting point’ for understanding the nature of ‘eating disorders’. However, from a feminist, critical psychological perspective, they are nevertheless profoundly problematic. In strictly “adhering to the tenets of the disease model” (Efran, 1990, p. 17) the DSM-IV and other clinical diagnostic texts are premised on a notion of the individual sufferer of eating disorders as “the point of origin of illness”. The above criteria for eating disorder diagnoses
thus locate this ‘problem’ solely with the individual sufferer. Pathology is conceptualised as internal to the individual who thus becomes totalised as ‘anorexics’ or ‘bulimics’. Within this ‘disease model’ a ‘context of culture’ is thus markedly absent. The ‘anorexic’ or ‘bulimic’ is understood in a framework, which isolates her from her cultural context, and which positions her as pathologically deviating from ‘the norm’. Yet, these diagnostic criteria (DSM IV 1994, pp. 549-550) also serve to construct eating disorders in such a way that the criterion circuitously constructs ‘normality’, reproducing assumptions about what constitutes ‘normality’ and therefore ‘abnormality’ (Crowe, 2000a).

1.3.2 Prevalence

The prevalence and demography of anorexia and bulimia is hard to assess for a number reasons. These reasons include the widely different methodologies used in research. For example, studies involve different types of participants, differing methods of diagnosis and differing methods of assessment (Pike, 1998; Rosen, 2003; Herman & Polivy, 1984). There are also differences in referral practices for different sections of the population (Wardle et al., 1993) and researchers have privileged Western definitions of eating disorders over other possible definitions (Ngai et al., 2000). In short not only are the results of epidemiological studies somewhat varied (Manson, 1998), but research findings on prevalence need to be treated with caution.

However, it is widely recognised that eating disorders occur more commonly in adolescent and pre-adolescent girls, and younger women (Emans, 2000; Laurie & Mitan, 2002; Herpertz-Dahlmann et al, 2000; Touyz & Beumont, 2001; Rosen, 2003), with an estimation of a 9:1 (female: male) ratio figuring this disorder as an overwhelmingly ‘female’ disorder (Feingold & Mazzella, 1998; Gordon, 1990). Amongst adolescent girls and women estimates of the prevalence of diagnosable anorexia rise to between 0.7% (Røsenvinge et al., 1999) and 1% of the female population in the United States (DSM IV 1994; Laurie & Mitan, 2002). And these estimates can be higher in particular populations, for example, women in sports,
gymnastics and ballet (Cockey, 1999; Westmore, 2000; Henrich, 1994; Gaskill & Sanders, 2000). In relation to bulimia, some studies detail that one in five young women report that they have the condition. (Kaplan & Sadock, 1992). In research using strict DSM-IV diagnostic criteria for bulimia there is an estimated prevalence of 1 percent of girls between the ages of 16 and 19 years and a 0.5 – 1 percent prevalence of women aged between 15 – 40 yrs (Van den Broucke, 1997).

1.3.3 Aetiology

Research seeking to estimate the prevalence of ‘eating disorders’ usefully provides some indication of the pervasiveness of this problem. Such research, however, is predicated on a reified medical or quasi-medical notion of ‘eating disorders’ as real clinical entities located within the individual. This reified notion of ‘eating disorders’ similarly underpins the majority of research and theory on the aetiologies of eating disorders. Thus, this literature tends to assume ‘eating disorders’ to be real clinical entities for which (individualised) causes can be found.

The majority of literature concerned with aetiologies of ‘eating disorders’ thus tends to preclude questions about the nature of ‘eating disorders’ or about how ‘eating disorders’ are theorised in relation to cultural context. A feminist critical psychology perspective however, problematises this medical or quasi-medical notion of ‘eating disorders’ as individual psychopathologies. From this perspective eating disorders can be conceptualised not as real clinical entities but as specific socio-cultural, historically contextualised phenomena (see: Malson, 1998, see also Bordo, 1998). Thus ‘eating disorders’ can be understood as arising out of and within a plurality of contradictory discursive positions (Malson, 1997, 1998; Malson & Ussher, 1997; Malson et al, 2004). Contradictory discursive positionings that produce and sustain the patriarchal ‘gendering’ of women - in particular the ‘gendering’ of young women (see Weatherall, 2002a) – and that shape ‘the thin body’ as an idealisation of the ‘feminine’ and as an expression of a multiplicity of contemporary cultural concerns and values (Malson, 1998). Such a theorisation of eating disorders involves a radical
problematisation of medical and quasi-medical perspectives, but importantly it involves no less recognition of the seriousness or complexity of this problem or of the significant medical sequelae. Understanding eating disorders as discursively constituted phenomena does not minimise the problem, but relocates the problem within a wider discursive, cultural and (gender) political context.

Conversely the medicalised, disease model of eating disorders, upon which the majority of aetiological research and theory is based, tends to privilege biological and individualising explanations. This model essentialises eating disorders, locating them in individual suffers who are themselves pathologised as ‘abnormal’. The pathologised individual thus becomes the cause of the eating disorder (Malson, 1998) as the disease becomes an entity (Efran et al., 1990, p. 31). In the disease model individual sufferers of eating disorders are abstracted from the wider and more proximal discursive contexts to become human bodies that are biological bits and pieces (Smail, 2001, p. 62) with culture tacked on (see Littlewood, 1991) in a monodetermination of what constitutes personhood as well eating disorders. Of course individuals do suffer with eating disorders. But the disease model unfortunately confuses the locus of suffering with cause. It confuses the “essential participation [of biology] with unique responsibility” (Maturana, & Varela, 1992, p. 69). In other words, the medicalisation of eating disorders constitutes eating disorders as caused by and manifesting as an individual mental health problem. ‘Mental health’ in the medical model is associated with neurological functioning and cognitive processes locating ‘mental health’ somewhere in the area of the individual mind or brain. This understanding of eating disorders thus brackets off the body as the container of ‘mental health’, rendering it conceptually isolated from any wider cultural context. In this instance, it is ‘the thin body’ of the anorexic that both is and contains the disorder. Thus, from a medical model perspective ‘the thin body’ is not seen as multiply positioned and inscribed by discourse, but as occupying a singular position of ‘unique responsibility’ for its ‘eating disordered’ status.
The dominance of a medical (or quasi-medical) model of ‘eating disorders’ in medical, psychological and psychiatric research thus works to privilege a priori certain kinds of aetiological explanations over others. The following discussion offers a brief overview of aetiological explanations. Within the theoretical framework adopted in this thesis, eating disorder are understood not as reified entities but as discursively constructed. Nevertheless a brief discussion of aetiological explanations is useful in understanding contemporary, conventional treatment approaches.

Despite eating disorders having been researched and theorised from a wide range of perspectives, the aetiology of eating disorders remains elusive and poorly understood. Notwithstanding this it is widely accepted that there are complex causal pathways involved in eating disorders (Treasure & Schmidt, 2001). Thus there is wide acceptance of a multi-dimensional perspective in which neural-chemical, socio-economic, socio-cultural, psychological, familial and genetic factors are thought to combine in the aetiology of eating disorders (see Malson, 1998; Grothaus, 1998). In recent literature there is trend towards a view of eating disorders emerging out of a complex range of contributing risk factors that can influence the development of a disorder in individuals with ‘vulnerable’ personalities.

‘Vulnerable’ personalities (Crisp & McClelland, 1996) are variably and widely construed in the literature as an individuals’ inherent specific type of temperament and character that is a precursor to developing an eating disorder (Bulik et al, 1999). ‘Vulnerable’ personalities are invoked in a variety of aetiological explanations.

For example, researchers have proffered causal explanations in which an individual is viewed as ‘vulnerable’ to developing an eating disorder because that individual’s alleged dysfunctional thinking, personality, biological make-up or other attribute. Hence, it has been asserted that eating disorders arise because of an individual’s absolute, negative, and dichotomous beliefs she holds about herself (Cooper et al, 2001); because an individual has low self esteem or a biologic predisposition to eating disorders (Emans, 2000); because she has a problematic body image or
significant body dissatisfaction (Bribeck & Drummond, 2003; Stice & Whitenton, 2002) or because the individual has one or many of a plethora of traits, for example, impulsivity, perfectionism, obsession-compulsion, anxiety or simply a globally maladaptive personality (Johnson et al, 2002).

The individual who is viewed as ‘vulnerable’ to developing an eating disorder is construed as being potentially influenced by various ‘risk factors’. These ‘risk factors’ include an individual’s possible experiences of trauma and stressful life events (Gaskill & Sanders, 2000; Johnson et al., 2002), the socio-cultural pressures to be thin (Stice & Whitenton, 2002), an individual’s association with ‘sub-cultural environments’ such as ballet (Gaskill & Sanders, 2000), gymnastics (Henrich, 1994) and sport (Cockey, 1999; Westmore, 2000), and the experience of peer teasing (Steiner & Lock 1998). Other ‘risk factors’ that have been identified by researchers include familial risk factors where a familial clustering of eating disorders suggesting familial influences (Wisotsky, et al., 2003) and/or genetic transmission (Steinberg, 2002; Klump et al., 2001; Gaskill & Sanders, 2000). Significantly, researchers have also referred to being female as a ‘risk factor’ (Gaskill & Sanders, 2000; Steiner & Lock 1998; Redenbach & Lawler, 2003). There are therefore a considerable breadth and number of ‘risk factors’ that have been identified as potential influences in the development of an eating disorder in ‘vulnerable’ individuals. In all of this literature however, there is a blurring between the notion of an individual being ‘vulnerable’ (that is, having a potential to develop an eating disorder) and the notion of being exposed to ‘risk factors’ which could influence that potential. Thus, whilst the medical model of eating disorders remains dominant in this literature, research and theory on the aetiology of eating disorders begins to indicate the necessity of re-theorising the individual-society dichotomy on which that model is based as well as indicating the importance of attending to cultural context.

1.3.4 Socio-cultural Factors

The above discussion indicate that the ‘medical’ conceptualisations of eating disorders also attach some significance to socio-cultural factors as playing an
important aetiological role (Shaw, 1995; Hardin 2003) such that eating disorder symptoms and the accompanying psychological distress can be viewed as being, at least partially, produced by dominant values, ideals and normative practices of contemporary Western cultures (Malson 1998; Krusky, 2002; Jutel, 2001). In particular, there is a growing body of research that considers the potentially damaging effects of idealising thinness as a central criterion of feminine beauty (Malson, 2000; Krusky, 2002; Jutel, 2001), of idealised media images of thin women; of media promotions of ‘dieting’ as a means of achieving this feminine ‘ideal’ (Grogan, 1999; Shaw, 1995), and of representations of the ‘thin body’ in adolescent-targeted literature as the ‘preferred’ expression of sexual attraction and success (Younger, 2003). Trends toward an increasing idealisation of thinness and of a growing ‘dieting’ and ‘weight loss culture’ amongst Australians (Nowak et al., 1996; King & Turner, 2000) are therefore a matter of particular concern in the particular context in which this study is conducted.

The cultural production of ‘thin’ and ‘fat’ bodies (Malson, 1998; Lester, 1997; Jutel 2001) can therefore be seen to carry both significant meaning and influence in our Western culture. These ‘meanings’ include that “to be thin is to be beautiful, in control, fit, and content. To be overweight is to be ugly, helpless, lazy and unhappy” (Amara & Cerrato, 1996). They are also expressed in statistics that “fat people are much more likely to die suddenly than thin people” (Jutel, 2001, p.284), and that

overweight women [in America are estimated as] 20% less likely to get married than thinner women - and they [are also estimated to] earn about $6,700 per annum less than thinner women” (Amara & Cerrato, 1996).

These meanings, and their very real material impact, drive our Western culture’s absorption with weight loss and physical appearance, wherein it is commonly recognised that both young and older women are taught that their value is intimately associated with their bodies and appearances (Bordo, 1990). This idealisation of
thinness substantively contributes to a world wide *multi-billion* dollar diet industry (Steinberg, 2002) in which the

ideal of slenderness, then, and the diet and exercise regimes that have become inseparable from it, offer the illusion of meeting, through the body the contradictory demands of the contemporary ideology of femininity (Bordo, 1989, p. 19).

It is this cultural context that specifically leads to the critical re-theorisation of eating disorders as ‘culture bound’ phenomena. MacSween (1993, p. 2, 210, 252), like Bordo quoted above, conceptualises eating disorders as a socio-cultural phenomena. Arguing, that at the “level of the individual body” anorexia constitutes an attempt to resolve the irreconcilability of individuality and femininity in a bourgeois patriarchal culture [where] reconciling the hidden incompatibility between individuality and femininity is the central task of growing up female in contemporary Western culture … [and it] is this hidden incompatibility which lies … at the heart of the anorexic symptom

such that, an understanding of “the anorexic symptom” demands an analysis of “the structures of social meaning and practice within patriarchal culture”. For within our patriarchal culture “women’s bodies become a reflection of woman as ‘other’” (Robertson, 1992) where ‘other’ is understood against the gendered ‘norm’ of the masculine. Cultural meanings and regulatory practices are transformed into eating disorders where, for example, Gremillion (2002, p. 384) suggests feminine ‘fitness’ itself helps cause anorexia. Thus, she argues, “the body tends to be cordoned off as a mere resource for the activity of social construction itself”. Feminine embodiment and subjectivity can therefore be regarded as central in an analysis of eating disorders as cultural phenomena (see Malson, 1998 & 1999; see also Robertson, 1992). And hence the discursive practices wherein these subjectivities are re-produced assume a
central focus in this study (see Malson 1997 & 1999). As feminist theorisations of
anorexia indicate, this diagnosis “is not apolitical but one which indicates tensions
inherent in the dominant gender order” (Robertson, 1992, p. 45). That is, as
suggested above, discourses, and discursive practices actively constitutes ‘feminine
subjectivity’ rather than ‘reflect’ objectified and fixed identities (Hall, 2001) then an
examination of discursive constructions of ‘feminine subjectivities’ and ‘subject
positions’ is deemed here to be essential in explicating the conditions of production
of eating disorders (see Malson, 1997; see also Henriques et al, 1984).

Recent critical feminist work has also expounded how other cultural values
associated with for example, Cartesian dualism (Malson and Ussher, 1996; Bordo,
1993), capitalist modes of production and consumption (Malson 1999; Brumberg,
1988), postmodernity (Malson, 1999; Probyn, 1987) and death (Malson & Ussher,
1997) as well as femininity and gender-politics (Orbach, 1993; Malson, 2000;
Hepworth, 1993) may also be deeply implicated in the production of eating
disordered identities, experiences and body management practices. That eating
disorders can be understood as expressive of a number of key values, concerns and
dilemmas of contemporary Western cultures (Malson, 1998, 1999; Malson & Ussher,
1996, 1997) illustrates ‘its’ profoundly culture-bound nature (Malson & Ussher,
1996; Bordo, 1993, 1998). It thereby highlights the problems inherent in making
categorical distinctions between normal and disordered eating (Malson, 1999; Malson
& Swann, 1999). Yet, while the status of the body as a ‘cultural product’ is at stake
here, “the cultural production of bodies remains almost entirely untheorised within
biomedicine” (Gremillion, 2002, p.383). As outlined below, such insights from
critical feminist work in this field may have significant implications for
understandings of treatment issues in eating disorders.

1.3.5 Current Approaches To The Treatment Of Eating Disorders

Treatment approaches to eating disorders encompass the delivery of clinical
rehabilitative services, as well as the delivery of health promotion and related issues
at social and individual levels including the issues of prevention, early detection, and the delivery of relevant education (Sanders & Gaskill, 2000). While the issues of health promotion, prevention, early detection and education are very important; the following brief overview focuses on the clinical treatment of eating disorders.

As Sanders & Gaskill (2000, p. 9) note, eating disorders can be understood as involving emotional, socio-cultural, physical, and psychological elements and as spanning the realms of physical, mental and social health. This, they suggest, is reflected in both the range and emphases of current treatment approaches. Specifically these treatment approaches include dietetic (Mehler & Crews, 2001) pharmacological (Treasure & Schmidt, 2002) behavioural and cognitive-behavioural approaches (Martin, 1985; Dare et al., 2001; Gowers & Bryant-Waugh, 2004), family therapies (Krusky, 2002), individual and group psychotherapies (Newton et al., 1993; Gold, 1999; Gowers & Bryant-Waugh, 2004), feminist psychotherapies (Orbach, 1993; Fallon et al., 1994), and multi-dimensional approaches (Lacey & Read, 1993). Hospitalisation of eating disorder patients is frequently part of treatment and this may include in-patient and/or outpatient treatment, which is frequently noted in the literature to be expensive and lengthy (Sanders & Gaskill, 2000; Beumont, 2000; Waller et al., 2003) as well as being of questionable efficacy (Ben-Tovim et al., 2001; Lock & Litt, 2003). ‘Re-feeding’ (Mehler & Crews, 2001) in this patient group is often successful during hospitalisation thereby increasing weight to a specific target weight (Gowers & Bryant-Waugh, 2004). However, notable rapid weight loss post-discharge is also well reported (Maguire et al., 2003; Sanders & Gaskill, 2000). Recent researchers have also questioned the efficacy of mono-treatment approaches (Fennig et al., 2002), and broad multidisciplinary team approaches combining multiple treatment strategies are now more usually adopted strategy (Gaskill & Sanders, 2000; Muscari, 1998a; Crisp and McClelland, 1996; Laurie & Mitan, 2002; Beumont et al., 2003).

Treatment effectiveness can be hard to measure and research into treatment effectiveness varies considerably not only in terms of the types of treatments assessed
and the measures used assess and compare efficacy but also in terms of the broad aims of these studies. For example, recent research has sought to compare effectiveness between psychoanalytic, family and cognitive therapies (Dare et al., 2001); to identify the types of treatments patients sought after discharge from hospital (Grigoriadis et al., 2001); and to compare effectiveness of inpatient and outpatient care (Meads et al., 2001). Other recent research has considered the effectiveness of a continuum of care model of care (Waller et al., 2003); compared the effectiveness of psycho-social and pharmacological treatments (Peterson & Mitchell, 1999); assessed treatment outcome studies and considered the course of ‘the disorder’ (Ben-Tovim et al., 2001; Fairburn et al., 2001; Herzog et al., 1999; Keel et al., 2000). And, in addition to this diversity of research aims, studies investigating treatment efficacy have also adopted a wide range of measures and methodologies, such that research may be retrospective, prospective, comparative or longitudinal. It might (or might not) involve record linkage, qualitative and/or quantitative approaches quantitative or meta-analysis. Comparison between studies is thus made highly problematic with the results of these studies varying as much as their aims and methodologies.

However, overall the studies reviewed strongly indicate that long-term outcome is often unfavorable (Button & Warren, 2001; Fichter & Quadflieg, 1999; Herpertz-Dahlmann et al., 2001; Crowe, et al., 1999), and that currently available interventions are often of only limited success (Button and Warren, 2001; Fichter & Quadflieg, 1999; Loewe et al., 2001). Estimated recovery rates range between 17 and 77% (Herzog et al., 1999). For example, Loewe et al., (2001) in a 21-year follow up of anorexia patients found only 51% had fully recovered; 21% had partially recovered and 10% suffered from the full syndrome and met with all the diagnostic criteria. A similar picture emerges for bulimia where, for example, a 9-year follow up study (Reas et al., 2000) found 33% of bulimic patients continued to have an eating disorder. Fairburn and Belgin (2000), reporting on a 5 year follow up of bulimic patients, similarly found that participants had a “relatively poor” outcome. And Keel et al., (2000), reporting on a 10 year psycho-social follow up of bulimic patients, found that there were suggestions of continued difficulties in social adjustment and
interpersonal difficulties. There are also considerable problems of chronic relapse (Deter & Herzog, 1994) and of anorexic patients ‘crossing over’ to develop bulimic symptomatology (Eddy-Kamryn et al., 2002). Additionally, Emborg, (1999) estimates that 8.4% of patients with eating disorders die (a markedly higher death rate than that of the total patient population which is 6.69%) from either self-starvation or suicide (Crisp et al., 1992; Bulik et al., 1999).

Clearly, therefore the research suggests poor outcomes. And, additionally, there is also evidence of patient dissatisfaction with treatment. While, to date, there has been relatively little research into treatment acceptability (Newton et al., 1993), recent research demonstrates relatively low levels of satisfaction amongst service users. For example, a survey of 1638 British service users (Newton et al., 1993; EDA, 1995; see also Yager et al., 1989) found perceived helpfulness of intervention varied considerably between different forms of intervention with self-help groups, counseling and individual psychotherapy rated as most helpful and outpatient behavioural therapy as least helpful. However, all forms of intervention were rated as ‘unhelpful’ or as ‘making the situation worse’ by at least 17% or respondents, a figure that rose to 69% for outpatient behaviour therapy.

Thus, as the above discussion suggests, whilst ‘treatments’ are plainly difficult to evaluate and whilst comparison between studies is highly problematic, the research does indicate considerable scope for improving both efficacy and acceptability. There is therefore need for further research into treatment and, moreover, a need for research which engages with a wider variety of theoretical perspectives. As Gremillion (2002, p.390) observes from a cultural anthropological perspective “clearly one of the reasons that anorexia is so difficult to cure is because treatment practices re-create forms of bodily control that are already the defining features of anorexia”. From this perspective, treatment practices are viewed as (problematic) cultural practices, a perspective which is notably absent in the research discussed above. These ‘treatment practices’ viewed as cultural practices however, are the subject of this thesis, which develops a critical understanding of treatment by
investigating nurses’ accounts of their work in caring for eating disorder patients. This study therefore seeks to contribute a small but growing body of literature on eating disorders conducted within critical psychological (Malson, 1998, 1999, 2000) and cultural studies (Bordo, 1993, 1998) frameworks, where this research has to date focused primarily on discursive constructions of ‘eating disorders’ per se rather than on treatment issues.

1.3.6 Treatment and Nurses

While there is considerable variation in treatment approaches used, a multidisciplinary team approach is very often employed in hospital settings and elsewhere (Muscari, 1998b; Laurie, 2002). Nursing staff forms a vital component of multidisciplinary teams, not least because of the considerable time they spend with patients relative to other team members (Newell, 2004; King & Turner 2000; Ramjan, 2004). Yet, while nurses clearly spend considerable time with hospitalised eating disordered patients, and are involved in numerous aspects of their treatment, there is little research investigating either the contribution of nursing to treatment for eating disorders or the experiences and perspectives of nurses working in this field (Garrett, 1991; King & Turner, 2000; Newell, 2004; Ramjan 2004).

What research does exist suggests that nurses may find caring for eating disordered patients to be particularly challenging for a number of reasons (King and Turner, 2000; Grothaus, 1998; Garrett, 1991; Ramjan 2004). For example, eating disorders are well recognised as complex, and eating disorder patients are thus deemed to need holistic nursing management. However, these patients are also described in treatment literatures as having difficulties identifying and expressing their needs, feelings and emotions so that the implementation of this holistic care may be difficult for the nurse (Anderson, 1997). Additionally research also indicates that eating disordered patients often experience body image distortion (Birbeck & Drummond, 2003; Wardle et al, 1993). They may overestimate their body size (Cooper et al., 2001) and may cherish or feel ambivalent about their ‘anorexic’ status (Malson, 1998). These patients may
therefore be opposed to or ambivalent about the goals and perspectives of health care workers (Treasure and Schmidt, 2001). That is, some patients may not want a diagnosis or treatment so that there may be 'gross disparities' between the perspectives and goals of patients and health care providers (Treasure and Schmidt, 2001). Within this context it may be difficult to develop therapeutic relationships that the nurses are auspiced to foster (Halke, 1997; Marks, 2000). Indeed, it has been suggested that the development of a therapeutic relationship with eating disorder patients often necessitates that the nurse suspend assumptions concerning how rapport usually develops when caring for people in distress (Newell, 2004). Instead, what may be required is sustained intentionally high quality communicative activities on the nurses' part, accompanied by relentless commitment to build trust and rapport (Ramjan, 2004). Nurses themselves can struggle for understanding concerning the complexities of this 'disorder' and may experience the difficulties of implementing a 'controlling' treatment programme while working with the patients who are understood as controlling themselves (Ramjan, 2004).

Patients diagnosed as anorexic have been described as uncooperative and difficult to treat (Robinson, 2000) and challenging to nurse (Ramjan, 2004; King & Turner, 2000; Grothaus, 1998). Open or covert resistance may lead to feelings of frustration, exhaustion, emotional turmoil and feelings of failure amongst nursing staff (Ramjan, 2004; King & Turner, 2000). Where resistance to treatment programmes is seen as covert additional challenges may arise where patients are seen as untrustworthy (King & Turner, 2000; Garrett, 1991), so that potentially therapeutic relations between nursing staff and patients may again be undermined and difficult to re-constitute. Researchers have also suggested that nurses may find in this work that at times their 'core values' are challenged (King & Turner, 2000), and there maybe difficulties of maintaining 'non-judgmental attitudes' to patients (King & Turner, 2000), especially where frustration and emotional distress for nurses can regularly occur in caring for this patient group (King & Turner, 2000; Newell, 2004; Ramjan, 2004; Grothaus, 1998). In short whilst there is very little research into nursing eating disorder patients,
what research there is strongly suggests that this may be a particular difficult and challenging area of nursing.

1.3.7 Conclusion

The above review of literature shows the ways in which eating disorders are discursively constituted within clinical as well as academic contexts and additionally illustrates the ‘feminisation’ of eating disorders. The literature shows that eating disorders are complex, highly patterned phenomena, the prevalence of which is very difficult to estimate. The above review also indicates that treatment effectiveness is difficult to assess, that treatment satisfaction tends to be low and that long-term outcomes are often unfavorable. It also clearly indicates that there is a paucity of research that considers the work of nurses working with eating disorder patients.

The context of culture in which young women become eating disordered was also discussed, where from a medical perspective ‘culture’ is constituted as ‘risk factors’ that may provoke eating disorders in ‘vulnerable’ personalities. Herein, the disease model of eating disorders remains pre-eminent, as the causes of eating disorders are constituted as pathologised/able personalities. This perspective is challenged by the work of contemporary feminists and cultural theorists where culture is viewed not as a ‘bucket’ that holds individuals, but as part of ‘eating disorder’ subjectivities and body management practices.

This study can therefore be seen as a timely and apt contribution to research on eating disorders, as the project focuses directly on an analysis of the participants’ discursive representations of their own experiences of nursing eating disordered patients, and where the important nurse-eating disorder patient therapeutic relationship is viewed as emerging out of co-implicative contexts of culture. The following section of this chapter discusses the aims of this project and the methodology used in this study to investigate them.
1.4 Methodology: How Can A Critical, Feminist Psychology Theorisation Work?

This final section of this chapter outlines the study’s aims, and how these aims are related to the qualitative, discourse analytic, interview-based methodology adopted, and introduces the data.

1.4.1 Aims

As discussed in the introduction, this study poses a number of questions that challenge the ‘givens’ concerning eating disorders as psychiatric disorders. The study here is concerned with the discursive construction and regulation of both the eating disorder patient and the nurse and with the gendering of these subject positions. It is concerned with elucidating the sense and meaning that nurses’ make of their work, and with how ‘care’ and ‘cure’ are imbricated in the processes of nursing and therapy. These research interests shape this study as an investigation into the participants’ experiences of nursing eating disorder patients. Its intention is to add to the knowledge base concerning the hospitalised therapeutisation of this patient group.

The specific aims are to identify and examine the ways in which the participants:

* construe their professional identities in the context of nursing eating disordered patients
* construe the identities and behaviours of the eating disordered patients they nurse
* frame and make sense of their therapeutic relationships with these patients
* frame and make sense of their experiences of the various aspects of hospital-based therapeutic interventions for eating disorders with which they are involved
* frame and make sense of their particular contribution as nurses to patients’ care
* perceive the challenges and benefits they may view as being specific to nursing of eating disordered patients
and construe the support they do and could receive in providing optimally effective nursing.

In other words this study intends to investigate how and in what ways the participants’ construe their roles as ‘nurse’, ‘therapist’, and ‘colleague’; with how they account for ‘eating disorders’, ‘this patient group’, ‘the treatment programme’, ‘therapeutic relationships’ and ‘the multidisciplinary team’. This approach enables a focus on the processes of treatment (rather than treatment outcomes only) in which nurses are engaged in their care of eating disorder patients. As such this study adopts a discourse analytic, interview-based methodology that focuses directly on an analysis of the participants’ accounts of nursing eating disorder patients. This analysis was designed to investigate the participants’ representations of their experiences of nursing this patient group as a way of capturing the immediacy, texture and complexity of the participants’ discursively constituted experiences, and importantly as a way of situating the nurse-eating disorder patient therapeutic relationship in the contexts of culture in which it occurs.

1.4.2 A Qualitative, Discourse Analytic, Interview-Based Methodology

In deploying a qualitative, discourse analytic methodology the term ‘qualitative’ designates this study as ‘non-statistical’. But this does not mean that a non-statistical ‘content analysis’ is offered where words replace numbers, and where what the participants say in their accounts is considered to reflect or to report on fixed situations that exist outside of their talk (see Ball & Smith, 1992). Rather, the participants’ accounts are privileged in their own right. This may well be the case for other qualitative, non-discursive methodologies. However, in keeping with this study’s theoretical framework, the participants’ accounts are not measured against an external ‘reality’ of nursing practices or protocols that may be construed differently by others such as patients, medics or other health care professionals. In taking the participants’ accounts as the object of study in their own right this study does not view competing perspectives as objectively true or false (Harré, 1992), but as
culturally, historically and politically contingent (see Malson, 1998, 1999). As well, these competing perspectives are viewed as different versions of reality, rather than as more or less accurate representations of an objectively existing truth about reality (see Burman & Parker, 1993, see also Potter & Wetherell, 1987).

While there are differing approaches to ‘discourse analysis’ that emphasise linguistic (Schiffrin, 1994), and critical linguistic approaches (Fairclough, 1992a, 1992b) this study’s post-structuralist Foucaultian-informed approach to discourse analysis takes ‘discourse’ to be constitutive of reality (Burman & Parker, 1993), Discourse is not viewed as an unproblematic reflection of an underlying reality (Malson, 1998; Malson et al., 2004 forthcoming) that lies anterior to the participants’ account. Rather, discourse is viewed as systematically constituting objects, events and identities in a particular context specific ways (Malson et al., 2004). As such this analysis of the participants’ accounts investigates ‘objects of discourse’ as they arise in what the participants say. As Foucault says:

an object of discourse … does not await in limbo the order that will free it and enable it to become embodied in a visible and prolix objectivity; it does not pre-exist itself … it exists under the positive condition of a complex group of relations. These relations are established between institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, modes of characterisation, … these relations are not present in the object … but what enables it to appear, to juxtapose itself with other objects, to situate itself in relation to them, to define its difference, its irreducibility … to be placed in a field of exteriority. (Foucault, 1986, pp. 44 - 45)

The “complex group of relations … systems of norms … process and patterns” that Foucault says constitutes ‘objects of discourse’ are understood here as woven through and in the participants’ accounts. In this analysis I have used the term ‘discourse’ in two ways. Firstly, to mean how the participants actively constitute ‘objects of
discourse’ in their talk, and, second, as meaning the discursive resources the participants draw on to do this. The following analysis explores how the ‘objects of discourse’ are discursively ‘worked up’ in the participants’ accounts with the analysis identifying and examining what discourses the participants do and do not draw on in their talk and in what ways their talk reference relations of influence operating between co-implicated contexts (see Burke, 2000; see also Wilson, 1999). In order to do this I have used inter-disciplinary understandings that ‘context’ can mean:

- a weave
- a connection
- a place
- a stress on the power of place and time
- how and when something was done in order to persuade effectively
- a consideration of ‘social frames’ through which ‘contextual’ stimuli and contextual clues have brought memories to the surface
- situational thinking … bound to the immediate experience of unique objects and situations’ in discriminating concrete from abstract thought
- a ‘field theory’, which considers that a viable understanding of groups and individuals must include a study of the ‘life space’ or environment of the group or individual;
- an establishment of an understanding of an individual ‘in a system of relations … to place it in its historical context’
- an attention to ‘the fact’ that “Thinking is never done in vacuo: it is always done by a determinate person in a determinate place.”
- an attention to the ‘the non-identity of the identical in different psychological contexts
- locale
- situated knowledge
- the difference in the ‘performance’ of the same people in different settings
- regions, circulation and negotiation used deliberately instead of context (see Burke, 2002)
This inclusive, though not exhaustive list of what can constitute understandings of ‘context’ was used as a resource in the analysis as a way of considering how the intersubjective can be identified as contingent upon ‘context’ and ‘history’.

In order to obtain data that was as rich as possible and that would allow commonalities and differences to surface in the analysis a semi-structured interview schedule (see appendix 1) was developed with the intention of eliciting the participants’ ‘plush talk’. That is, talk that was candid and immediate characterised by a texture that would evidence variability, difference and sameness within and between the participant’s representations of their work. Whilst interviews are inevitably performative my aim was to facilitate an interview interaction in which participants talk was not ‘merely’ the rhetoric of what the participants may have thought they were expected to say about their work as professionals working in a highly pressured and accountable area. (Such rhetoric would provide a valuable but different type of data and analysis).

1.4.3 Participants

Twenty participants were recruited from across a large, metropolitan hospital complex in Australia. (During one interview I forgot to turn the tape recorder on so that interview was unfortunately forfeited leaving 19 transcripts.) Participation in the study was voluntary. Participation was invited from all nurses who cared for eating disordered patients across the four ward areas in the hospital that had eating disorder beds. Participation was sought by contacting the nurse unit mangers of wards. The project was explained to the managers, and permission sought to invite nurses’ participation in this project by word of mouth. It was explained to prospective participants that all participation was private and confidential that no monies were involved. It was also explained that participants could withdraw at any time without needing to offer an explanation of withdrawal, and without penalty or prejudice. Copies of the ‘Participant Information’ sheet (see appendix 2) were left with the nurse unit mangers. It was arranged that I, as sole interviewer, would be available for
interviews on particular days, and at times that were convenient to the ward, and interested staff could anonymously and privately approach me, which they did.

1.4.4 Confidentiality In The Hospital

All the participants had personally nursed eating disorder patients. The roles in which they worked ranged from clinical nurse consultants, clinical nurse educators, nurse unit managers, registered nurses and enrolled nurses. The four main wards areas where the participants worked were two children’s wards, the first that cared for eating disorder patients under the age of 10 years old and the second, which took children from 10 years to approximately 14 years old. There was one adolescent medical ward that had beds for eating disorder patients from approximately 15 - 18 years of age and one psychiatric unit that took eating disorder patients from over 18 years of age.

Each of those four areas that were involved in the study had an eating disorder multidisciplinary team that provided care, treatment, and had up to three interdisciplinary team meetings per week. It was at these team meetings that the teams made decisions concerning therapeutic treatment changes for each eating disorder patient. Each of these teams included nursing staff, whose positions included clinical nurse consultants, clinical nurse educators, clinical nurse specialists; nurse unit managers, registered nurses and enrolled nurses. Each team also included medical staff. The type of medical staff varied across wards but included a senior hospital paediatrician, or senior hospital psychiatrist in the case of the psychiatric area, a paediatric registrar, a resident doctor and an intern doctor, a consulting senior paediatrician, and/or a consulting psychiatrist, plus a resident senior child and adolescent psychiatrist, and a psychiatric registrar. In addition the teams included a dietitian; a physiotherapist; an occupational therapist; a medical psychologist and an intern medical psychologist, a social worker, teachers from the hospital school and an art therapist. These disciplines are variably represented on an area’s multidisciplinary team depending on the specialty of the area in dealing with eating disorders i.e. early
childhood, childhood, adolescent and young adult (psychiatry). A number of the doctors and some of the nurses were members of more than one of the teams across the four areas in the hospital.

Nurses who participated in the study varied in a number of ways including their differing levels of seniority and differing nursing backgrounds and experiences that the participants brought to the work of caring for eating disorder patients. Clearly, given the different wards from which participants were recruited, they also worked with differing age groups of patients and in multidisciplinary teams whose configuration differed on these different wards. While every position in the hospital hierarchy privileges access to some discourses and not others this consideration of differences in participants’ positions, level of seniority and working context, while important, has been elided to ensure absolute anonymity for the participants.

1.4.5 Ethics

Prior to initiating any contact with any of the nursing staff, I submitted ethics proposals to the relevant Hospital Ethics Committees as well as to The University of Western Sydney Ethics Committee all of which were approved. And an addendum to one of the ethics proposal initially submitted to the Hospital Ethics Committee was completed and approved, after it was suggested to me by a senior hospital staff member that ward staff on a ward, which was not initially included in the study, were now available to be involved. The number of interviews cited in the study’s original proposal was fifteen, and this was increased to twenty through inclusion of this additional ward.

1.4.6 Procedure

Prior to commencing each interview the aims, purpose and structure of the study were explained to each participant. Further, each participant was asked to read the ‘Participant Information’ sheet in my presence, which participants then initialed. A written consent form (see appendix 3) was also read and discussed, then signed by
each participant and the interviewer in front of an independent witness. Copies of both the initialed Participant Information sheet, and the signed consent forms were given to each participant, with the originals being held by myself. At each interview after the consent forms were signed and before turning the tape recorder on I reiterated clearly that no-one would know or be able to find out who had participated in these interviews, and that the protection of all participants’ identity and privacy was my first priority in this study. I urged the participants to say whatever they wanted to in whatever way, that they were ‘in-charge’ of the interview, and could stop the interview partly or wholly without being questioned. I did not proceed until I was sure that each participant understood this to my satisfaction.

1.4.7 The Data

The data consists of nineteen semi-structured confidential, one-to-one, audio taped interviews that were transcribed verbatim by an independent transcriber and the data was fully anonymised. (A copy of the transcription convention is provided in appendix 4.)

1.4.8 Analysis

An ordered and detailed approach to the analysis involved the transcripts being systematically coded, and the smaller interview extracts sorted into categories, which were then subjected to an in-depth analysis. Two complete, detailed close readings of the transcripts were initially undertaken. The data was transferred onto N-Vivo - 3 and the resulting categories, and corresponding account extracts were compiled into a compendium of coded data. (A copy of the N-Vivo category index is provided in appendix 5.) This made the data manually and electronically accessible. Each of the extracts from the accounts that are used in the analysis have an abridged N-Vivo notation at the end of the quote - for example, [Document 'Data - Millie' Paragraph 79] - to identify from which data document and from which place the quote was drawn.
1.4.9 The Process Of This Analysis

This analysis took approximately fifteen months. The analysis of the participants’ account was based upon my close reading and re-reading of the precise detail of the participants’ accounts. It was also informed and influenced by having interviewed each participant myself, by having written a series of post-interview reflections, and by my having attended a weekly eating disorder multidisciplinary team meeting for thirteen months at the hospital campus to listen to discussions. Despite having met each of the participants and having been well familiarised with the teams in which they worked, reading the participants’ accounts was like entering a maze of murmurs with the analysis proceeding from these informed readings.

The analysis itself was a process of ceaseless questioning myself as reader to answer a number of questions of the texts. These included:

* What work is done by a ‘discourse’ here and why?
* How is the speaker positioned so as to talk this way?
* What is not said in what is said?
* In what ways are ‘gender’ and ‘power’ discoursed here, and why?
* What constitutes discourse membership here and does it belong elsewhere?
* Who cannot enter this discourse and why?
* And what do these discourses constitute and coordinate?

I therefore did not approach the participants’ accounts by presupposing there was a fixed and unified commonality of understanding between the nurses, which the analysis would ‘fish out’ from participants’ accounts, and against which these accounts could be adjudicated for strengths and weakness. Rather the theoretical framework, which subtends this methodology, allows the participants’ subjectivities in the specific context of the nurse-to-eating disorder therapeutic relationship to be revealed in the shifting, ambiguous and inconsistent ways in the participants talk. The analysis thus investigated the textures of these subjectivities, the textures of other objects of discourse such as ‘patients’ and the “texture of relationships ... assembled
out of the surface clues in relation to knowledge of culture” (Baker, 2000, pp. 102 – 104).
1.5 Conclusion

In the first section of this chapter this study’s feminist, critical psychology framework was discussed against the background of the ‘positivist’ framework that underpins much of contemporary conventional psychology. The differences between a conventional psychology perspective and a critical perspective were discussed in terms of the differing respective epistemological and ontological orientations. While this differentiation of epistemological and ontological orientations initially suggested that there is a unified and coherent feminist, critical psychology epistemology a further brief overview of feminist theorisation showed rather that there is marked theoretical differences and challenges indicating differing feminist epistemologies. I identified this study as taking a feminist post-structuralist Foucaultian position.

A feminist - post-structuralist, critical psychology framework informs among other things a rejection of

the possibilities of absolute truth and objectively-established knowledge [and instead considers that] far from being neutral, widely accepted conceptions of the material and social world tend to be consistent with the values associated with the dominant moral order (Weatherall, 2002a, p. 88).

This theoretical framework importantly conceptualises gender and power from a Foucaultian (1986) perspective as constituted in discourse (see Malson, 1998; see also Henriques et al., 1987). This perspective thereby allows different conceptualisations of ‘eating disorders’, ‘patients’ and ‘nurses’ than does a conventional psychology approach. It therefore allows different questions to be asked. Within a feminist, critical psychology framework ‘representation’ is understood not as a ‘reflection’, but implies “the active work of selecting and presenting, of structuring and shaping: not merely the transmitting of an already-existing meaning, but the more active labor of making things mean” (Hall, 1997, p 64).
The literature review that followed the theoretical overview discussed the difficulties and lack of agreement in understanding eating disorders, therapeutisation, and treatment outcomes. This review also highlighted the lack of research that investigates nursing of eating disorder patients and the nurse - eating disorder patient relationship. Nursing in this field was thus identified as an aspect of ‘treatment’ requiring further research. And, in addition, as the above discussion of the literature on eating disorder treatment also indicates, research employing a feminist, critical psychology perspective can be considered as having the potential to make an invaluable contribution to current research in this field.

The current literature figures the eating disorder patient as a ‘young woman’ (Emans, 2000; Laurie & Mitan, 2002), who has an overwhelming desire to be thin, where her desire to be ‘thin’ reflects her intense prolonged fear of gaining weight - of being fat (DSM IV, 1994). Her fear and desire is portrayed as being characterised by a particular cognitive style of a ‘distorted’ - ‘all-or nothing’ type of thinking (Muscari, 1998a). ‘She’ is characterised as probably holding strong negative self-beliefs about herself as part of her ‘core’ eating disorder pathology (Cooper, et al., 2001). ‘She’ is likely have a ‘distorted’ physical self-image, where instead of seeing an emaciated body when ‘she’ looks in the mirror, ‘she’ may see herself as obese (Wardle, et al., 1993). In order to become ‘thin’ and stay ‘thin’ ‘she’ intentionally engages in distinctive, characteristic patterns of behaviour (Beumont et al., 2003; DSM IV, 1994; Treasure et al., 1995) including obsessively exercising, avoiding family meals or changing her diet dramatically diet, and being secretive about all of the above activities. Importantly, in this literature on ‘eating disorders’, ‘she’ collapses into her eating disorder. ‘She’ is sustainedly disordered. At no point in the DSM-IV criterion of diagnosis is this eating disordered patient not disordered – ‘she’ is the unitary, originatory and constant ‘thin’ figure instantiating this pathology. ‘She’ also happens to live in a Western or Westernised world were women’s value is intimately linked to their appearance and to slenderness, and where this ‘idealised’ thinness is symbolic of great fortune (Malson 1998; Krusky, 2002; Jutel, 2001). At a certain point some of

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these young women die in their ‘ideal’ state. Approximately, 8.4% of them (Crowe et al., 1999; Emberg, 1999). This is the inescapable stereotype of ‘the typical anorexic’ (or ‘bulimic’) that precedes the eating disorder patients into hospital. And it is a stereotype that the participants in this study necessarily negotiate with in their day-to-day contact with eating disorder patients. That, eating disorder nurses experience conflict and struggle in their work is thus entirely understandable (Newell, 2004; King & Turner 2000; Ramjan, 2004), that they do so well in their work is dazzling.

In the last section of this chapter (section 1.4) I considered this studies aims, methodology and process of analysis as issuing from a feminist, critical psychological perspective, and the need to ask questions differently concerning the therapeutisation of eating disorder patients. This study’s aims constitute a way of investigating the processes by which the participants engage in a therapeutic liaison with this client group. These aims can be summarised as an investigation of the discursive resources the participants draw on in framing and making sense of their work in their particular area of care. The qualitative, discourse analytic, semi-structure interview-based methodology was discussed at length, as was the analytic process. In discussing the aims and methodology of this thesis I have sought to show the value of this methodological approach in satisfying the projects aims, clearly delineating researcher ‘bias’ and ‘non-neutrality’ as a member of Western culture, and noting the positive value of this ‘bias’ as a tool of analysis.

The following analysis is presented in the next three chapters. As stated in the introduction these chapters deal successively with how participants discursively construct the eating disorder patient (Chapter 2); how they constitute themselves as nurses working in this area of care (Chapter 3), and how they construe the multidisciplinary team as part of the institution in which they work.
Chapter Two
The Discursive Constructions of ‘Eating Disorders’
and the ‘Eating Disorder Patient’

2.1 Introduction

This is the first of the three analysis chapters of this study. The following analysis is about how the participants’ accounts constitute the eating disorder patients, how both ‘the eating disorder patient’ and ‘the nurse’ are gendered in these accounts, and how a flow of power is constituted in the participants’ accounts.

In these chapters the participants’ accounts will be shown to both intensify and explode stereotypes of the eating disorder patient, the nurse and of what it is like to work in a multidisciplinary team. These accounts are rich in provocative contradictions that show the eating disorder patient as a powerful and simultaneously subjugated patient; that disrupt the image and ideal of the nurse as unified, coherent and ‘good’. The role of the nurse is also shown to occupy a time-honored ‘good-bad’ dichotomy that holds specific tensions in how the nurses are positioned as working with eating disorder patients. The accounts will also be shown to locate nurses as caught between the medicalised pursuit of ‘cure’, and the nursing mandate to ‘care’ when the patients they are meant to care for allegedly respond to both ‘care’ and ‘cure’ with cunning and vitriol. In each of the chapters the analysis is also concerned with exploring the relations of power and patriarchy, which seemingly ‘stalks’ the participants through their accounts of themselves, their patients and their work.

The organisation of the analysis is as follows: this first chapter concerns the constructions of ‘eating disorders’, and the eating disorder patient. Following this, chapter three considers the constructions of ‘the eating disorder nurse’. The last analysis chapter, chapter four, considers the participants’ constructions of ‘the multidisciplinary team’ and the ways in which the nurse is discursively constituted and regulated in that context. Each of these three chapters are organised into sections
that are introduced at the beginning of each chapter and summarised at the end of each chapter.

2.2 The Problematic ‘Identity’ Of ‘The Eating Disorder Patient’

This first chapter considers participants’ constructions of eating disorders per se and the eating disorder patient. In the participants’ accounts ‘the eating disorder’ patient is constructed in multiple, complex and often contradictory ways. The following seven sections in this chapter consider: (1) the problematic ‘identity’ of ‘the eating disorder patient’; (2) the participants’ constructions of these patients as different and the ways in which these patients are construed as considering themselves to be different; (3) the eating disorder patient as deviant and deviancy as ‘feminised’; (4) the eating disorder patient as other than normal; (5) the eating disorder patients’ families as pathogenic; and (6) eating disorders as a mental health issue and simultaneously not a mental health issue.

Amongst these various constructions in the participants’ accounts, a construction of the eating disorder patient as someone who had problems or issues with ‘identity’ was particularly prominent. Within participants’ accounts the term ‘identity’ appeared like a ‘passport photograph’ (Sarup, 1996, p. xv), intended to fix and record a faithful unchanging image of a person. In this the participants can be read as drawing on “foundational thinking about identity” (Gaudelli, 2003, p. 60), which automatically assumes that each ‘bounded’ individual has a single ‘identity’ - an intact internal ‘self’ that is unified and fixed over time (Malson et al., 2002, p. 470). Within this culturally dominant construction of subjectivity, ‘identity’ is characterised by a few ‘essential’ traits or attributes that function to totalise the individual (Gaudelli, 2003, pp. 61 – 64) and to circumscribe individuals’ ‘real’ [or] ‘authentic’ selves (see Malson et al., 2002, p. 484; Widdicombe, 1993). And it is in relation to the notion of “the self sustaining subject at the centre of post-Cartesian Western metaphysics” (Hall, 1996) that the ‘identity’ of the eating disordered patient is constituted as problematic and deficient.
These constructions of eating disorder patients as having ‘identity’ problems were evidenced in various ways in the participants’ accounts through notions of ‘lack’, ‘absence’ and ‘delayed development’. Thus, for example, in the following quote a ‘lack of identity’ is inferred through an account of patients’ alleged developmental ‘failure’.

Loretta: … they’re very confused and they’re very conscious of what people are saying and looking at them. They haven’t actually developed an identity. [Document ‘Data - Loretta’ Paragraphs 176-185]

Loretta’s construction of eating disordered patients as having not (yet) ‘developed an identity’ draws on developmental psychological notions of identities (and other psychological attributes) developing ‘egg-wise’ according to some ‘normal’ timetable. The account thus implies both an absence of identity and an immaturity in ‘the patients’. In Loretta’s account, moreover, ‘undeveloped identity’ is associated here with constructions of ‘patients’ as ‘confused’, ‘wary’ and ‘very conscious of what people are saying and looking at them’. And, by associating an ‘undeveloped identity’ with ‘confusion’, ‘wariness’ and ‘too much’ consciousness of others’ views, the account implies that ‘identity’ can have some self-orienting and stabilising function that is lacking or deficient in the eating disorder patient. As these patients are construed as ‘confused’ and ‘wary’ – as overly orientated to others’ views and less than stable – the construction of the eating disorder patient as lacking a ‘mature identity’ is thereby consolidated.

In the extract above ‘identity’ is constituted as something separate from (and absent for) ‘the patient’. As Dorothy Smith has argued, (Smith, 1999, p.59) “the presence of the subject” can be suspended through nominalisation “wherein a verb expressing the action of a subject is given the form of a noun. … Once nominalised social phenomena are constructed, agency can be attributed to them rather than to people”. In terms of what Loretta says above, ‘identity’ can be read as a nominalisation with the person partitioned off as if their ‘identity’ were separate to them but ‘housed’.
within (or missing from) them. This nominalisation of ‘identity’ is variously repeated in the following quotes that again constitute ‘patients’ as lacking ‘identity’.

Phillipa: … they’re looking for their own identity. [Document 'Data - Phillipa' Paragraphs 54]

Millie: there's underlying identity issues. [Document 'Data - Millie' Paragraph 79]

Carol: for me, this [eating disorder] is part of their identity. This …[eating disorders] is them and maybe that’s, you know. It’s, it’s all they’ve got. [Document 'Data - Carol' Paragraph 82]

Susan: and yeah you’re taking away from them the one thing they feel that they do well and it provides them with a sense of identity. [Document 'Data - Susan' Paragraph 59]

Vicki: from your experience …what do you think it's about - anorexia and bulimia?
Faye: Um, identity. But I mean, who they are and where they’re going. Their survival. Yeah. Yep. [Document 'Data - Faye' Paragraph 280]

In the first of these extracts, ‘identity’ appears as ‘something’ the eating disorder patients do not have and are in want of. As Phillipa says: ‘they’re looking for their own identity’. Her statement reifies ‘identity’ as a ‘thing’, giving ‘it’ the quality of ‘object-ness’ and implying ‘it’ is somehow lost or absent for ‘the eating disorder patient’. In Millie’s, Carol’s, Susan’s and Faye’s quotes patients are again constructed as lacking identity, in these cases, through an explicit construction of ‘eating disorders’ as being about failed, problematic or absent ‘identity’. For example, Millie construes the eating disorder patients as having ‘underlying identity issues’ thus suggesting that the ‘eating disorder’ is a visible part that overlays pre-existing but hidden ‘identity’ issues’ with the ‘eating disorder’ functioning to either obfuscate or express these ‘identity issues’. And whether ‘the eating disorder’ expresses or hides
the 'identity issue', the eating disordered patient figures as a pathologised 'identity'. In these above four quotes 'eating disorders' are construed as being fused with the patients' (absent) 'identities' so that 'the eating disorder patients' are their 'disorders'. In Carol's quote 'an eating disorder' is constructed as being "part of [the patient's] identity", perhaps implying that patients have an 'identity'. However, this possibility is then closed off by Carol's construction of eating disorders as synonymous with 'the patient'. Her account thus articulates a totalised identity (see Gaudelli, 2003, p.68; see also Hall, 1996) in which the patient's identity is comprised entirely and only of their diagnosis so that without the eating disorder identity would be absent: "this [eating disorders] is them. It's all they've got". A grim category where these patients are their pathologised 'identity'.

Susan and Faye's extracts, like Carol's, similarly suggest that the 'identity' of 'the eating disorder patient' occupies a single and 'disordered' space. For Faye the eating disorder is 'who they [the patients] are and where they're going' again essentialising the patient to be the 'eating disorder'. However, in contrast with the other extracts, Faye also constructs an 'eating disorder' as being 'a way of survival'. Even though Faye has equated the 'eating disorder patient' with their 'disorder' - with 'who they are and where they're going' - the simultaneous construction of eating disorder as 'a way of survival' suggests a notion of eating disorders as having a positive 'purpose' rather than being a purely 'pathological' (absence of) identity.

In the extracts analysed above, 'eating disorders' are construed as indicative of problematic or absent identity, and as pathological substitutes for identity such that 'the eating disorder patient' is lacking or defective in identity. 'The eating disorder patient' is constituted as failing and lacking in relation to the culturally dominant construction of subjectivity as a singular, stable and always present psychological identity. In this way, 'she' is also constituted and regulated as different from 'the norm', a construction which can be read as always-already gendered in that her differences are constituted as deficits (see Weatherall, 1998b, p.1).
Additional to the above constructions of this patient group as having ‘identity’ problems, Susan also talked about the possible influence that a nurse’s ‘identity’ can have in their work. Susan says:

Susan: I think its life experience that they [the nurses] bring us [that] is really important. I don’t think it’s the position. I think it’s the person … the issue is how interested are they in these young people, how much do they enjoy working with young people … what life experiences they bring … to their job, how confident they are as a person and how strong their own identity is as a person, if they’ve got children … If they’ve had those life experiences, mature aged. … Um, all those things make a difference and it’s not the position it’s the person in the position.

[Document 'Data - Susan' Paragraph 342]

In this quote the ‘eating disorder’ nurse becomes an ‘identity-disorder’ nurse whose ‘confidence and …. strong … identity make[s] a difference’; whose role as a nurse and whose personhood are inferred to make a positive ‘difference’. By privileging the nurses’ strength of identity as curative, Susan’s account thus implicitly positions the eating disorder patient as having some sort of ‘identity - impairment’ in relation to which the nurses ‘beam-in’ their ‘personhood’ - their strong identities - through their nursing role ‘to make a difference’. Her account implies here that this sort of ‘difference’ that a nurse’s strong identity can make is a valuable ‘difference’, not some kind of negative ‘difference’. Susan’s encapsulation that ‘its not the position it’s the person in the position’ that makes a ‘difference’ structures a latitude of subjectivity for the nurses to be ‘more than’ their role with the ‘more than’ part being positively valued. But this latitude is not extended to the eating disorder patients. As Susan’s previous quote illustrates, the eating disorder is construed as being fused into the patients’ sense of self where it ‘provides them with a sense of identity’, sealing them tight into their ‘medicalised unity’ (see Miller, 2000, pp. 337 – 341).
2.3 Self-perception

The above accounts show how the participants construct the eating disorder patients as having problematic ‘identities’ and how these constructions position this patient group as ‘different’ to the ‘norm’. The participants also constitute these patients as ‘different’ in other ways in their accounts. In the following three quotes Phillipa, Loretta, and Bridget explicitly construe this patient group as ‘seeing’ or ‘perceiving’ themselves as different. In these accounts the patients are positioned as being different from ‘normal’ people precisely through a construction of the eating disorder patient as someone who sees herself as different. Phillipa, Loretta, and Bridget say:

Phillipa: they see themselves as really quite different to the rest of the adolescent population. [Document 'Data - Phillipa' Paragraph 56]

Loretta: They see differently from what we see. ... I know it’s something in the brain. ...they’re coming on a different level and it’s hard to connect at the level with them [Document 'Data - Loretta', Paragraphs 40-54]

Bridget: they didn’t sort of mix with the other patients. Um, so they were all very much together. And they saw themselves as different. [Document 'Data - Bridget' Paragraph 25]

In the above quotes the eating disorder patients are constructed as ‘different’ from ‘normal’ girls through the participants’ construals that they - the eating disorder patients - consider themselves to be different. Phillipa, Loretta and Bridget’s construals of the eating disorder patients as ‘see[ing] themselves as different’ suggest a different type of patient to that figured by Phillipa, Carol, Millie and Susan’s above construals of these patients as ‘identity-impaired’. For ‘difference’ here is not necessarily ‘lack’. Phillipa, Loretta and Bridget’s above construals position this patient group in a hall of mirrors in which these patients are constructed as ‘viewing’
themselves as ‘different’; a construction of difference which implies that ‘normal’
people see themselves as ‘the same’.

Here, the participants’ talk mobilises commonplace nursing conventions wherein
nurses report their observations of their patients as ‘facts’; as ‘observations’ that are
stamped with the imprimatur of the nurses’ clinical authority, altruistic purpose and
objective gaze. Their detailed accounts thus have a ‘truth-effect’ of being reportage.
The participants’ talk therefore functions to construct these patients as ‘different’ in
such a way that the participants’ are curtained off from potential accusations that they
are singling out this group of patients as ‘different’. The perspective offered in the
participants’ above quotes is given a ‘veracity’ similar to that given to nurses
‘observations’ and ‘reports’ of patients’ weight, blood pressure or pallor. Here,
however, the nurses’ reportage concerns not the patients’ bodies, but the patients’
alleged self appraisals: it is the patients themselves who ‘see themselves as really
quite different’, ‘[t]hey see differently from what we see … they’re coming on a
different level’ and ‘they saw themselves as different’. The accounts thus also beg a
question concerning against whom or what these patients might adjudicate
themselves to be ‘different’?

The lack of specificity about what constitutes this alleged perceived ‘difference’ hints
at a possible indeterminate moral offense. It is possible that a moral evaluation shapes
the construction that these patients ‘see themselves to be different’. That is, the above
construals can be read as resonating with an alternative question: ‘Who does she
think she is?’ And this sub-textual question perhaps instances those moments of both
‘felt’ and ‘enacted’ judgments that lace and unlace our lives with fleeting power. Yet
this possibility of moral evaluation “is rendered invisible through … [the] apparent
impartiality” (Laws and Davies, 2000, p. 213) of these accounts which appear to
function as the mere reportage of the nurses’ expert gaze which is stamped by their
authoritative institutional positioning, ratifying ‘the truth’ of their expert, professional
construals.
So far, in the above two sections of this chapter, two ways have been considered in which the participants construct ‘the eating disorder patient’ as ‘different’. ‘She’ is constituted as different, firstly, through a construction of ‘her’ as having a problematic ‘identity’ and, secondly, through a construction of patients as young women who ‘see themselves as different’. These two constructions are incongruous and quite ironic. That is, in the first section this patient group is constituted as ‘different’ by virtue of their flawed, faulted or immature identities. Yet in the second construction it is the patients’ own alleged perceptions of themselves (as different) that structures their ‘difference’ and which, in contrast with that first construction, infers a strong sense of identity, but one marked by moral confusion rather than ‘lack’. In the next section ‘difference’ is again discussed. In the participants’ accounts analysed below the eating disorder patient is construed as ‘deviant’ and this ‘deviance’ is feminised.

2.4 Deviancy

In this section of the analysis consideration is given to how the participants construct the eating disorder patient as ‘deviant’ and therefore ‘different’. In the following discussion the ‘feminine’ and the ‘eating disorder patient’ will be shown to arise as co-terminus constructions in the participants’ accounts where the eating disorder patients are construed as ‘cunning’, ‘lying’, ‘manipulative’, ‘untrustworthy’, ‘nasty’, ‘controlling’, ‘destructive’ but also as ‘perfectionistic’, ‘intelligent’, and ‘high achieving’. These are constructions through which, as Ruth Bankey says, “the deviant is marked by external signs and …[t]hese signs and movements [are] often associated and conflated with representations of the feminine” (Bankey, 2001, p 42). In the following accounts the eating disorder patient is constructed as ‘deviant’ where the participants construe the eating disorder patients as ‘intelligent’ and ‘high achieving’, yet as pathologised and irrational in their ‘intelligence’ and ‘high achievements’ (see also Walkerdine, 1989). These and other construals figure the eating disorder patient as
La Donna e' mobile” translated from the Italian, as the woman in motion [which] does not refer to spatial mobility, rather, it is in reference to the instability and disorder of women’s bodies and minds. The feminine, and consequentially women … [are] pathologised as unstable, deceitful, naturally inferior and irrational (Bankey, 2001, pp. 37 – 38).

In constructing the eating disorder patient as ‘deviant’, and therefore ‘different’ the participants position this patient group against assumptions of what constitutes ‘normality’ and ‘the ordinary’. In the following accounts ‘normality’ and ‘the ordinary’ can be read as ‘always-already’ present in the participants’ accounts. Thus, the participants’ various construals of the eating disorder patient as ‘deviant’ function as implicit but inverse indices of ‘normality’.

The following discussion of the participants’ constructions of the eating disorder patient as ‘deviant’ is ordered in two parts. First, consideration is given to the participants’ accounts where the eating disorder patient is construed as pathologically intelligent, high achieving and perfectionist and, secondly, consideration is given to accounts where the eating disorder patients are construed as manipulative, venial and cunning.

2.4.1 Pathologically Intelligent, High Achieving And Perfectionist

In the following quotes Bridget, Sally and Loretta talk about these patients as intelligent, they say:

Bridget: They were highly intelligent young people … all females. … [Document 'Data – Bridget' Paragraphs 17]

Sally: and they're all intelligent. Very intelligent. [Document 'Data - Sally' Paragraph 178]
Loretta: they’re very, very smart. They have answers for everything. [Document 'Data – Loretta’ Paragraphs 40-54]

The above quotes construe the eating disorder patient as ‘intelligent’ and can thus be read as ‘positive’ constructions of the eating disorder patients. Yet Bridget adds that ‘they’ are ‘all female’, and Loretta also says these patients ‘have answers for everything’ thus rendering these construals of the eating disorder patients ambiguous, and inferring that ‘intelligence’ in this patient group is a problem. Loretta’s says that these ‘very, very smart’ patients ‘have answers for everything’ implying that this ‘smartness’ is irritating and unpleasant. Bridget’s construal of these patients as ‘all female’ as well as ‘highly intelligent’ invokes a sense that ‘intelligence’ is somehow contradictory within this ‘all female’ patient group, rather than being a positive and welcoming appraisal of ‘intelligence’ in these young women.

These less-than-positive construals of eating disorder patients as ‘intelligent’ reinstate what Lester (1997) talks about in her discussion of the cultural constructions of thinness in relation to anorexia. Lester (1997, p. 486) argues that a “thin body communicates absolute purity, hyper-intellectuality, and transcendence of the flesh”. Here, as the participants construe these patients as ‘intelligent’, contradictions emerge. For example, how is it that these ‘so smart’ patients, who ‘have answers for everything’, have ‘failed’ by becoming hospitalised with an eating disorder? Would ‘intelligence’ in an ‘all male’ patient group be similarly problematised? In this context ‘intelligent’ young women are perhaps implicitly construed as ‘too clever for their own good’. And, as the quotes below illustrate, their ‘intelligence’ is implicitly construed as ‘suspect’ and as a symptom of their disorder, as is their ‘femininity’.

In the following quote Loretta talks about the eating disorder patients as ‘smart’ in a way that suggests that they are ‘over the top’. She says:

Loretta: Most of the eating disordered we have come across are very smart girls … Um, won’t accept, like an ordinary person would just accept a 90 percent of a 100
percent, these girls would go to 105. ... they’re very, very smart. [Document 'Data - Loretta' Paragraph 46]

In Loretta’s account the eating disorder patients are implicitly construed as ‘not being ordinary’ because ‘they’re very smart girls’ and because of their high achievements: ‘these girls would go to 105[%]’. ‘Ordinary people’ Loretta says would accept ‘90 percent of a 100 percent’ but not the eating disorder patients who ‘would go to 105[%]’. Her account suggests that this patient group wants more than is possible or necessary. Their intelligence is constituted as ‘too much’ (see Bordo 1993), as feminine excess (see Malson, 1997) and thus implicitly as symptomatic of pathology. Here the eating disorder patients are disqualified from being ‘intelligent’ in an acceptable way. There is something remiss and inappropriate in their especial ‘smartness’. Loretta’s construal of these patients as dominated by their desire to ‘over-achieve’ academically suggests perhaps that they are infected by their ‘intelligence’. Similarly Max, Casey Anne, Justine and Bridget also construe these patients as problematically ‘perfectionistic’ and ‘high achieving’. They say:

Max: they often, um, are high achievers. [Document 'Data - Max' Paragraphs 65-67]

Casey Anne: they’re high achievers, a lot of them ... very precise about keeping their room, their bed space clean and tidy. They like things well organised and ... they like to be in control of their environment [Document 'Data - Casey Anne' Paragraphs 42]

Bridget: [they are] all high achievers all came from fairly wealthy families. ... most of the ones I came across were very high functioning they actually ruled everybody around them, by this eating disorder. That was their one weapon, and they used it. [Document 'Data - Bridget' Paragraphs 17-29]

Justine: Often kids that are high achievers and also perfectionists. You’ll just know that, I mean just silly little things like you’ll go in and notice their beds are perfectly
made in the mornings ... you can actually rule them and say ‘Yep. They’re perfectly in line. ... sometimes I think with some of the kids it’s [the eating disorder] actually a need to actually break out of that, out of being perfect ... and being a high achiever ... it’s their only little control they have or if they’re in hospital or they’re seen as being sick then the expectations [to be perfect] no longer on them. [Document 'Data - Justine' Paragraphs 37-47]

Like the above construals of the eating disorder patient as ‘intelligent’ where ‘intelligence’ is inferred to be a ‘taint’, Casey-Anne and Bridget’s construals of the eating disorder patients as ‘high achieving’ and ‘perfectionistic’ imply that these personal characteristics of these patients are of a ‘different’ and less favourable order. In the above accounts ‘high achieving’ and ‘perfectionism’ in the eating disorder patient are inferred to be an unhealthy excess streaming out of these patients with this surfeit being in evidence to the nurses when ‘their [the eating disorder patients’] beds perfectly made’ and when they are ‘very precise about keeping their room their bed space clean and tidy ... [t]hey like things well organised’. These patients are construed in the above accounts as more than competent in their excess of precision and organisation. In her analysis of how girls’ and boys’ mathematical competence is differently regarded, Valerie Walkerdine (Walkerdine, 1989, p. 33) argues that

... girls’ correct performance was not only seen as wrong but as pathological ... girls may be able to do mathematics, but good performance is not equated with proper reasoning.

In the above accounts the eating disorder patient’s ‘high achievement’ is situated in a one to one correspondence with their eating disorder. The ‘high achievements’ of this patient group is thereby coupled to their pathology, rendering these patients’ achievements aberrant and portraying a feminisation of their ‘high achievement’ whereby it becomes valueless and futile. What is the point of making a bed with exquisite precision except the exercise of compelling precision?
In the above quotes Casey-Anne, Bridget and Justine link the qualities of ‘high achievement’ and ‘perfectionism’ to problems of ‘control’. Casey-Anne says the eating disorder patients ‘like to be in control of their environment’. Here Casey-Anne’s explanation that the eating disorder patients’ ‘perfectionism’ and ‘high achieving’ serves their seeming desire or need ‘to be in control of their environment’ thus again construes these patients as ‘abnormal’. But this inference that the eating disorder patients are ‘abnormal’ in this regard contradicts developmental discourse where learning to control, learning to take responsibility and learning to be accountable are considered as important aspects of Western socio-cultural maturation by which individuals take up ‘adult’ roles in the world at large. The implicit construction of ‘lik[ing] to be in control’ as ‘abnormal’ rather than commendable can thus be seen not so much as an ‘identification’ of pathology than as a discursive working-up of ‘patients’ as pathological (see also Smith, 1990).

Bridget also constructs these patients as abnormally controlling, and additionally as aggressive when she says that these patients ‘actually ruled everybody around them, by this eating disorder.’ She says ‘[the eating disorder] was their one weapon, and they used it’. Bridget clearly suggests some sort of intent on the part of the eating disorder patient to the extent that they abuse those around them by using their eating disorder ‘as a weapon’. Bridget’s construction of the eating disorder patient as ‘very high functioning’ and as using their disorder as a ‘weapon’ figures this patient group as immoral in their desire for control, in that they should ‘know better’ than to ‘actually rule everybody around them’. And in this construal Bridget positions the eating disorder patient as an ‘outlaw’, as breaking the moral code, in an instantiation of the culturally dominant image of the inherently and irrevocably corrupt ‘feminine’ – bad is as bad does.

Justine (quoted on the previous page) also links ‘perfectionism’ and ‘high achievement’ with ‘control’ but quite differently and in contradiction to Bridget and Casey-Anne’s above accounts. Justine construes perfectionism in the eating disorder patient as ‘[the] only little control they have or if they’re in hospital or they’re seen as
being sick then the expectation’s no longer on them [to be perfect].’ Here, Justine construes the eating disorder patient as experiencing pressured expectations of perfection from outside of them, such that these expectations of needing to be ‘perfect’ are relieved during their hospitalisations. Justine says when the patients are ‘seen as being sick then the expectations no longer on them [to be perfect]. For Justine these expectations of being ‘perfect’ do not necessarily arise from within the individual eating disorder patient, as is construed in Max, Casey-Anne, Bridget and Loretta’s above quotes of ‘perfectionism’ as internal to the eating disorder patient.

In constructing this patient group as ‘perfectionist’ Justine also says that these patients make their beds perfectly. And, in this, these patients can be read to behave like ‘good girls’ - ‘you’ll go in and notice their bed’s are perfectly made in the mornings you can actually rule them and say ‘Yep. They’re perfectly in line”. Bankey observes concerning self-identified ‘perfectionism’ in women diagnosed with panic disorder with agoraphobia (PDA) that

[i]hey [the PDA patients] try to be good daughters, good wives, good friends and good mothers, but their sense of what makes them ‘good’ is judged by how others perceive and respond to their actions. This is not only characteristic of their personalities as self-declared perfectionists, but reflects a societal norm that women must be accountable and responsible for the welfare of others before their own. … In seeking validation from others, many women lose their authority to reframe their own experiences. (Bankey, 2001, p 48)

Whilst Bankey (2001) suggests an internal individualised and psychologised notion of ‘perfectionism’ as a personality characteristic, her account nevertheless usefully elucidates this perfectionism as gendered. Justine’s above construal of the eating disorder patient as making her bed perfectly, as having morsels of control - ‘it’s their only little control they have’ - as being shaped by discourses of perfectionism echoes Bankey’s observations. It shows another way in these accounts where eating
disorders are routinely engendered as feminine. Further to this Justine’s account reveals an important inherent contradiction in the discursive construction of eating disorders where as

[p]aradoxically … these pathologies of female “protest” (and we must include agoraphobia here, as well as hysteria and anorexia) actually function as if in collision with the cultural conditions that produced them” (Bordo, 1998, p. 105) (parenthesis in original).

As the eating disorder patients make their beds perfectly they are constituted as “good daughters, good wives, good friends and good mothers” (see Bankey, 2001, p 48) and, at one and the same time, they are constituted as pathologically precise. They are simultaneously ‘ideal’ and pathological young women.

Up to this point in this section of the analysis I have considered the participants’ construals of the eating disorder patient as ‘intelligent’, ‘high achieving’ and ‘perfectionistic’ in the construction of this patient group as ‘deviant’. With some exceptions these constructions of ‘deviance’ arise through the inference that, in this patient group, ‘intelligence’, ‘high achievement’ and ‘perfectionism’ are negative traits, extruding from their inherent pathology. In the following section consideration is given to how the participants talk more explicitly about this patient group as deviant – as ‘manipulative’, as ‘lying’, as ‘nasty’ and ‘destructive’. And in analysing this construction of the eating disorder patient, further consideration is given to the construction of the ‘feminine’ as manipulative, venial and cunning.

2.4.2 The Eating Disorder Patient And The ‘Feminine’ As Manipulative, Venial And Cunning

When talking about what it is like caring for this patient group and about how these patients are ‘different’ from other patients, the participants frequently talk about their frustration in relation to caring for this patient group. The participants’ talk about
their ‘frustration’ as partly caused by the doctors (discussed in Chapter four of the analysis), but also as being due in part due to how these patients allegedly ‘manipulate’ staff, situations, and their treatment. Delphi, Max, and Millie talk broadly about manipulation. They say:

Delphi: Some of the girls, with an eating disorder if they’re having constant different nursing staff they can learn to manipulate things a lot easier [Document 'Data - Delphi' Paragraph 35]

Max: I mean they are very, very difficult in terms of the detail of their treatment here. They will continuously challenge you about whether or not yes this was actually said. And so we spend a lot of time involving the patient, involving the team and setting out a plan of action. And then they will still manipulate past that. [Document 'Data - Max' Paragraph 102]

Millie: And the patients tend to be really manipulative so you have to realise when you’re being manipulated as well. And sometimes that’s difficult to deal with. … cause they have devious behaviour. You have to be very observant, and actually watch them closely. Cause they do all sorts of things. [Document 'Data - Millie' Paragraph 63]

As well as construing the eating disorder patient as ‘manipulative’ Delphi also construes this patient group as having a latent propensity to ‘manipulate’ when she says they ‘learn to manipulate things a lot easier … if they’re having constant different nursing staff’. In saying this Delphi positions these patients as a ‘suspicious lot’ - not to be trusted, locating the difficulties of caring for this patient group within the individual patients.

In Max’s account ‘manipulation’ is inferred to be ‘irrational’. Max says that despite staff ‘spend[ing] a lot of time involving the patient, involving the team and setting out a plan of action’ the eating disorder patient ‘still manipulate[s] past that [and]
continuously challenge[s]‘ staff about ‘the detail of their treatment’. Here Max offers an account of good nursing practice (see Newell, 2004; see also Marks, 2000) wherein the nurses are consultative toward the eating disorder patient they care for, by rationally and step-wise ‘involving the patient’ in planning their treatment. But, in Max’s account, this process of ‘inclusion’ does not work for the eating disorder patients. In spite of the nurses’ well-intentioned efforts these patients ‘still manipulate past that’. Max’s construal of this patient group as relentlessly manipulative in the face of the nurses’ reasonable efforts to include these patients constructs these patients’ manipulations as ‘non-understandable’ - as ‘irrational’.

This construction of the eating disorder patient as relentlessly manipulative, and as ‘irrational’ within their manipulations can be seen as disruptive of the traditional nurse – patient relationship where “the patients’ requests [for] assistance’ are met with “the ‘good intentions’ of the nurse” (Crowe, 2000b, p. 964). For Max the eating disorder patient does not conform to these norms where “[b]oth nurse and patient are required to act in predictable ways in their relationship with each other …[and where] the patient is expected to be amenable and demonstrate compliance with the treatment provided” (Crowe, 2000b, p. 965). Max’s construction of the ‘relentlessly manipulative’ eating disorder patient, positions this patient group as possibly lacking motivation for change and as defiantly resisting treatment (see Michel, 2002, pp. 470 – 471), to again prefigure this patient group as ‘deviant’.

In Millie’s account the eating disorder patient is construed as ‘manipulative’ with the construal of ‘manipulation’ acting as ‘a given’ in her account of dealing with this patient group: ‘you have to realise when you're being manipulated … [y]ou have to be very observant, and actually watch them closely’. These above three quotes construct the eating disorder patient as ‘manipulative’. And, within these constructs of the eating disorder patient as ‘manipulative’, these patients are figured as tenacious – ‘[t]hey will continuously challenge you’ - as fixated - ‘they are very very difficult in terms of the detail of their treatment’ - and as plural in their manipulations - as Mille adds ‘they have devious behaviour … they do all sorts of things’. Millie, Max
and Delphi explicitly construct the eating disorder patient as ‘manipulative’, ‘challenging’ and ‘devious’, that is, as *La Donna e’ mobile.*

In the following quotes Carol, Sally and Bridget talk about these patients being ‘slick’ in their manipulations as well as ‘ganging up’ together and as being ‘cunning’. Phillipa, Lucy and Bridget also talk about these patients as ‘bitchy’, ‘game-playing’ and ‘destructive’ consolidating to quite a fine point the eating disorder patient as *La Donna e’ mobile.* Carol says:

Carol: Well they’re just more extreme [than other adolescents] … more manipulative … I suppose they’ve got a more of a vested interest. … Because they’re so slick in getting it, in getting, getting it right. [Document 'Data - Carol' Paragraph 207]

Phillipa, Lucy and Bridget also construct this patient group as more than manipulative when they say:

Phillipa: it can be challenging … dealing with um, the nastiness, either between them, like bitchy little girls being bitchy to each other or to me, they can be very hurtful at times [Document 'Data - Phillipa' Paragraphs 205-207]

Lucy: the games we feel the girls play … it’s the constant splitting. [Document 'Data - Lucy' Paragraphs 12-19]

Bridget: if, um, you had them in a group, some of them could be very disruptive and destructive. [Document 'Data - Bridget' Paragraph 25]

In the above quotes the eating disorder patients are construed as ‘sophisticated’ in their manipulations - ‘so slick [in] getting it right’, as ‘bitchy little girls being bitchy’, as patients are who are ‘nast[y] … hurtful at times’ and who seemingly exhaust the nursing staff by ‘the games … [they] play … the constant [staff] splitting’. Bridget
explicitly constructs the eating disorder patients ‘en group’ as aggressive and ‘very disruptive and destructive’ in this plethora of ‘challenging behaviours’.

These ‘challenging behaviours’ - the eating disorder patients’ attributes and ‘certain personal characteristics’, are widely reported to occur more frequently in the context of mental health nursing (Gatward, 1999; RCN 1995; MacDonald, 2003, pp. 306 - 307), where socially unacceptable behaviours “range from minor inappropriate behaviours or eccentricities to more serious violent or aggressive propensities”. Interestingly ‘challenging behaviours’ can be seen to “reflect not only the severity of the behaviours but also the resources …. available to the carer to manage the situation” (RCN, 1995, pp. 32 – 33). While it is well known that the NSW Public Health system is under great duress, marked, among other things, by ongoing nursing shortages, the above accounts construe the ‘real’ difficulty to be the eating disorder patients themselves. In the above accounts ‘the difficulty’ and ‘the challenge’ is located squarely within the eating disorder patient herself, construed in the above accounts in terms of ‘her’ deviant and difficult attributes and “personal characteristics”.

These construals fall well wide of the mark where care is “enhanced by patients being dependent, alert and personable” (Olsen, 1997, p. 514). Given the above substantially negative construals of this patient group it is therefore not surprising that construals of fraught nurse-patient relationships arise in the participants’ accounts of caring for eating disorder patients when the desired ‘norms’ are so thoroughly abrogated. That is, to the extent that the eating disorder patients may be ‘alert’ to these participants’ constructions of them as the obverse of being ‘dependent’ … and personable’ - that is, for example as ‘bitchy little girls being bitchy’ - conflict seems quite likely. The gendered infantilising of this patient group as ‘little bitchy girls’ also positions the eating disorder patient in a way that seeks to invalidate any power they may otherwise exert.

Sally and Bridget talk in more studied terms about these patients’ attributes:
Sally: this ah, eating disorder are very cunning. Manipulative. And challenging. They keep challenging you how much you, is your limit. ……. they're very cunning, and manipulative. … just let them know who's the boss … because they will try to, especially if they saw a new face there they lie, they manipulate people. They gang up on that nurse. Yes [Document 'Data - Sally', Paragraphs 44-50]

Bridget: being very bright they also learned a lot from one another … they actually ruled everybody around them, by this eating disorder. That was their one weapon, and they used it ….I felt it wasn’t a unit you could actually ever relax on because they played so many games. They were past masters at manipulation and staff splitting. Document 'Data - Bridget' Paragraph 17-29]

Sally and Bridget explicitly construe the eating disorder patient as having unpleasant and hostile characteristics. For them these patients are no less than ‘very cunning. [m]anipulative … and challenging’. They ‘gang up’ and ‘being very bright they also learn a lot from one another … they actually ruled everybody around them …this eating disorder … was their one weapon, and they used it’. Here these patients are constructed as ‘aggressive’, as using their eating disorders as ‘their one weapon’ and with no hint that they do this to defend themselves. Rather these patients are ‘past masters at manipulation and staff splitting’. As Sally says, ‘especially if they s[ee] a new face there … they lie they manipulate people ..[t]hey gang up on that nurse’. In these accounts the eating disorder patients are construed to be antagonistic, barely-controllable, young femmes with Sally and Bridget’s construals of ‘staff splitting’ and ‘ganging up’ on the eating disorder nurse constructing the nurse as ‘victim’ to the eating disorder patient in a clear reversal of traditional power relations.

In the above three quotes the traditions of the ‘nurse to patient’ relationship are disrupted by constructions of the eating disorder patient as not only ‘manipulative’ but also as intentionally and pointedly aggressive toward ‘their carers’ – with their eating disorder construed as ‘their one weapon … and they used it’. Sally and
Bridget’s constructions notably locate these aggressive behaviours within the eating disorder patients in ways which can be seen to problematise both the traditions and the materiality of the ‘nurse to patient’ relationship.

In the above constructions of the eating disordered patient as ‘deviant’, the participants’ construals of eating disorder patients as ‘intelligent’, high achieving’, ‘perfectionistic’, ‘manipulative’ ‘challenging’ and ‘cunning’ portrays the eating disorder patient in her ‘feminised’ deviancy as venial and willingly aberrant. The participants’ construals of the eating disorder patients as engaging in a litany of noxious behaviours seem to have little to do with the DSM IV criteria (APA, 1994) on which these patients’ diagnoses are supposedly based, and more to do with disrupted ‘norms’ of what should constitute ‘illness’, ‘young women’ and ‘proper behaviour in hospital’ in a pathology of manners. With the DSM-IV criterion (APA, 1994) being viewed therefore as pre-potent in structuring inevitable power asymmetries into the nurse-patient relationships, perforce the nurses being positioned as ‘normal’ and aligned with the power and authority of ‘expert’ diagnosis, and the eating disorder individuals being marginalised as ‘abnormal’ (Crowe, 2000). In the following section consideration is given to the implicit and explicit construal of ‘normality’ as it functions in the participants’ accounts.

2.5 Normality

The above constructions of the eating disorder patients as ‘deviant’ positions this patient group to be other than ‘normal’ and suggests that nursing of eating disorder patients constitutes a discursive site in which contradictory and shifting constructions of ‘normality’ are contested. Smail valuably considers

that ‘Anorexics’ seem, usually, literally unable to see the extent of their terrible emaciation, while ‘bulimics’ remain convinced of and anguished by their ‘obesity’ even though to an objective observer they are conventionally slim and attractive .... it is the apparent irrationality, the clash with our
normal understandings, that brings such phenomena into the field of psychiatry ... people with eating disorders seem to be trying to do something with imaginary difficulties ... rather than concluding that there is something the matter with the sufferers themselves, it is more fruitful in my view to question the adequacy of our normal understandings and to begin to see that our everyday conceptions of rationality and will power are exposed as lacking rather than confirmed by the so-called pathology of compulsive behaviour. Sufferers from these kinds of difficulties are not a race apart form the rest of us, but are as puzzled and pained as anyone else by the apparent inconsistencies in their conduct. They are neither unconscious schemers nor willful architects of artful plans to seek attention or manipulate relations with others, but find themselves enacting often with excruciating shame, patterns of behaviour which are as mysterious to them as they are irresistible. (Smail, 2001, pp. 300 – 301)

In this section the elusive ‘normal’ is considered as it arises in the participants accounts. Again, quoting Smail, he says that

[lying right at the centre of the psychological enterprise, the tacit if not explicit focus of everyone’s concern, is the concept of normality…… the essential psychological judgment in one that pronounces on the degree of the individual’s departure from the average. ... the principal consequence of all of this is that social life becomes a process of comparison, usually invidious, and to consult a psychologist or psychiatrist is like coming before a judge (Smail, 2001, pp. 332 - 333).

In the following quotes Ramise and Phillipa seesaw between what constitutes ‘normal’ and ‘not normal’ in constructing the eating disorder patient as ‘normal’, but also at the same time as ‘different’ to the ‘norm’.
Ramise: Um, I would say they're normal people just like you and me but only *that* they have a problem with food, their issues with food. ... there's a different *reasons* why there's a problem with food [Document 'Data - Ramise' Paragraphs 39-41]

Phillipa: [they are] very similar to all the other adolescents that I come across ... *they* have the same mood swings ...the same milestones that ordinary adolescent *people* have but it's more difficult because in one of those milestones there'd be something that doesn't add up to them. [Document 'Data - Phillipa', Paragraph 56]

For Ramise and Phillipa ‘normal’ is assumed knowledge. ‘Normal’ is a ‘given’ and, against the labyrinthine processes that constitute cultural regulation, where both thoughts and practices “divide, classify and allocate” (Sarup, 1996, p. 50) us as ‘normal’ and/or ‘other’, the eating disorder patients are measured and found lacking in certain details. ‘They are normal people just like you and me *but* they have a problem with food’. ‘[They are] very similar to all the other adolescents *but* it’s more difficult one of those milestones doesn’t add up’. These two constructions suggest that each eating disorder patient has her own signature style of being eating disordered - in being both ‘normal’ and ‘different’ at the same time. Here the elusive ‘normal’ is reified as a real and objective measure. Yet its measure is present only by the absences it defines.

In the following quote Susan ‘zones off’ ‘normal’ from ‘non normal’ attributes in the eating disorder patient. She says:

Susan: they're not boisterous ... egocentric, loud teenagers, they're reserved, they find it less easy to trust you, um, they struggle to balance this overwhelming desire to be thin um, with a need to please and a need to be liked, which normal teenagers *don’t* have, they [normal teenagers] don’t care what they say or what they do, they're, they know, they know everything you know. Whereas these girls are constantly, I think, trying to be liked which normal teenagers don't necessarily [Document 'Data - Susan' Paragraphs 25-27]
In Susan’s above account eating disorder patients are not ‘normal teenagers’. Instead they have ‘a need to please and a need to be liked’ and an ‘overwhelming desire to be thin’. This construction contradicts Phillipa and Ramise’s above construals of these patients as being ‘normal people just like you and me’ and ‘very similar to all the other adolescents’. Susan constructs the eating disorder patient as ‘reserved’, as ‘find[ing] it less easy to trust’ and as striving to manage anomalous longings. In this, Susan’s construction of the eating disorder patient more closely resembles ‘the traditionally negative characteristics considered to be feminine’ (Bankey, 2001, pp. 40 - 41) with their ‘reserve’ representing traditional ‘passivity’ and their ‘overwhelming desire to be thin’ suggestive of an ‘excessive emotionality’. And as Susan construes these patients as ‘not boisterous’ this construal infers that these patients are ‘timid’. Susan’s above account is a very different construction to the ‘staunchly cunning’, and ‘repeatedly manipulative’ eating disorder patients constructed in Sally and Bridget’s above accounts. It can been seen that notions of ‘normality’ differ between and within this site-specific nursing community, calling into question what constitutes grounds of ‘objective’ clinical nursing evaluation with respect to this area of patient care. Yet whilst there is considerable variation here in how ‘the eating disorder patient’ is constructed, these constructions converge in producing ‘her’ as different from the norm, and as ‘feminised’ in that difference.

In the following quote Phillipa constructs the goal of nursing eating disordered patients as re-orientating these patients to ‘ordinary’ life. Here Phillipa is explicit about the role of the nurse in the ‘making of the ordinary’. Phillipa says:

Phillipa: These little girls, you can, if you can make a difference now in their lives, earlier, they can grow up to be average, ordinary people … and that’s where I see my role. [Document 'Data - Phillipa' Paragraph 113]

Phillipa’s above construction that the goal of nursing eating disorder patients is to ‘normalise’ them into ‘ordinary’ lives, suggests that there is a great value in helping
these patients to achieve a ‘normal’ life that they are inferred to lack. However, Phillipa’s construction of the ‘normalising’ function of the nurses’ role positions the eating disorder patient outside of the ‘normal’ and hence as needing to be normalised. This construction effectively brackets off any consideration that ‘eating disorders per se’ arise within and are of and are about this very ‘normality’ they are deemed to need (see Bordo, 1993, see also Malson, 1998).

Phillipa’s and the other participants’ constructions above of the eating disorder patient as both ‘normal’ and ‘not normal’ shape disparate and, on occasion, conflicting discursive constructions, not only of the eating disorder patient and eating disorder per se, but also of ‘normality’ - that references much of what is said about this patient group. In the following section of this chapter ‘normality’ is again considered, as it is arises in the participants’ accounts where they talk about the eating disorder patient as a product of family ‘dysfunction’.

2. 6 Eating Disorder Patients’ Families as Pathogenic

In the above sections of this chapter, where the participants’ accounts have been shown to constitute the eating disordered patients as ‘deviant’ and ‘abnormal’, the participants’ own ‘orthodoxy’ and ‘normality’ arises against these constructions. But this ‘orthodoxy’, and ‘normality’ is only temporarily protected. Temporary protection only is available because objects of discourse are constituted in shifting and patchy aggregates of talk and practice. And nothing is guaranteed despite our deeply held desires for guarantees for ‘everything’ and especially for ‘normality’ - inclusion in which seems to hold so much protection. An additional way in which this patient group is constructed as different (from ‘normal’ nurses) is through account of their families as different. The following section discusses the participants’ constructions of the eating disorder patients’ families as pathogenic.

In the following accounts where the participants talk about eating disorders per se, they also spoke about the families of eating disorder patients. In part, the participants’ talk about these patients’ families reflects a search for aetiology, an attempt to get a
handle on what is causing this perplexing disorder. This is to some degree consistent with living in a ‘psychoanalytic culture’ (see Parker, 1997) where the medical model has been mandated to cure ‘problems of living’ and where problems of living are often understood as originating in childhood, in the context of ‘familial dysfunction’ (see: Bruch, 1973; Minuchin et al., 1978; Palaozzoli, 1985). With regard to considerations of ‘family’ and living in a ‘psychoanalytic culture’ Parker says that

the dominant family form [a nuclear family] is not necessarily the most widespread. [Rather] it is “dominant as an image”, and that image structures our perceptions of our own ‘incomplete’ or ‘broken’ family group’s. ... The relationships within the family are constructed as if the family were, or could be or should be, a nuclear structure. ... That structure is always already there ... [a]s a point of reference. (Parker, 1997, pp. 31 - 32)

In the participants’ accounts the pathologisation of the eating disorder patients’ families instantiates an image of a functional nuclear family as a point of reference, from which the families in question fall short. This ‘short fall’ ‘provides’ a partial response to the question of the aetiology of eating disorders and simultaneously functions to ‘Other’ these families, bracketing off the participants’ own families from a hypothesis of dysfunction. In the following quotes Jenny, Phillipa and Lucy explicitly construe their own families as ‘normal’, when they say:

Jenny: I’ve got two [children] that are normal. [Document 'Data - Jenny' Paragraph 133]

Phillipa: our family’s fairly, fairly normal ... and I just feel so sad for these girls that they have so much hassles, to try and get through [Document 'Data - Phillipa' Paragraph 127]

Lucy: [having] children of your own ... gives you some experience but if after having two healthy, what I call normal children ... plus what I’ve discovered as I go along a
normal life myself ... a husband, a job ... a family without any of the traumas that you listen to ... with these young kids ... the background that they came from, ... the baggage that their parents ... they seem to come from such dysfunctional families ... from a variety walks of life. There's very few that I have seen that seem to fit into what I consider a normal family. ...there's difficulties, they're fighting the battles out there. [Document 'Data - Lucy' Paragraph 3 - 11]

In Jenny, Phillipa and Lucy's above accounts 'normality' is a valued aspect of their own families, with what constitutes 'normal' operating as an unquestioned 'given' and a 'given' that is a privileged accent of the participants. Phillipa says 'our family's fairly normal'. Jenny says 'I've got two [children] that are normal' and similarly Lucy's life is construed as 'normal'. She has 'children ... a husband... a job ... a family without any of the traumas'. The aggregation of 'normal' across these three accounts locks the dominant image of the family firmly into place with a vocabulary of 'normal children', 'job', 'husband' and 'no trauma' whilst 'hassles', 'trauma' and 'battles' are externalised out as occurring in these 'Other' families – but not ours. Such 'other' families are thus implicitly constituted as a context and cause of eating disorders.

In the following quotes Casey-Anne, Sandra, Justine, Max, Sally, and Justine variable construe the eating disorder patient as coming from a dysfunctional family with dysfunction issuing from the families. They say:

Casey Anne: I do know that a lot of them come from funny families ... as we say funny families, um, where's there issues at home. ... quite a bit of it [the eating disorder] manifests from ... their [the eating disorder patient's] upbringing.

[Sentence missing from the document]

[Sentence missing from the document]

Sandra: [you] get to know the person and get to know the family structure. I used to often be a believer of once you met the mother you knew why, why the child was anorexic. ... [you don't] realise until down the track when we're actually had them
admitted... that maybe the mums may well have been anorexic. [Document 'Data - Sandra' Paragraphs 257-263]

Justine: ... you can normally look at their families and there's some kind of power struggle thing happening, so a bit dysfunctional in the families. [Document 'Data - Justine' Paragraphs 33-43]

Max: I think there's a whole stack of things that go along with [an eating disorder] ... plus the family, whatever's happening with the family [Document 'Data - Max', Paragraph 67]

Sally: So many of them ... several patient[s] come here maybe let's say ... dysfunctional family. Or probably their parents are too bossy and this and that. [Document 'Data - Sally' Paragraph 82]

Here the 'families' are constructed around the notion of 'dysfunction' and, again, as in the above accounts, 'dysfunction' is difficult to pin down and to define. Dysfunction is variably construed above as possibly 'some kind of power struggle' or in terms of 'parents [who] is too bossy' or as something 'happening with the family'. But in each case family 'dysfunction' is nevertheless in evidence explaining the children's pathology. When Casey-Anne construes some of the eating disorder patients' families as 'funny families' these families are automatically positioned in diffuse dysfunction against an idealised 'family' where, as Lucy and Phillipa suggest above, there are no traumas or hassles. Thus, 'funny families' - distressed families - suddenly become a medical problem. In Sandra's above account the issue of family as implicated in the pathogenesis of eating disorders becomes focused on 'the mums [who] may well have been anorexic', with this construal of problems in families being discursively re-worked as really being problems about the mother. Accounts of the family as causative of eating disorders thus focus on a construction of the mother as pathogenic such that the gendering of eating disorders is again further consolidated in a construction of feminised causes (see also Malson, 1998).
In the above quotes there is a clear and categorical distinction between the 'normality' of nurses' families and the 'funny' dysfunctionality of patients' families, thus serving to consolidate the dichotomies of normal/abnormal and nurse/patient. Within this consideration of the participants' construal of the eating disorder patients' families as dysfunctional, one of the concerns is that children often suffer in their families. This is a question of 'but what about what really happens?' I mention 'reality' specifically here because the occurrence of child abuse is a fraught and tender issue. Even glossing acts of any sort or form of child abuse as an 'issue' can seem to jam up productive discussion because a sense of urgency is provoked by the mere idea of children suffering. So this 'aside' concerns the analytic becoming ensnared in materiality. There is no doubt at all that some children come from families wherein frightful things can happen and happen often and that these 'things' happen in some families and not in others. Hence some families are understood to be malign. This is not questioned. However, despite the suggestion of an identifiable typical 'anorexic family', instanced in Casey Anne's construal of some patients' families as 'funny families' there are "no universal patterns of family aetiology" (Malson, 1998, p. 88). That is, Lucy and Phillipa above talk about families constructs the idealised, imaginary 'nuclear family' as a trauma-free, hassle-free family, which functions as a dominant socio-cultural image to reference other families.

The above constructions of family dysfunction construct 'anorexia' as a consequence of familial environment but fail to locate the family within any sociocultural environment. Moreover, as noted with Sandra's account,

there is a 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, pp. 88 – 89).
And in the entire 19 participant accounts there is a remarkable absence of the ‘father’, but the contouring presence of ‘patriarchy’ is fully evidenced.

What is being contested here is the concept that ‘meaning’ constructs *everything* that presents as the ‘real’. Specifically, that this analysis can be viewed as damping down or excusing, or rationalising acts of oppressive power where children are hurt and where a possible history of ‘hurt’ becomes a risk factor in the aetiology of eating disorders. This analysis, however, constitutes a push to ground the concept that the extent and degree of particularity of ‘meaning’ (where ‘meaning’ is conceptualised as a power/knowledge product of discourse and discursive practices) shapes the vocabularies of our experience, hence our understanding, and hence responses to the ‘real’ (see: Foucault, 1986; Hall, 2001; Malson, 1998). The problem is not - what is real or not real, but where the meanings come from, and what functions these meanings serve (Hall, 2001). In some senses the appeal of ‘the real’ is more about assuaging a diffuse cultural anxiety than it is about anything that may indeed *be* real, because at the most proximal point in our lives we can only possibly deal with ‘what is real’ to us at that time, in what ever way we apprehend it. In this context this means that as the participants construe families as dysfunctional and pathogenic, notions of what *should* constitute ‘normality’ shape distress as a singularly focused family disorder. The point is that the possible pluralism of how families are constituted does not necessarily have a ‘goodness of fit’ with dominant culturally inscribed images of reality (see Parker, 1997). The extant understandings of eating disorders that are dealt with in this report are principally medicalised, and these understandings are based in a positivist paradigm that regards, among other things, that

[s]ocial reality is ... a complex of causal relations between events, which are depicted as an emerging patchwork of relations between variables. (Blaikie, 1993, p. 94).

Hence families become variables to be factored in and out of equations that sum to a pathology. Yet we live in an a ‘psychologised’, ‘psychoanalytic culture’ where
‘family’, as mentioned above, means the ‘dominant image’ of a (‘normal’) family which is a nuclear family (see Parker, 1997). Yet the ‘nuclear family’ is not necessarily the most widespread of types of families, nor the ‘best’ type of families.

In the above analysis participants’ accounts have been shown to draw on a ‘family-orientated discourse’ as an important but nonetheless problematic way of understanding eating disorders (see Malson, 1998). And, as noted above, there participants draw on this ‘family-orientated discourse’ there is a concomitant furthering and consolidation of the gendering of the causes of eating disorders. The above accounts also again position the eating disorder patient as ‘abnormal’ in that ‘she’ has an ‘abnormal’ family. In the following section ‘normality’ is again considered where the participants’ accounts constitute eating disorders per se simultaneously as mental health problems and not mental health problems.

2.7 Mental Health

This section considers the participants’ constructions of this patient group as mentally ill. The construction of mental illness is important because, aside from dangerous medical compromise that requires urgent medical redress, eating disorder patients are hospitalised, often against their wishes because they are constructed as ‘mentally ill’ according to DSM-IV (APA, 1994). As well, this patient group is hospitalised in a clinical environment where, as already discussed, they are constructed as ‘deviant’ in a number of ways. What is of interest here is to understand in what ways eating disorder patients are constituted as ‘mentally ill’ within this overly determined clinical environment where mental illness/health is already a highly gendered category (see Ussher, 1991) - one in which ‘psychoanalytic misogyny’ stubbornly persists (see Parker, 1997), and where a ‘feminised’ subjectivity is vulnerable to pathologisation in patriarchal and positivist portrayals of the ‘feminine’ as pre-potent pathology. For example, in the literature review in chapter one, one of the risk factors for developing an eating disorder cited in three papers (Gaskill & Sanders, 2000; Steiner & Lock 1998; Redenbach & Lawler, 2003) is being female. In the traditions
of mental health and illness there still holds the image of ‘woman’ that coincides with Western notions of what constitutes mental illness. Clinical descriptions of what constitutes the attributes and characteristics of a mentally healthy ‘adult’ closely resemble that of a mentally healthy ‘man’, but do not necessarily describe a mentally healthy ‘woman’ (see Russell 1995; see also Ussher, 1991). Such gendered knowledge sustains the derogation of the ‘feminine’ (see Ussher, 1991). Traditional notions of what constitutes mentally healthy women include the imaginary ‘feminine’ as:

differing from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance and less objective, and disliking maths and science (Russell, 1995, p. 30 – 31).

These traditional discourses of ‘mental illness’ position doctors, psychiatrists and psychologists, and by association nurses, as adjudicating the mundane of normality and abnormality (vis-à-vis section 2.5 of this chapter where ‘normality’ was discussed) where the ‘masculine’ and the ‘feminine’ are regulated differently (Ussher, 1991, p. 10) against supposedly gender-neutral ‘norms’ (see Malson 1997 & 1998), which brackets off ‘real women’. In the following accounts the participants take up provisional positions construing the eating disorder patients as mentally ill and then, in contradiction to these positions, they simultaneously construe the patients as not mentally ill. Delphi, Susan and Phillipa, however, construe an eating disorder purely as a mental health issue. They say:

Delphi: Yeah. it’s a mental health issue. [Document ‘Data – Delphi’ Paragraphs 56-71]

Susan: it’s a, a psychological problem, … a psychiatric problem with severe physical complications. [Document ‘Data - Susan’ Paragraphs 33-35]
The above accounts constitute eating disorders as an unambiguous and serious mental health problem. Delphi, Susan and Phillipa unequivocally construe an eating disorder as ‘a mental health issue’, ‘a psychological psychiatric problem with severe physical complications’. In other extracts however this construction of eating disorders as a mental illness becomes problematised. For example, Phillipa says:

Phillipa: it’s very difficult to go through puberty … let alone with an eating disorder, or with a mental illness … [an eating disorder is] even worse than some mental illnesses because … the general public has come to accept things like depression and anxiety as real illnesses but they still think that eating disorders are spoilt little girls trying to get attention. [Document 'Data - Phillipa' Paragraphs 42-48]

Phillipa frames eating disorders as not a ‘real illness’ like depression and anxiety. She suggests that ‘the general public … think that eating disorders are spoilt little girls trying to get attention’ and that eating disorders are therefore ‘even worse than … mental illness’. This construction shakes up both the category of ‘mental illness’ as well as that of ‘eating disorders’ where for Phillipa one doesn’t fit the other. Yet the ‘feminisation’ that typifies both ‘mental illness’ and ‘eating disorder’ is not disrupted. Bridget also talks about the eating disorder patient as not having a ‘designated mental illness’ when she says:

Bridget: [these patients] haven’t got a designated mental illness like schizophrenia or an affective disorder, they have this eating disorder …. some sort of personality disorder. …you’re dealing with a very dysfunctional person. Um, the eating disorder, I feel, is like a catalyst that sits there. But there’s a multitude of problems underneath. [Document 'Data - Bridget' Paragraphs 210-222]

Bridget like Phillipa constitutes eating disorders as not ‘a designated mental illness like schizophrenia or an affective disorder’, both accounts suggesting something problematic about categorising eating disorder as mental illness. Nevertheless this
patient group is still construed as ‘disordered’ and ‘dysfunctional’, as having ‘some sort of personality disorder’ as well as being ‘very dysfunctional person[s]’.
Suggesting that the vocabulary of mental illness is nearly inescapable as Bridget attempts to talk about these patients as not being mentally ill in a ‘designated’ sort of way. In the following quote Bridget talks further about eating disorders being ‘an illness and not an illness’ and draws a parallel between the medicalisation and pathologisation of ‘birthing practices’ and ‘treatment of eating disorders’, strongly invoking the ‘feminine’. She says:

Bridget: I don’t know what other word you’d use, because they are sick because … they have this thing up here [pointing to her head] about food. I know they get complications … But it’s a bit like people having babies … you went into hospital, it was like a sick role and you had a baby and you had doctors and you had this and that. Now they have these birthing units and they go home after 24 hours, some of them go home the same day. I’m not advocating that, but I’m advocating that type of sort of thing … it needs to be taken out of hospital. [Document 'Data - Bridget' Paragraphs 283-285]

Here Bridget clearly constructs eating disorder patients as ‘sick because … they have this thing’ in their heads. But at the same time they are ‘not sick’ in that while the eating disorder patients ‘get complications … it’s a bit like people having babies you went into hospital, it was like a sick role’. Bridget’s construction is complex and functions on two levels at once. Firstly, this constitution of eating disorder patients as ‘sick but not sick’ - with the parallel drawn between the hospitalisation of birthing mothers and the hospitalisation of eating disorder patients - positions the ‘amenorrhoea-ic’ eating disordered patients beside what is often considered to be irreducibly ‘feminine’ - ‘reproduction’. That is “[r]eproduction - its presence, absence, process and experiences – has always occupied a significant place both in women’s lives and in cultural knowledges about ‘woman’” (Malson & Swann, 2003, p. 191). This juxtaposition of the eating disorder patient and the birthing mother might be seen to reflect the ‘absence’ of reproduction in the eating disorder patient
nuancing another context of ‘lack’. Secondly, Bridget’s construction functions at another level in its advocacy for a different order of ‘care’ for eating disorder patients. She abjures the institutionalisation of eating disorder patients in a ‘hospital’ wherein a pre-given ‘sick role’ shapes the eating disorder patient as ‘sick’. Bridget’s construction suggests, as Efran et al., say, that “the misleading metaphors of medicine …. are stretched beyond all recognition” and that the “…’problems of living’ … are not like an attack of the flu or acute appendicitis” (Efran et al., 1990, pp. xii – xiii) (parentheses in original). For Bridget in the above quote the complex and highly patterned presentations of eating disorders do not map neatly onto ‘a sick role’. Like the birthing mother, the eating disorder patient is positioned in a feminised sick role but the parallel drawn also further suggests that, like childbirth, eating disorders might not be best thought of as pathologies. Here, the resistance to the medicalisation of eating disorders is straight jacketed by the vocabulary of pathology it seeks to remove. That is, despite Bridget explicitly saying that this patient group is not sick and that they don’t have a real mental illness there seems to be a ‘gap’ or a pause in how then to best show the seriousness of eating disorders.

Here the language of disorder quickly re-fills the gap for want of options. This is possibly because our Western medicine, and hence our medicalised understandings of how we function, is a language of disease and symptoms and not a language of healing: Westernised assumptions of ‘cure’ primarily involving working toward the absence of disease. With respect to eating disorders ‘cure’ from this medicalised perspective is radically complex because eating disorders are already figured along a series of absences – of ‘food’, of ‘rationality’, of ‘normality’, of the compliant ‘feminine’, and of the disappearing ‘thin body’. This questions how then can ‘cure’ occur? And, as the literature review in chapter one suggests, this is most problematic.

For Sandra too an ‘eating disorder’ is also not a neat and reliable diagnosis. ‘Sometimes’ an eating disorder is a mental disorder but not ‘always’. She says:
Sandra: [I] don’t always look at it as a mental disorder. I just, look at it sometimes as someone’s who’s gone off the tracks for whatever reason. [Document 'Data - Sandra' Paragraph 256]

Sandra takes a provisional position that eating disorders is a ‘mental disorder’ but not ‘always’. She offers instead a ‘cushioning’ construal of the eating disorder patient ‘as someone’s who’s gone off the tracks for whatever reason’. While the construal of ‘gone off the tracks’ still instantiates what is ‘other’ to the ‘given norms’ concerning what is ‘correct’, ‘normal’, ‘healthy’, it does not necessarily encode ‘pathology’ and is closer to a recognition of ‘difference’. Sandra’s constitution of eating disorders as a mental health diagnosis but not ‘always’ can be read as a tentative deliberation between ‘resemblance’ and ‘difference’ – so that ‘distress’ and ‘difference’ are not immediately pathologised.

Justine and Faye’s following accounts also talk about eating disorder patients as ‘ill’, but they construct the term ‘illness’ as useful to them in caring for these patients. Faye says:

Faye: …I find it a challenge. And you understand, it’s not them it’s the illness. So if you can get past, it’s not the individual it’s the illness that is causing all their problems. Separate the person from the illness. … It’s the illness that’s making them do these things. To control their environment, the people and they’re not letting the health professional see the real them [Document 'Data - Faye' Paragraph 94]

Here Faye’s construction separates ‘the illness’ and ‘the patient’ - ‘it’s not them it’s the illness’. Yet the ‘illness’ - the eating disorder - remains associated with aberrant behaviours – they ‘do these things’. This division between ‘the illness’ and ‘the patient’, which contrasts with the conflation of patient and pathology discussed above, figures the eating disorder as ‘other’ to the patient, who Faye construes as ‘the real them’. In constituting the eating disorder patient as ‘choice-less’ as the effect of her ‘illness’ that makes her do ‘those things’ Faye constructs a way to exonerate this
patient group from blame for their at times ‘challenging’ behaviours. This construction of the eating disorder patient as not being at fault resists the totalising pathologisation of their ‘identity’ - it is after all the illness not them - but simultaneously figures these patients as hapless females not in control of themselves in a classical pathologisation of the ‘feminine’.

In the following quote Justine like Faye construes eating disorders as an illness. Justine says:

Justine: it’s frustrating nursing them when you have someone next door [a patient in an adjacent room] that can’t eat, … having two kids [a non eating disorder patient and an eating disorder patient]… constantly come in and be in for at least six, nine months of the year, that could not eat due to medical reasons and having these other children in that choose not to eat. I mean, yes it’s a um, disease … but it’s very frustrating to actually see the two sides and trying to … nurse the two patients totally different, and … not you build up resentment or anything … you’ve just got to accept that it is a disease it’s got to be looked at as a disease … otherwise you do get too frustrated and you can’t understand, like why someone just, they’re not, ‘Well why don’t you eat?’ you’ve got to understand that it is a battle for them every time that they actually do it. And I think then that you care for them appropriately. I think if you can’t see that it’s a disease then you can be very detrimental to them getting better, through the way that you deal with them. [Document 'Data - Justine' Paragraphs 52 - 56]

Justine’s above account shows the dilemma she faces in caring for this patient group. In her account of her work she encounters two types of patients: those who “could not eat due to medical reasons …and these other children … that choose not to eat”. In Justine’s construal of eating disorders as a ‘disease’ she explicitly construes the notion of ‘disease’ as a way of facilitating her care for these patients. Justine’s deliberated construction of the eating disorder patient as a child who ‘choose[s] not to eat’ as having a ‘disease’ is hugely practical to her by helping mitigate ‘resentment or
anything ... otherwise you do get too frustrated'. Justine's construal of these patients 'choice' not to eat as a 'disease' also facilitates her understanding that for this patient group 'it is a battle for them every time they [eat]' so that to 'care for them appropriately ... if you can't see that it's a disease then you can be very detrimental to them getting better, through the way that you deal with them'. Like Faye's above construction of eating disorders as 'not them [the patients] it's the illness' Justine's considered deployment of the medicalisation of eating disorders helps her do her work, but radically problematises the relationship between the category of 'disease' and notions of 'agency'.

The above discussion has attended to the participants' constructions of eating disorders as simultaneously a mental health issue and not a mental health issue. The constitution of eating disorders as a mental health issue consolidates the always/already pathologised 'feminine'. Yet as shown above the participants have not always taken up this theme of 'pathologisation' in how they talk about the patient and when it is taken up it has also been questioned and resisted. Rather, their talk is fragmented and the eating disorder patient is not figured as a wholly psychiatric identity. These accounts also figure the nursing group to be heterogeneous in how they deploy the medicalisation of eating disorders, disrupting the certainties of diagnosis and nursing response that may well be expected in this clinical setting.
2.8 Conclusion

This chapter has considered the different ways in which the participants discursively construct eating disorders’ and ‘the eating disorder patient’. The participants’ accounts are rich and complex in their constructions of the eating disorder patients as ‘identity-deficient’, as ‘seeing themselves as different’, as ‘deviant’, as ‘other than normal’, as coming from ‘dysfunctional families’ and where eating disorders is constructed as a ‘mental health issue’ and ‘not a mental health issue’ revealing the dilemma and puzzlement of eating disorders, as well as show the unremitting ‘feminisation’ and ‘othering’ of this patient group.

The sustained ‘feminisation’ and ‘othering’ of ‘the eating disorder patient’ is not the product of the individual voice of the nurse (plural). Rather, these voices arise in a vast net of discourse, inclusive of the pervasive discourses of patriarchy. ‘Discourses of patriarchy’ is used here to refer to the age-long process and situations of control of ‘the feminine’ by ‘the masculine’ in the mind-body dichotomy of Cartesian dualism … in which ‘man’ is associated with the mind, rationality and science and woman’ with the body, nature and emotion” (Malson, 1997, p. 235);

This ‘control’ includes control of both the body of ‘woman’ and the representations of the body of ‘woman’ (see Malson, 1997, 1998; see also Robertson, 1992; MacSween, 1993). For the purpose of this analysis ‘patriarchy’ is treated as the encompassing context, in which and through which discourses of the ‘feminine’ are constructed. Foucault (1986, p. 29) says that

[p]roviding one defines the conditions clearly, it might be legitimate to constitute, on the basis of correctly described relations, discursive groups that are not arbitrary, and yet remain invisible.
This is to suggest here that while so much is known, written and understood concerning ‘patriarchy’ the effects of the discourses of ‘patriarchy’ which occur in the above participants’ accounts as decidedly ‘not arbitrary’ in the ceaseless layering of ‘gendering’ of eating disorder patients and eating disorder nurses, where this engenderment surfaces as repressive, controlling and ‘othering’. The effects of the participants’ constructions disclose an ‘agency’ of patriarchy in that the eating disorder patients are structured as needing to be submissive to their treatment to regain a place in the social order, with their identity as eating disorder patients constructed in a process of repression and restraint (see Flax, 1991 & 1993). The discourses of ‘patriarchy’ take up effect as a “hidden dialogic partner” (Sampson, 1993, pp. 19 - 23) as the participants construct the eating disorder patient as ‘feminised pathology’ and ‘pathologised femininity’. Here patriarchy is brought to a sharp focus. Yet the explicit voice of ‘patriarchy’ remains concealed. That is, there is an implied democracy of gaze in the image of the nurse: that a nurse’s role involves a clinical and more or less neutral impartiality that allows a nurse to be objective. But the above accounts disrupt this idealisation of impartiality and neutrality. Instead the accounts reveal the full vault of patriarchal en-culturalisation that is wound into much of what the participants say. Thus, when the participants speak in these ways their voices intone the verses of ‘the father’. The analysis of these constructions (the eating disorder patients constructed as ‘deviant’ and ‘deviancy’ as ‘feminised’, and the construction of these patients as ‘other than normal’) can be therefore understood as an explication of the “the complex circulation of power” (Flax, 1993, p. 24) between and within the ‘feminised’ positions of the nurse and the eating disorder patient, and within the discourses of patriarchy.

The voice of ‘patriarchy’ is, I have argued, evidenced in the tension between the participants’ constructions of this patient group as ‘deviant’ and as ‘other than normal’. Tension is also manifested in the construction of the eating disorder patient as ‘other than normal’ in the two ways that ‘othering’ is constructed in the above accounts. The construction the eating disorder patient as ‘deviant’ and ‘deviancy’ as ‘feminised’ and the construction of these patients as ‘other than normal’ alternately
and simultaneously position the eating disorder patient in both a positive and negative frames as ‘other’. That is, the eating disorder patient is positioned in a positive frame as ‘deviant’ when construed as ‘aberrant’ as someone who is cunning, manipulative and combatitive with a highly suspicious intelligence. This is an ‘upbeat’ construct where she is visibly foregrounded as wrongful in her positive presence. Yet, the eating disorder patient is also constructed in ‘relief’ on a negative axis as being in ‘lack’ of what is ‘normal’. Her presence is shaped through what she is not in a ‘downbeat’ construction of her subject position where she is in default of the ‘normal’. She is distinct by what she is not, as the participants construe her ‘milestones not adding up’. What she is and what she does are not what other teenagers are and do, and she is, importantly, remiss with her food. Her presence is thereby figured by ‘lack’. In consideration of the function of constructions of ‘lack’ Stuart Hall (1997, p. 6) writes, “Identities are … always constructed across ‘lack’ … across a division, from the place of the ‘Other’…”. The eating disorder patient can be seen therefore to be doubly positioned as ‘Other’: as negatively ‘Other’ through what she is not, and as positively ‘Other’ through what she is and what she does. Her position is twice bound in these constructions, where ‘Other’ is both ‘excess’ and ‘lack’ simultaneously. Importantly concerning the construct of ‘lack’ Gatens argues from a psychoanalytic perspective in her discussion distinguishing the terms ‘sex’ and gender’ that the male body is perceived as ‘complete’ or ‘phallic’ and the female body image as ‘incomplete’. Gatens continues that

‘seeing’ is itself an active and constructive process rather than a passive experience … images are themselves social, and it is only the social that can be haunted by ‘lack’. Such ‘lack’ is constructed and learned, not discovered (Gatens, 1996, p. 34).

Here, the discourses that constitute social ‘lack’ that figure the eating disorder patient as ‘other than normal’ intensify the discursive attenuation of the already ‘thin’ body, deepening as it were the layers of ‘lack’ in this patient group at the levels of body, psyche and society.
Taken together these tensions - firstly, ‘the circulation of power’ within and between the gendered positions of the nurse-eating disorder patient relationship and, secondly, the eating disorder patient positioned as a ‘twice bound other’ - illustrate the shifting but overlapping discursive constructions of ‘normality’ and ‘other than normality’ that arise in the participants’ accounts, through which gendering is progressed, sustained but at times also resisted.

Chapter three the second analysis chapter follows, and offers a consideration of the participants’ discursive constructions the eating disorder nurse.
Chapter Three

Discursive Constructions of the Nurse

3.1 Introduction

In chapter 2 the participants’ constructions of eating disorders *per se* and the eating disorder patient were discussed. The constructions discussed included the eating disorder patient constructed as ‘identity-deficient’, as ‘seeing themselves as different’, as ‘deviant’, as ‘other than normal’, as coming from ‘dysfunctional families’, and eating disorders constituted as ‘mental health issue’ and ‘not a mental health issue’ simultaneously. These variable and shifting constructions of this patient group evidence the non-unitary ‘identity’ or ‘positionings’ of the eating disorder patient as well as the figuring of this patient group as both ‘challenging’ to work with, and as experiencing great distress. The participants’ talk was also seen to sustain ‘gendering’ and ‘othering’ of this patient group. This raises an important question concerning the process of ‘gendering’ and ‘othering’ wherein the participants themselves are also positioned as ‘nurse’ - a ‘feminised’ position within the patriarchal institution of the hospital (Davies, 2003; Farrell, 2001; Suominen *et al.*, 1997; Evans, 1997). That is, as the participants take up a gendered ‘feminised’ role as ‘the nurse’ - which is not dependent on whether the individual participants are ‘male’ or ‘female’ - a link emerges between the feminised role of ‘the nurse’ and the discursive ‘working up’ of the ‘feminisation’ of the eating disorder patient group. This question of gender/power is investigated further in this chapter where the participants’ constructions of ‘the nurse’ are discussed. As could be expected the participants’ accounts contain numerous explicit construals of their work as ‘caring’ and ‘nurturant’ and this re-articulates the traditional foundations of the nursing profession that are predicated on an inextricable interweaving of the precepts of ‘care’ and ‘cure’ (Kottow, 2001). Notwithstanding these ‘essentials’ of ‘care’ and ‘cure’ the participants’ accounts also evidence construals of working with this patient group as involving ‘discipline’, ‘punishment’ and ‘policing’, and furthermore the participants’ construals of ‘other’ nurses working in this area as involving ‘yelling’,
‘bullying’ and ‘disdain’. Taken together these construals of nurses and nursing are discussed in the following analysis across four categories: ‘the nurse as mother’, ‘the nurse as warden’ and nursing as ‘battle and force’ and constructions of ‘other’ nurses.

These categories collapse into each other as a ‘bundled-up’ representation of the participants’ “complicated experiences of being nurses [and] their diverse understandings of themselves and their practices” (see Ceci & McIntyre, 2001, p. 123). They thus mark out incongruities and disparities in the participants’ work, as well as disrupting the notional ‘unity’ of the traditional image and identity of the ‘nurse’. The following discussion concerns the ‘gendering’ of the nursing role by considering the circulation of power (Flax, 1993, p. 24) - a delineation of power relations between nurses themselves (Farrell, 2001) as well as between nurses and the patients and within the wider context of the institution of the hospital (Holmes & Gastaldo, 2002) in their care of the eating disorder patient. This discussion is divided into four sections. The traditional role of the nurse is considered, first, where the nurse is constructed as ‘mother’. Secondly, I discuss constructions of the ‘nurse as warden’ and consider the participants’ construals of their work as involving negatively construed or problematised aspects of nursing eating disorder patients. Thirdly, constructions of nursing this patient group as ‘battle and force’ are discussed in term of how constructions of power as oppressive function in the accounts; and lastly an analysis of the constructions of issues with ‘other’ nurses is offered.

3.2 The Nurse as Mother

When talking about their work the participants explicitly construed themselves and other nurses as ‘mothers’. For example, when talking about what type of therapeutic engagements that she had with eating disordered patients Bridget says:

Bridget: [I] did a lot of self-esteem work and assertiveness training with them, um, they [the patients] saw me basically … like another mother figure … Oh, the staff
used to call me mother. They used, you could hear it from one end of the hospital to
the other, Mother! [Document 'Data – Bridget Paragraph 31]

Here Bridget construes herself as a nurse offering treatment while also being ‘another
mother figure’ to this patient group in a ready exchange of the roles and positions of
‘nurse’ and ‘mother’. The construction of the ‘nurse as mother’, as Bridget talks
about it here, is one in which ‘the nurse’ is specifically constructed as ‘a good
mother’, who acts intentionally toward curing the eating disorder through ‘mothering’
as well as through therapy. The construction of ‘the nurse’ as ‘mother’ is also explicit
when Phillipa says:

Phillipa: I’ve been called a lot of things, like probably ‘the mother of the ward’ is the
one that I like the best, because I try to be kind all of the time. [Document 'Data -
Phillipa' Paragraph 52]

Like Bridget, Phillipa constitutes ‘the nurse as mother’, again equating the role of
‘the nurse’ with that of a ‘mother’. Phillipa emphasises that amongst being called ‘a
lot of things’ that ‘mother of the ward’ is what she likes best thereby valuing the
‘mother role’ in its association with her nursing role.

The participants also explicitly articulate constructions of both themselves and other
nurses as ‘mothers’ when they talk about what constitutes desirable qualities in nurses
who care for eating disorder patients. Delphi and Tanya say:

Delphi: one of the young grads, … she had a very close, a nice relationship with her
mother [and] an open-mindedness about herself. She had extremely good eating
habits. …She um, had a nice image of herself. [and] we’ve had another young girl
that was here, …she’d been married only for a few years and had, did, had done her
um, um, her nursing and she had a young, a young family [Document 'Data - Delphi' -
Paragraphs 145-156]
Tanya: [the eating disorder patients] take you more seriously if you're older, like a mother age. ... I find the younger nurses in their twenties aren't taken as seriously as someone like middle aged. ... I think that is important [being a mother]. And, so long as they've children themselves, girls helps too, but you can hardly conduct an interview and say 'Are you a mother of daughters?' But I do think it makes a difference. [Document 'Data - Tanya' Paragraphs 116-118 & 259-269]

Here the experiences as well as influences of 'motherhood' are talked about as contributing directly to structuring the role of the nurse. In the first instance Delphi construes an 'idealised nurse' as being consonant with having personally experienced 'a good mother-daughter relationship'. The professionalism of the first nurse whom Delphi references is constructed as a product of this nurse's 'very close, ...[and] nice relationship with her mother'. And, in consequence of that 'good mother-daughter relationship' this nurse's ensuing 'open-mindedness... extremely good eating habits [and]...a nice image of herself' is inferred to predicate her efficacious nursing of eating disorder patients. In this quote a 'good' eating disorder nurse emerges from a 'good' relationship with her own mother. Similarly the second nurse whom Delphi refers to is constructed as a 'good' eating disorder nurse in a merge of 'nursing and ...[caring for] a young family', again inferring a vital link between motherhood and good nursing care. Similarly, Tanya's above mock interview question 'Are you a mother of daughters?' positions eating disorder nurses as being taken more seriously by these patients if they are (also) mothers. Additionally Tanya says that even if a nurse is 'older, like a mother age', if she has the conventional look of motherhood, then this is construed as strengthening the nurses' authority with these the patients. Thus, in each of these quotes 'motherhood' is imbricated in the construction of the ideal nurse in constructions of 'the nurse' either as a product of good mothering and/or as a consequence of being a mother in an equation of 'mothers' with 'nurses'.

This clearly prizes both the skills and image of motherhood in the constitution of a good eating disorder nurse, to the extent that if nurses do not have these experiences, or do not 'look' to have had these experiences, then they 'aren't taken as seriously'.

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These constructions of the nurse as ‘a mother’, and specifically as a ‘good mother’, the importance attributed to the ‘image of motherhood’, and constructions of the nurse as ‘infused with good mothering’ blur any crisp definition of what might constitute the professional identity of an eating disorder nurse. These accounts consolidate the construction of the nurse as a feminised position. And, in doing so the construction of the ‘nurse as mother’ illustrates a positive valuing of mothering skills in a professional context. But conversely the construction of nurse as mother also draws on a non-professional identity (of ‘the mother’) in constructing ‘the nurse’. In view of particularly dominant constructions of mothers in contemporary society (see Phoenix et al., 1991), where motherhood is conflated with ‘woman’ and ‘mothering’ is constituted as the ‘natural’ destiny of woman (see MacSween, 1993), the nurse becomes constituted as a feminised role involving the skills of ‘every woman’ that are dominantly construed as ‘natural’ to women, rather than as particular results of professional training or education.

In the above quotes a ‘good’ eating disorders nurse is constructed as open-minded, able to bond, having a nice, singular, positive self-image, and good eating habits. And these qualities are constituted in an image of motherhood. The skills and ‘motherly’ qualities that figure a ‘good’ eating disorder nurse draw on the ‘givens’ concerning ‘motherhood’ in the everyday world. These ‘givens’ include assumptions that motherhood is “the necessary … inescapable and natural life of woman” (MacSween, 1993, pp. 55 – 56). And that, as ‘motherhood’ and ‘domesticity’ naturally co-occur the ‘idealised’ good mother as endlessly nurturant, generically capacious and ‘domestic’ (MacSween, 1993, pp. 55 – 56) is fused with nursing identity. These constructions essentialise the work of caring for eating disorder patients as the work of ‘mothers’ thereby sustaining the gendering of nursing in this area of care. This ‘feminisation’ of the work role of the nurse - the construction of the ‘nurse as mother’ - can be read to also reveal an informal statement of duties for the nurses who care for eating disordered patients, as much as the concrete work of ‘motherhood’ also has an informal statement of duties (see Phoenix et al., 1991). In addition, these constructions of the ‘nurse as mother’ have implications concerning constructions of
the eating disorder patients' mothers as pathogenic (as discussed in chapter 2; see also Malson, 1998) so that a 'good mother'/ 'bad mother' dualism is instantiated, with nurses constructed as 'good mothers' and the eating disorder patients' mothers positioned as 'bad mothers'.

The above accounts show that 'mothering' and the 'image of mothering' are constituted as important in caring for eating disorder patients. Further to this, the participants spoke about different qualities of motherhood as underpinning vital aspects of their day-to-day care of these patients. Susan, Casey Anne, Phillipa and Sally say:

Susan: [we give them] positive feedback through giving them time and giving them love when their behaviours are appropriate. ...In helping them to feel good about themselves, finding things for them to do that give them a sense of achievement [Document 'Data - Susan' Paragraph 151]

Casey Anne: you can become quite attached to some of these kids and feel very sorry for their home situation. ... Some of them have got the most wonderful personalities and a lot of them are lovely kids [Document 'Data - Casey Anne' Paragraph 96]

Phillipa: I counsel them with a lot of love [Document 'Data - Phillipa' Paragraph 52]

Sally: We can offer them support. ...give them sort of love [Document 'Data - Sally' Section 0, Paragraph 214]

Here the eating disorder patients are figured as basically lovely kids with 'the most wonderful personalities' in a markedly different construction from the constructions of venomous, vengeful deviancy that figured these same patients in chapter 2. The above accounts instantiate a kind, loving, and gentle approach to nursing this patient group where 'motherly-like' attributes and actions such as 'giving [the eating disorder patients] love, helping them to feel good about themselves, finding things for
them to do that give them a sense of achievement', 'counsel[ling] them with a lot of
love', 'offer[ing] them support' and becoming 'quite attached to some of these kids'
are construed as nursing practice. While these above attributes and actions are in no
way limited to the provenance of 'motherhood' they do identify traditional 'motherly'
ways of caring, and this 'form' of 'motherly-like' care is inferred to be fundamental
in the care of these patients.

Arguably this construction of care as maternal may occur 'across the board' in
nursing as an identified "feminine working style that stresses a care-orientated
rationality" (Evans, 1997, p. 227). What is significant here about this constitution of
nursing care as 'mother-like' care is that the participants' talk arises as a gendered
link between the 'feminised' role of the nurse and the 'feminised/pathologised'
positioning of the eating disorder patient. This linkage between the 'feminised' role
of the nurse and the 'feminisation' of the eating disorder patient can be read to
concern a number of issues none of which are easily delineable. Firstly the density of
gendering in the overlap of this nurse-patient relationship in this field of care suggests
provocatively that the 'feminised' role of the nurse acts to bind the eating disorder
patient in the process of gendering. This suggests that 'feminisation' is a restless
process, where a sort of 'switchback' or 'micro-buckling' in 'feminised' positions
does the work of patriarchy without patriarchy being visible. In other words - the
nurses' role is 'feminised', and in this 'feminised' role a furtherance of 'gendering'
arises in the accounts where the participants constitute their experiences of caring of
the eating disorder patient group. In some of these constructions of care this patient
group is 'gendered' in the participants’ talk - a nearly seamless 'flow on' of
'gendering' seems to occur between the nurse and the patient. And this seeming
seamless-ness is suggestive of possible micro-fine process of 'feminisation' that
functions in a 'hand-me-down' fashion to sustain patriarchy – albeit most discreetly.
Secondly the linkage between these two feminised positions also references the
profound imbrication of 'the mother' and 'the daughter', who are typified in
contemporary culture as battling it out. Both the possibility of the 'feminised nurse'
binding the eating disorder patient in 'co-feminisation' and the nuance of 'the
mother’ and ‘the daughter’ can be seen as products “of the patriarchal fantasies that underlie … the productions of Western culture” (Flax, 1993, 59). Further to this, irrespective of whether nursing care is also ‘motherly-like’ care in other nursing contexts, in this specific context of nursing eating disorder patients the discourse of ‘the mother’ as it is articulated in the above accounts indicates that the discursive position of ‘mother’ is available to the participants to take up, much as the discursive position of ‘deviant’ is available to the eating disorder patients to take up (see chapter 2, see also Laws & Davies, 2000). Which is to say that in terms of the eating disorder patient figured as ‘feminised pathology’/‘pathologised femininity’ (as discussed in chapter 2), here the accounts evidence the nurses constructed as the ‘good mother’, so that ‘the eating disorder patient’ and ‘the nurse’ are paired in opposition, inferring an essentialised but dichotomised pre-existing ‘feminine’ that is articulated across both discursive positions.

The above discussion has considered different aspects of the participants’ construction of the nurse as ‘mother’. The participants’ accounts evidence explicit ‘naming’ of the nurse role as a ‘mother’ role. The participants also talk about the skills, influences of ‘motherhood’ as well as the ‘image’ of ‘motherhood’ as valuable resources in their care of eating disorder patients, such that the tender qualities of ‘mothering’ are talked about as fundamental to their nursing practice in this area of care. Thus, as outlined in chapter two, the patient is constituted as ‘other’ – positioned explicitly as ‘the feminised deviant’, and a product of ‘bad mothering’ – and is thus figured as an essential ‘background’ in producing the nurse as ‘good mother’.

Additional to the above discussion, there are two others aspects of the construction of the ‘nurse as mother’ that were prominent in participants’ accounts. These aspects are the constitution of the nurse as ‘mother’ who is present ‘twenty-four hours a day seven days a week’, and the constitution of the nurse as ‘the dutiful mother’. Throughout their accounts the participants talk about the constancy of care they offer as ‘twenty-four hours a day seven days a week’ (hereafter 24/7). This construction of
nurses’ pan-availability and constancy of care can be read as a close identification with commonly accepted notions of what constitutes a ‘good mother’. That is, the participants constitute their role as endlessly nurturant in much the same way that ‘good mothers’ are constituted as providing constant and stable care for their children (see Phoenix, et al., 1991).

Following this consideration of the nurse as ‘mother 24/7’, the participants’ construction of the role of nurse as ‘the dutiful mother’ is also discussed. The discussion of these last two aspects of the construction of ‘the nurse as mother’ is intended to further delineate the intertextuality of this discourse of the ‘mother’ as it occurs in these accounts, showing that the participants shift within their discursive positions while still deploying a discourse of ‘the mother’. ‘Intertextuality’ here refers to the way that discourses exist with other discourses, often in conflict, and contain traces of other discourses such that “discourses that emerge within work organisations are mediated by the interpenetration or intertextuality that exists with other discourses” (Leonard, 2003, p. 221; see also Mills, 1997).

When discussing what is important in the nursing care of eating disorder patients, and how nurses work with this patient group Delphi, Charlie, Lucy, Susan, Faye and Justine say:

Delphi: [it’s] important to have constant um, I think in looking after some of these eating disorder patients is that they have a constant care of, a constant carer. … I find that my role is very valued in that way. … As a constant, as a somebody whose just not coming and going [in] their lives [Document 'Data - Delphi' Paragraphs 31-35]

Lucy: …the multidisciplinary team can’t exist without [the nurses] because we’re ones here that you know, 24 hours a day, seven days a week. [Document 'Data - Lucy' Paragraphs 37-39]
Susan: The nurses … they’re giving the 24 hour care, they’re the pivotal people and I would see [that] patients come into hospital because the rest of the team aren’t managing them on an outpatient level, so they actually come into hospital because they need to be nursed. [Document 'Data - Susan' Paragraphs 195-203]

The above accounts explicitly construct constant nursing presence as pivotal to the care of the eating disorder patients. Thus, ‘the multidisciplinary team can’t exist without [the nurses]’. The nurses are ‘the pivotal people … [the eating disorder patients] actually come into hospital because they need to be nursed’. (The relationship between the nurses and the multidisciplinary team is discussed in chapter four.) And this construction that the nurses are of key importance to the multidisciplinary team in the hospitalisation and therapeutisation of this patient group is construed in terms of the nurses offering constant care ‘24/7’, resonating with notions of ‘the mother’ as central and indispensable to her family – as constantly available.

The above quotes construct both the value and the mandate of the nursing role as managing the care of this patient group ‘24 hours a day, seven days a week’, ‘giving the 24 hour, care’, being ‘the ones with [these patients] 24 hours a day’. This construction of the eating disorder nurse as a constant carer ‘24/7’ also meshes with the nurses’ performing conventional home duties such as ‘making the bed with [the patients] or hassling [the patients] about something’.

Charlie: …the nursing team [is] here 24 hours a day and they see everything and they’re handing over to each other, you know, three times a day so they know what’s going on. … So from a nursing perspective … like you’re not the psychologist, which comes down twice a week to talk about how their feeling today … you’re the nurse that’s making the bed with them or hassling them about something you know, and all of a sudden you can turn conversations around or pick things up which are totally different. So its definitely looking after eating disorders is definitely hands on um, …
and the treatment is in with everything you do. [Document 'Data - Charlie' Paragraphs 85-87]

Here the therapeutic functions of the nurse are achieved in the course of performing domestic ‘maternal’ duties. For the eating disorder nurse these tasks become opportunities to therapeutise this patient group, as it is the nurses who ‘see everything ...can turn conversations around or pick things up’. Treatment, in this account, is not confined to particular programmes or therapy group sessions, but is mediated by these domestic tasks as these accounts anchor ‘mothering’ to nursing. The construction of nurses as indispensable to the treatment of the eating disorder patients as well as to the infrastructure of multidisciplinary team, per force their constant ‘24/7’ presence, suggests that the eating disorder nurse like a ‘good mother’ is ‘always there’ to care for her children, in such a way that a ‘good mother’s’ availability and presence infers an ‘intact family’ (Smith, 1999, p. 158). The co-implicative context of ‘motherhood’ suggests the weighty responsibility that being positioned as an eating disorder nurse holds.

In constituting the nurse as the constant carer ‘24/7’ there is a slippage in how the individual participants take up a speaking position as nurses who are gazetted to work eight (8) hour shifts, yet who construe their work as constituting as a 24/7 presence. That is, ‘the nurse’ is constituted here as present 24/7. Yet whilst nurses are present on the ward 24/7 any individual nurse is not. This constitution of the nurse as the constant carer ‘24/7’ thus effectively constructs a ‘notional nurse’ - a nurse ‘en group’ - who anonymously offers a ‘24/7’ presence and care. In this, these accounts speak as ‘I the nurse’ and ‘we the nurse’ simultaneously, constituting another level of plurality within the nursing role.

This also suggests an unclear reckoning of the relationship between individual nurses and the work of nurses as a group. It raises questions about the ways individual nurses take up a ‘group nurse’ identity and in what ways they do not take this up.
This also questions how the 'group nurse' identity functions in the immediate context of caring for eating disorder patients as well as in the larger institution of the hospital.

In addition to being constituted as available '24/7' the nurse is also frequently constituted implicitly and explicitly as dutiful, a construction which, it could be argued (Phoenix et al., 1991), again converges with the construction outlined above of the nurse as 'maternal'. However, in the following account Millie talks about herself not as willingly dutiful, but as compelled to obey – care not springing spontaneously from what is 'natural' in the 'feminine, i.e. with gender relations becoming more apparent when Millie says:

Millie: Well it's very difficult; you know, for the team to make, the multi-disciplinary team who make decisions. Um, and then they're not the ones that have to carry it through. It's the nursing staff that has to carry it through. Um, whether you agree with them or not [Document 'Data - Millie' Paragraph 95]

For Millie 'the nurse' does her duty 'whether you agree ... or not' - whether you like or not, whether you want to or not. The previous constructions (Lucy and Susan's accounts on page 105) position the nursing presence as leading and anchoring the multidisciplinary team. However, Millie draws on a much less idealised construction of the nurse. That is, traditional and contemporary depiction of nurses include alternately exaggerated figures such as the compliant, willing and receptive 'feminine', and the cruel and mad avenger, much as mothers are figured as either 'good' or 'bad', dichotomised against patriarchal unity and neutrality. For example, dichotomised 'good' and 'bad' nurse are respectively portrayed in the films Girl Interrupted where Whoopi Goldberg plays the sagacious senior nurse 'Valerie', and One Flew Over the Cuckoo's Nest where Louise Fletcher plays the malign Nurse Ratchet.

Millie's account begins to counter the idealised construction discussed above of 'the nurse as mother' that can be understood as one side of this good/bad mother or nurse
dichotomy. She figures the nurse in powerless subordination, such that what was
previously a mandate to ‘care’ in the above construction of the nurse as ‘the mother’ -
the ‘constant carer 24/7’ is now a mandate to ‘comply’. This constitution of the nurse
as a ‘dutiful mother’ sees the eating disorder nurse constructed as ‘obliged’, when
they as individual nurses ‘have to carry [the team’s decisions] through’. Millie’s
construction of the eating disorder nurse as obliged and ‘dutiful’ nuances the ‘nurse
as mother’ to be the nurse as a ‘captured mother’, as a mother who has to be ‘good’
by virtue of compliance, willing or not.

The above accounts that constitute the nurse as ‘mother’ converge with, and are
consolidated by constructions of the nurse as available ‘24/7’ and the nurse as
‘dutiful’. As ‘good mothers’ the nurse is positioned in opposition as both ‘willingly
compliant’ but also as ‘obliged in her compliance’ and these positions reveal issues of
gendered power. In this section the accounts have clearly shown the construction of
the nurse as a ‘good mother’, conflating these constructions with the idealisation of
the ‘feminine’ in the image of a traditional Madonna. In contrast with this
construction the following section considers the construction of the ‘nurse as
warden’.

3.3 The Nurse as Warden

In section one above the participants’ accounts have been shown to construct the
‘nurse as mother’, and specifically as ‘good mother’. In contrast to this benign
portrayal of the nurse the participants also constituted their role and their work as that
of both ‘warden’ and ‘soldier’. There are numerous instances in the accounts where
the participants constituted part of their role as needing to ‘contain’ particular patient
behaviours. According to the current literature nursing eating disorder patients can
involve difficulties for nurses who are expected as part of their role to contain and or
marshal certain behaviours (Garrett, 1991; Anderson, 1997; Marks, 2000). For
example, nurses monitor food intake ensuring that ‘re-feeding’ of these patients is
achieved (Newell, 2004). Yet nurses are also expected to establish and sustain a
therapeutic milieu (Marks, 2000; Ramjan, 2004), as well as provide appropriate education to these patients (Amara & Cerrato, 1996), and also to act as role models for these patients (Marks, 2000). The literature therefore constitutes the nurses’ role in part as modifying the patients’ behaviours through surveillance and discipline. Additionally however, the participants also spoke clearly about their roles in terms such as monitoring the length of parents’ visiting times, locker and luggage searches, watching that ‘the perimeters’ of the programme are maintained, and the continuous hyper-vigilant scrutinising of these patients. The participants talked about how they and ‘other’ nurses argued, forced, fought, bossed, structured, disciplined, and were in authority over these patients. Additional to these construals the participants spoke about how at different times the eating disorder patients viewed these above nursing actions as ‘punishment’. In talking about this aspect of their work the participants constituted their role as ‘warden’ further revealing the various relations of power that structure their work. In the previous section the participant’s constructive their role as that of the ‘good mother’ and, as such, as loving, nurturant, available and caring feminising and naturalising the nurses’ role as ‘woman’s work’. However, in the following discussion of the nurse as ‘warden’ the feminisation of the nurses’ role is not so clear, at least not ostensibly clear. When discussing their day-to-day work Charlie, Lucy, Jenny and Sally say:

Charlie: there’s no courses on how to look after them or anything like that. ... But I think over the time [nurses have] actually found a balance of what to do where we’re not the authority, prison guards but we’re there, they know that we’re there, um, you know.

Lucy: I find that incredibly sad, to think that a hospital, staffed by strangers, basically, [is] the stable life that some of these kids have got. ... And really we don’t get a lot of runaways; we get the occasional one who rebels and runs every time you turn around but basically, they comply. It’s not a gaol, it’s not a locked ward, and they comply with the structure, the discipline. They might kick and buck a bit but basically, they stay. [Document 'Data - Lucy' Paragraph 108]
Jenny: And just sort of be there as a guiding figure /V: Hmm, hmmm/ also than being an authority figure. But at the same time you have to be firm with them. Make sure that ah, they keep within the perimeters of the program [Document 'Data - Jenny' Paragraph 161]

For Charlie and for Lucy the eating disorder nurse role is decidedly ‘not being an authority or prison guard’ and the ward is categorically ‘not a gaol [and] not a locked ward’ Rather, the nurse is a pervasive ‘presence’ that the patients are fully aware. As Charlie says ‘we’re there, they know that we’re there’. Lucy construes the nurse-patient relationship as a relationship of discipline that the patients ‘basically … comply with the structure, the discipline. They might kick and buck a bit but basically, they stay’. Here the potential interpretation of ‘nurse as warden’ seems apparent to both Charlie and Lucy and this, arguably, why they counter it with such emphasis. In these accounts the relationship between the nurse and the eating disorder patient is defined through a relationship of discipline. And whilst the nurse is constituted against notions of being a guardian, an enforcer, and a warden, the construction of the nurse in relation to discipline and surveillance where the patients are kept ‘within the perimeters of the programme’, enforces this simultaneously articulated and denied construction of the nurse as warden. In this construction of the nurse as ‘warden’, as the nurses deploy the processes of ‘discipline’, they are, as it were, themselves ‘captured’ by the wider discourse of ‘imprisonment’. A different sort of ‘capture’ - one that figures the nurses and the patients fitted into place together, rather than one where in a simplistic equation ‘the nurses’ are ‘wardens’ to ‘the patients’. Thus, Lucy says of this patient group in the throes of their ‘discipline’ ‘[t]hey might kick and buck a bit’, with Lucy’s metaphor of ‘horse-breaking’ resonant with Foucault’s descriptions of ‘dressage’ as the heart of ‘discipline’ (Foucault, 1995, p. 136).

In this section the construction of the ‘nurse as warden’ is the seeming obverse of the nurse constructed as ‘mother’. When positioned as ‘mother’ the nurse who is
constructed as a nurse who councils with love, offers support, helps these patients feel good about themselves. When positioned, as ‘wardens’ the nurses take up a role of authority seeming to privilege an implementation of duty and discipline, signifying a quasi-penal environment. The following section discusses the participants’ accounts of ‘punishment’ wherein this talk can be seen to converge with the above constructions of the ‘nurse as warden’ to consolidate this impression of the ward as a quasi-penal environment.

In the following accounts Bridget Millie and Phillipa talk about ‘punishment’ as not occurring, they say:

Bridget: Um, but there was never any punishment like “You can’t do this unless you gain weight.” and that, because … the responsibility was on them [Document 'Data - Bridget' Paragraph 61]

Millie: Well I mean I don’t think that they should, that the client should feel that they’re being punished cause sometimes they do. …I think that you need to make them realise that it’s not a punishment [Document 'Data - Millie' Paragraph 295]

Phillipa: I’m very, very, very big on telling them that this is, we do not punish people, we have consequences for actions. [Document 'Data - Phillipa' Paragraph 52]

Patently the hospital, the staff and the treatment programmes are at all levels involved in the cure, care and rehabilitation of their patients, and while this statement is wide open to interpretation it represents the idealised ‘image’ of Western medicine and the institutions of medicine as founded on neutral compassion. Notwithstanding this image of benign compassion the above accounts evidence that participants, on occasion, do offer an explicit defense of their work as ‘not punishing’ - to the very patients they are auspiced to care for in the hospital. These above three accounts function similarly to Charlie and Lucy’s earlier accounts of the ward as ‘not a gaol [nor] a locked ward’ and of the nurses as ‘not the authority [nor] prison guards’. By
explicitly stating what nursing is not there is the potential interpretation of treatment as ‘punishment’, which it could be argued is why Bridget, Phillipa and Millie counter it with such emphasis. The refutation of treatment as ‘punishment’ functions to instantiate it as punishment. Thus Bridget says ‘there was never any punishment’, and Millie says that the nurses ‘need to make [the patients] realise that [their treatment is] not a punishment’, and Phillipa says that ‘we do not punish people, we have consequences for actions’. In these accounts the eating disorder patients are construed as allegedly perceiving that their ‘curative’ treatment is punishing. And the nurses are construed as ‘not punish[ing] people but as nevertheless issuing ‘consequences for actions’. Between these two constructions of what the patients allegedly perceive and the nurses assertions that they are ‘not punishing’ a space opens and an imprint of ‘punishment’ surfaces - as the distinction between ‘punishment’ and ‘consequences for actions’ falters. For how does ‘punishment’ differ from ‘consequences for actions’ except in the perspective of who receives either?

Notwithstanding the apt legitimations and explanations of why quasi-combative/policing construals of nursing this patient group occur, the current literature does not explicate the relations of power arising between the nurses, patients and the institution of the hospital. It thus does not offer insight into the function of the constitution of the nurse as ‘warden’ and thereby potentially opens out a way of ‘blaming’ individual nurses. While individual accountability and thus culpability are an intimate part of nurses’ professionalism what is being addressed here is that which shapes the ‘reasonableness’ of the nurses’ responses. For example, in discussing the importance of nurses developing a comprehensive understanding of eating disorders so that they as nurses can offer informed care to this eating patient group, Marks (2000, p. 120), suggests that nurses adopt a metaphor that they [the nurses] try to think “[m]uch like a ‘profiler’ in a crime story”, so that nurses can “understand what it means to have the disorder”. That is, Marks' (2000) throwaway line suggests that nurses take up a perspective that eating disorders is a ‘crime’ that they the nurses are investigating by way of typifying who is most likely to have committed this crime. This metaphor of ‘crime’ and the conflation of the nurse role onto a ‘profiler’ role
surfaces in different words where the participants explicitly talk about ‘wardens’ and ‘punishment’, and imply that the ward is a quasi-penal environment.

The above accounts that variably construct the nurse as ‘mother’, as warden and as ‘not punishing’ strongly suggest that the participants’ work is mapped out by demand and dilemma of an order that nurses are not necessarily taught how to manage, and within which the dominant ‘feminised’ image of the nurse as giving and good is set contra to the image of the nurse as quasi-penalising enforcer. As the above accounts suggest, the participants are positioned as kind, nurturant and loving ‘mothers’. Yet they are also portrayed as maintaining the perimeters, ensuring patient compliance, as authoritarian ‘wardens’, and as issuing ‘consequences for actions’ to the patients they are auspiced to care for as inpatients. And this seemingly all at once with each position challenging or potentiating the other positions in some way so that the position of ‘nurse’ can be read as a collectivity of highly conflictual constructions.

In the following section the participants talk about battling with the eating disorder patients, and about the patients themselves battling with their disorders. These explicit construals of struggle strengthen the above inference that the work of nursing eating disorder patients is marked out as a site of conflict for the nurses.

Additionally, the above construals that constitute ‘the nurse as warden’ might be understood as ‘legitimate’ responses to what the limited literature on nursing eating disorder patients discusses: They might be understood in relation to ‘manipulation’ – patients being manipulative and resistive to treatment (Garrett, 1991; Marks, 2000; Ramjan, 2004) or patients exercising a broad-band type of adolescent non-compliance with medical advice (Muscari, 1998b). Or these construals could be read as a response to the ongoing difficulty of working with this patient group and therefore as expressions of stress, frustration and turmoil (King & Turner, 2000) figuring the plurality of nurses’ ‘struggles’ in this area care (Ramjan, 2004). The above accounts construct the eating disorder nurse as an authority figure, whose work can involve negative aspects such as scrutinising patients, searching belongings, and
perpetual surveillance. The relationships with the eating disorder patient, as constituted in these accounts, are relationships of power and discipline marked out by frequent argument and occasional force. These negative features of working with eating disorder patients can be seen to run contra to the participants’ professional nursing training, as well as, perhaps, their values and preferred way of treating people in general and patients in particular. Hence the above accounts also offer a raison d’être of the unique ‘struggle’ (Ramjan, 2004) and ensuing distress (Garrett, 1991; King & Turner, 2000; Newell, 2004) that can arise for these nurses in this area of care.

3.4 Battle and Force

In the following accounts the eating disorder patients and their families are lauded in their ‘struggle’ with eating disorders. When talking about the difficulties that the patients and their families experience Justine, Lucy, Ula and Charlie say:

Justine: you’ve got to understand that it is a battle for [these patients] every time that they actually [eat] [Document 'Data - Justine' Paragraph 56]

Lucy: [the patients are] fighting the battles out there. I think it’s just so much harder for their, for teenagers today. [Document 'Data - Lucy' Paragraph 11]

Ula: they still battle with the thoughts of wanting to diet but there's also more thoughts there about wanting to get better and wanting to get on with their lives. [Document 'Data - Ula' Paragraph 200,]

Charlie: I think the families [have] probably been battling this for quite some time, from six months, sometimes for years. Then all of a sudden they get you know, referred here and they see you know, the doctor who says yeah we can look at fixing this up. [Document 'Data - Charlie' Paragraph 129]
Here, the patients and their families are figured in the common parlance that constructs life as a battle, as ‘fighting the good fight’. And this has a certain resonance with the iconic Australian underdog title - ‘the little Aussie battler’ whose struggle is valorised, as ‘it is a battle for [these patients] every time that they actually [eat]’, ‘[the patients are] fighting the battles out there’, ‘they ... battle with the thoughts of wanting to diet’, and these patients’ ‘families [have] probably been battling this for quite some time’. In these construals the participants show an appreciation of both the eating disorder patients and the patients’ families as ‘battle’ locates a type of ‘strength’ and effort to overcome adversity with the patients and their families. This positive appreciation of the patients and their families is in clear contrast with the previous constructions of the patients’ families as pathogenic in chapter two, where ‘fight’ and ‘battle’ in these families is the demarcation of ‘abnormality’ and thus pathology. As with other categories of illness [e.g. cancer (see Sontag, 1978)] patients with ‘eating disorders’, and their families, are constituted here as sites of battle, and as combatants in battle. In the following quotes Sally and Carol talk about ‘battle’ differently again, as the site where the nurses and patients are positioned as equi-combatant, and as in opposition to each other in this combat. They say:

Sally: you just have to let them know who’s the boss but sometimes if there are so many of them it’s a battle. [Document 'Data - Sally' Paragraph 130]

Carol: ...sometimes people are anticipating a confrontation ... sometimes there’s a power issue between the nurses and the patients ... you can sense that before they’ve spoken to the patient they’re anticipating an issue, a problem...sometimes you feel that ... people enjoy it but because they’re anticipating it then it’s inevitable. ... I’ve been with the girls and we’ve had the confrontations and we’ve had them shouting and saying terrible, terrible things. ...we virtually force them to do as we wanted ... So it was always that sort of battle ground, daily. [Document 'Data - Carol' Paragraph 53, 61, 65]
Carol: What doesn’t work? Bullying. Sort of stand over tactics. It has happened, I’ve seen it happen like, I’ve tried not to be a part of it, but I s’pose, I suppose when I first started I was ‘cause I was convinced I thought, ‘Well this is what we’ve got to do.’ ‘This is the best thing to do. ‘This is what we’ve been told to do.’ So this is what we do. ... think in nursing ... you can get people who put on a uniform and become very powerful and I think with the eating disorder girls wanted just conflict. Like I said at the beginning ... you can look on the roster and know when there’s going to be an issue and there often is...there will be issues there’ll be conflict ... I don’t quite know how to put it ... overbearing and um, I’m not quite sure of the word. [Document 'Data - Carol' Paragraph 223]

The above accounts construe nursing as a ‘battle’, a contest of wills where the participants as nurses ‘let [the patients] know who’s the boss’, and where Carol explicitly says there is a power issue between the nurses and the patients. These accounts figure the ward area as ‘combat zone’, a bonsai-ed Gaza strip, where some nurses, Carol says, seem to anticipate and ‘enjoy’ the conflict. Here the patients are positioned as being at the mercy of nurses, who ‘put on a uniform and become very powerful’. The notion of ‘battle’, as it is construed in Justine, Lucy, Ula and Charlie’s above accounts, looses its sense of feisty and honorable struggle when Carol says that work is ‘sort of battle ground, daily’ - a relentless field of difficulty – a construction which carries suggestions of exhaustion, and battle fatigue.

Importantly, these construals of nursing as battling, as soldiering and as combatant work contrast with the constructions, discussed above, of the nurse as the nurturant and available ‘mother’. They construct the nurse-patient relationship quite differently.

The above constructions of the nurse-patient relationship as involving nurturance and tenderness (see section 3.2) shift here to constructions of nursing eating disorder patients as battling. Hence, there is a convergence here of the nurse and patient positions where both are located in ‘battle positions’ but where the nurse and the patients are also positioned in opposition to one another. Implicitly, whilst in conflict both are simultaneously combatants. This construction of this nurse-patient
relationship where the nurses and the eating disorder patients are linked but opposed resembles the nurse-patient relationships that are constructed in the construals of the nurse as ‘mother’ and the nurse as ‘warden’. That is, where the nurse is constructed as mother both the nurse and the patient are feminised, but one is constituted as ‘normal’ and one as ‘abnormal’, with this united but divided relationship strongly reminiscent of images of the ‘mother-daughter pairing’ reductively typified as a form of combat (Flax, 1993, p. 59). And further where the nurse is constructed as warden both the nurse and this patient group are positioned in a classic pose of antipathy between the jailer and the guilty. Yet, again, both nurse and patient are linked in the processes of ‘dressage’ as discipline structures this relationship. Suggesting that, as the participants’ account constructs these sets of oppositions, the nurse-patient relationship is possibly in the ‘thrall’ of partly visible, partly opaque relations of power that hold, shape and influence these positions into the patterns that are emerging in this analysis.

Within the above constructions of nurses’ work as ‘battle’ Carol also constitutes ‘power’ as visibly present in her construal of some nurses ‘who put on a uniform and become very powerful’. The ‘uniform’ here, signifies oppressive aspects of power – much as it does for the police, the military and correctional services. And Carol says ‘we virtually force them to do as we wanted’. She thus figures power relations as emblematic in the uniform and as explicit in the nurse-patient relationship. Her account thus consolidates, along with the constructions of the ‘nurse as warden’, the construction of the nurse as powerful, adding another layer of inference of the ward as a quasi-penal environment.

In this section the participants’ accounts construct the nurses’, and the patients’ work as ‘battle’ where ‘battle’ is construed, firstly, as an honorable struggle that the patients and their families take up against the eating disorder and, secondly, where the nurses and the patients are construed as co-combatants such that the nurse ‘uniform’ signifies current power relations, and echoes the long past history of para-military origin of Western style nursing. Taken together the construction of the nurse
as ‘warden’ and nursing constructed as ‘battle’ figures argument, confrontation, fighting, and force as part of the currency of the nurse to patient relationship, as much as kindness, nurturance, tenderness is figured where the nurse is construed as the ‘good mother’. In the following section the participants’ show a different and subtler nuance of contest and difficulty that concerns other nurses, their colleagues.

3.5 Other Nurses

In this third and last section of this chapter participants’ talk about ‘other’ nurses is considered. When talking about what ‘doesn’t work’ well in caring for eating disorder patients, and who should not nurse this patient group, construals of other nurses emerge in the participants’ talk in a slurry of undesirable characteristics and attributes. Loretta, Faye, Phillipa, Justine. Sally and Ramise say:

Loretta: The non-patient nurses. \(V:\) The non-patient nurses? \(/.\) you know, …like fruit, you wait for it to ripe, but some people couldn’t wait for that fruit to be ripe and they just become abrupt, I don’t think they’ll make good eating disordered nurses. …Yeah, how do you call it, ah, a nasty nurse [Document 'Data - Loretta' Paragraph 150]

Faye: I don’t want someone who accuses people. … Yeah there’s people that you know, accuses, the anorexic, … puts them down non-stop, like strict…. And others are over-enmeshed [Document 'Data - Faye' Paragraph 224]

Phillipa: And they can be very um, harsh in their dealing with them. [are] usually impatient with them [say things like] ‘For heaven’s sake why don’t you drink your cans and just get on with it [Document 'Data - Phillipa' Paragraph 135]

Sally: A nurse that shouldn’t be there? People who are very opinionated. They shouldn’t be there…. some people they say ‘Oh just smack on the bum and they will eat it’. ‘That’s all you have to do you just slap on the bum and they will go with it’. 122
‘That will be done and it’s finished’, they say. But they don’t understand the problem.

Charlie: I remember sitting down in my room here and just hearing people [other nurses] screaming at them, at them [the eating disorder patients] down in the um, dining room about eating and so forth [Document 'Data - Charlie' Paragraph]

Justine: [the eating disorder patients] are in hospital and they are sick and they need that support. I think if you come in and say, ‘OK’ ... ‘Come on skinnies, it’s time to eat.’ ... I think that’s very detrimental [Document 'Data - Justine' Paragraph 154]

Ramise: They shouldn’t um, be too strict on them, ... nurses that have been here for a while, they yell at them [Document 'Data - Ramise' Paragraph 108]

In these accounts ‘the-other-nurse’ is positioned as oppressively powerful and, while anonymous, she is visible in a litany of alarming characteristics and attributes variably construed explicitly and implicitly as ‘nasty’, ‘accusing’, ‘strict’, ‘over-ennmeshed’, ‘impatient’, ‘harsh’, ‘opinionated’, ‘aggressive’, ‘derogatory’, ‘condescending’ and ‘yelling’. These constructions of ‘other nurses’ are a long remove from the attributes that are construed to constitute the nurse as the ‘good mother’ (discussed in section 3.2 of this chapter) against which these above ‘unholy’ negative characteristics and attributes figure these ‘other nurses’ as no less than a certain type of ‘bad’ nurse, moreover, here a ‘bad nurse’ nurse in uniform. Importantly, these construals express the extent to which the participants abjure these awful behaviours. Yet, these constructions of ‘other’ nurses also signal firstly the potential interpretation of nursing actions as punishing actions (c.f section 3.3), and secondly represent a possible attempt to resolve the two conflicting constructions of ‘nurse as mother’ and ‘nurse as warden’ that the participants take up. That is, as the above accounts articulate negative and, moreover, seemingly ‘functionless’ qualities in ‘other’ nurses, the construction of the ‘nurse as warden’ suggests more a positive function - because the above construals of negative nursing qualities as allegedly
located in ‘other’ nurses articulates a careful demarcation of qualities between ‘other’ nurses and ‘good’ nurses.

Also the above accounts can be seen to work in a number of other ways. They clearly show that the participants position themselves as strong advocates for kind, tolerant, informed and professional care of this patient group. And the accounts also suggest a welter of possible issues that may be arise in the care for the eating disorder patient, including at times needing to protect these patients from allegedly unskilled, unhelpful ‘nasty’ ‘other’ nurses. Importantly, while negative constructions of the nurse and their work with this patient group arise in the participants’ accounts where nurses are construed as negatively powerful, punishing, and combative, these construals are brought to balance where the nurse is also explicitly and implicitly constructed as caring, comforting, nurturant and loving. The point being that while the former quite negative constructions throw a dark light on aspects of nursing, and the latter constructions conform to what is valued and expected of nurses, both these sets of constructions conform to dichotomised patriarchal fantasies of what constitutes ‘the feminine’.
3.6 Conclusion

The above chapter has considered the participants' constructions of the nurse as ‘mother’, as ‘warden’ and as ‘combatant’, as well as construals of ‘other’ nurses as sometimes mean, careless and harsh. These constructions reveal the nurses to be constructed in contradictory positions that suggest that there are diverging tensions in the nurse-eating disorder patient therapeutic relationship.

The above constructions also reveal the ‘feminisation’ of the role of the nurse. When the gendering of the nurses’ role is considered along with the gendering of the eating disorder patient (as discussed in chapter one) the positions of nurses and eating disorder patients are linked as similarly gendered with this similarity of ‘feminisation’ both containing and producing sets of dichotomised, opposing positions. These opposing positions reveal that relations of power fan out into negative, and at times seemingly hostile positionings in the nurse-eating disorder patient therapeutic relationship, where these positions configure a tableau of images that include the warden who ‘punishes’ the guilty patient, the image of the warring ‘mother and daughter’ duo, and the nurse and patient who battle with each other in a combat-style of therapy.

Further with respect to the feminisation of the role of the nurse the seeming disparate discursive positions of the nurse as ‘mother’ and nurse as ‘warden’ can also be read as different ‘levels’ in the ‘feminisation’ of the role of the nurse’. That is, whilst the construction of ‘the nurse as warden’ is not explicitly or obviously feminised, and might indeed be read as a ‘masculine’ position, it might also, in contrast, be read as the obverse ‘bad’ of the feminised ‘nurse as good mother’. Alternatively it might be read as a construction which forms part of ‘nurse as mother’ in that a ‘good mother’ is arguably also a legitimate ‘authority figure’, who is lovingly ‘firm’, who offers ‘guidance’ and is ‘watchful’. The positioning of the participants also as ‘warden’ then sets up an uneasy dis/continuity with the position of nurse as the ‘mother’ in an association of oppressive power, punishment and force with the role of the nurse.
This uneasy dis/continuity between these two positions, where the role of the nurse merges and shifts between ‘mother’ and ‘warden’, can also be understood to reveal the patriarchal dualism of the ‘feminine’ where the idealised feminine - the ‘good mother’ is figured against the taboo of the malign, constraining and punishing ‘feminine’ – ‘the warden’. A convocation of oppositions not dissimilar to the above consideration of the eating disorder patient positioned both as ‘victim’ and simultaneously as ‘potential aggressor’.

The above relations of power constituted in the participants’ accounts as arising in the mundane of their work strongly suggests that the nurses are caught in contradiction between the demands of working with eating disorder patients and the traditional precepts of how nurses are ‘meant’ to work with patients. That is, the participants’ appear to be dealing with an abrogation of traditions, conventions, and previously reliable expectations when caring for this particular patient group.

Additionally, and lastly, the above accounts that discuss the characteristic and attributes of ‘other’ nurses closely resemble in some respects the participants’ accounts of patients where the eating disorder patients are constructed as ‘deviant’ and deviance is ‘feminised’ as discussed in chapter two. The participants’ accounts were shown to construe this patient group as ‘cunning’, ‘lying’, ‘manipulative’, ‘untrustworthy’, ‘nasty’, ‘controlling’, and ‘destructive’. Yet this ‘chant’ seems to be taken up again in the above constitution of ‘other’ unskillful members of the nursing team. The similarity between these constructions links these previously distinct groups in an ‘ordering’ of nurses’ and patients’ positions that suggests a ‘feminised’ likeness between ‘nasty nurses’ and ‘nasty patients’. Invoking a truism that if you scratch the surface all women are sisters. Whichever side of the dichotomy ‘she’ falls (or is placed) both nurses (as good mother or punishing (other) nurses) and patients (as good girls or ‘bitchy little girls’) are caught in a highly gendered discursive field.
Chapter Four
Discursive Constructions of the Multidisciplinary Team

4.1 Introduction

In the following chapter I will discuss the participants' accounts of the multidisciplinary team. I choose to complete this thesis with this analysis to deepen the balance in the analysis as a whole, by exploring the relations of power between the nurses and the institution of the hospital in which they work.

In chapters two and three the participants' constructions of the eating disorder patient, and the nurse were discussed respectively. What became clear in these two chapters was that 'the patients', 'eating disorders', as well as 'the nurses' role' were figured as ambiguous and non-unified, with the participants' accounts often marking out this ambiguity and plurality in subject positions. These subject positions are for example: ‘the nurse’ constituted both as ‘mother’ and as ‘warden’, ‘the eating disorder patients’ constituted as both ‘deviant’ and as ‘lovely kids with great personalities’, and ‘eating disorders’ constituted as ‘a serious psychiatric problem’ and as a less pathologising ‘gone off the tracks’. The ambiguity and plurality revealed in these sets of oppositions (among others) suggests that the discursive field in which the nurses and the patients form and re-form their therapeutic relationship on a daily basis is a rugged and uneven terrain, and not always coherent - belying the image of what should possible constitute any hospitalisation or indeed what should constitute a therapeutic liaison. That is, the constructions in chapters two and three impinge on images of promises of idealised medicalised ‘care’ and ‘cure’.

The previous two analysis chapters also examined the ways that gendering of this patient group and the nurses’ role arose in the participants’ accounts. The participants’ implicit and explicit gendering of their own roles as nurses as well as of the patients they care for revealed patriarchal relations of power. That is both these
subject positions – ‘the nurses’ and ‘the eating disorder patients’ - appeared as constituted in part through subjugation. And, further, that this subjugation is difficult to identify in the economy of politically correct rhetoric. It is at this point that this third and last chapter of the analysis will look at the ways in which the participants frame and constitute their roles as multidisciplinary team members as a way exploring the wider contexts in which participants work.

4.2 Four Wards And Four Multidisciplinary Teams Analysed As One

The multidisciplinary team is itself nested in ever widening institutional contexts. However, this chapter focuses only on the context of the multi-disciplinary team. This is because of the limitations of this study (i.e. the interviews were only with the nurses on the team) and the fact that the nurse-multidisciplinary team relationship is arguably the participants’ most immediate institutional context, after the context of the other nurses with whom they work. The use the term ‘multidisciplinary team’ distinguishes this team from points where some participants refer the nursing team as ‘the team’. For purposes of clarity I will refer to both teams as either ‘multidisciplinary’ or ‘nursing’ teams. Also in the analysis I have used the singular of ‘multidisciplinary team’, whereas there were four teams that worked with the four ward areas where participants worked. As discussed in the methodology section concerning confidentiality this reference to a single multidisciplinary team is an important way of ensuring the participants’ full anonymity without loosing the central focus of the analysis, which is an exploration of the discursive resources that the participants draw on in framing and making sense of their work, the patients and their nursing roles.

To refresh the description of the wards and the multidisciplinary team structure offered before: the four main wards areas where the participants worked were two children’s wards, one of which cared for eating disorder patients under age 10 years old, and the other ward took children from 10 years to approximately 14 years old. In addition, there was one adolescent medical ward that had beds for eating disorder
patients from approximately 15 - 18 years of age, and a psychiatric unit that took eating disorder patients from over 18 years of age.

Each of those areas that were involved in the study had an eating disorder multidisciplinary team that provided care and treatment and had up to three interdisciplinary team meetings per week. It was at these team meetings that the teams made decisions concerning therapeutic treatment changes for each eating disorder patient. These teams were variably compromised of medical staff (a senior hospital paediatrician, or senior hospital psychiatrist in the case of the psychiatric area, a paediatric registrar, a resident doctor and an intern doctor, a consulting senior paediatrician, or a consulting psychiatrist, plus a resident senior child and adolescent psychiatrist and one or two psychiatric registrars); nursing staff (clinical nurse consultants, clinical nurse educators, clinical nurse specialists; nurse unit managers, registered nurses and enrolled nurses); a dietitian; a physiotherapist; an occupational therapist; a medical psychologist and an intern medical psychologist, a social worker, teachers from the hospital school and an art therapist. These disciplines are variably represented on an area’s multidisciplinary team depending on the specialty of the area in dealing with eating disorders i.e. early childhood, childhood, adolescent and young adult (psychiatry). A number of the doctors and some of the nurses were members of more than one of the teams across the four areas in the hospital.

In the following two sections of analysis in this chapter the participants’ constructions of ‘nurses’ as ‘multidisciplinary team members’ and of ‘the nurse-doctor relationship’ represent the preponderance of the participants’ accounts where they talk about in the multidisciplinary team. Given, that nurses and doctors take up the weight of numbers in the multidisciplinary team, and are represented in greater numbers than other professions, the participants’ focus on the nurse-doctor relationship can be appreciated. Having said this, the participants’ focus on the discursive constructions of the nurse-doctor relationship in the accounts nevertheless constitutes a more-or-less discursive bi-disciplinary core to the multidisciplinary team bracketing off much of a possible nine-discipline mix. In the following accounts Max is quoted as length
talking about several aspects of the nurses working as multidisciplinary team members.

4.3 Nurses As Multidisciplinary Team Members

In the following two quotes Max talks about the multidisciplinary team, the team meetings and the nurse-multidisciplinary team relationship, he says:

Max: It’s not very hierarchical. Like there’s not one person telling another person what to do. Everybody works together ... many of the nursing staff to go ... we’ve also got the psychologists, the social workers, plus the consultant, plus the medical director. ... We have medical students. We have the program nurse that goes as well. [Document 'Data - Max' Paragraph 137]

Max: it goes back to the days when the nurses were seen as handmaidens ... [for] some people there's a little bit of reluctance to sort of treat information [given by nurses] as being valuable [and] sometimes you get people [nurses] going in there who aren’t prepared to really say what they're thinking ... the more senior people just see [the nurses'] role as valuable as anybody else ... the more junior [nurses] can be quite reluctant to actually say something... I went through a terrible time ... I would go into the meetings and if somebody a bit louder than them was stopping them from talking, I’d actually stop that person and say ‘Look, can you finish what you're saying?’ ... I’d help them complete it and value what they’re doing because what they're doing is really the hub of what's happening. ... there might be ten or twelve people in the room but there's only a few of them that were actually delivering the day to day, twenty-four hour care. And it’s those nurses [who] go in there. The rest of them see the patient, do assessments and have a very valuable role but they don’t actually deliver the care. ... their contact with the patients is fairly limited in comparison to the hours that are spent with the nursing staff ... [the nurses] input is very valuable even if they raise an issue that they don’t get the outcome that they were really interested in, they’ve still raised that issue and some acknowledgement of
it, and some change has occurred ... it becomes part of the body of knowledge in the room. [Document 'Data - Max' Paragraph 199]

Max's above accounts construct both ostensible and subtler aspects of the multidisciplinary team, their meetings and the nurse-multidisciplinary team relationship. These two accounts will be used as a sort of 'flag ship' for the following discussion as they are thematically rich. The themes of interest are, firstly, where Max construes the multidisciplinary team as egalitarian and then as exclusionary of nurses' knowledge; secondly, Max' construction of nurses' knowledge as valuable - yet nurses' are also marginalised; thirdly, the nurses' role constructed in two ways as being both the focal point of the therapeutic enterprise and as subservient; fourth how the silencing of nurses within the rhetoric of inclusion is constituted; and, fifth and lastly, the ways in which nurses are positioned as 'the hub' of the multidisciplinary team yet as also non-participative in the decision making process.

4.3.1 Constructing The Team As Egalitarian Yet Exclusionary

Max's first account explicitly constitutes the multidisciplinary team as composed of a number of different disciplines and as 'hierarchical' but 'not very'. The team is constituted as one in which 'everybody works together' and in which 'basically many of the nursing staff go to the meetings'. Max clearly infers the relationships amongst multidisciplinary team are (nearly) egalitarian in this matter-of-fact, non-problematic sketch of the multidisciplinary team. Delphi and Susan also construe their nursing roles as being equal with the rest of multidisciplinary team.

Delphi: I feel as if ... I'm just one of the circle with everybody that fits in with them [Document 'Data - Delphi' Paragraph 119]

Susan: I see myself as being equal to every other member of the multidisciplinary team and I would hope and I think that our team encourages the nurses on the ward to feel that. /V: Uh-huh/ However, I think that there is some culture within nursing /V:
Yeah/ that. (.) I'm trying to, I'm strug, I'm struggling to find the words. /V: Aah/ But that doesn't value itself enough. [Document 'Data - Susan' Paragraph 195]

Delphi construes her role as 'just one of the circle with everyone else', and Susan constructs herself as 'being equal to every other member of the multidisciplinary team'. Yet, Susan's account of her own inclusion also keys into a hazy suggestion of something being remiss. Susan's account of her own sense of multidisciplinary team membership is set against something being remiss in 'the culture of nursing' as not 'valuing itself enough'. This juxtaposition of Susan's inclusion and egalitarian status on the one hand with on the other hand something being remiss in 'the culture of nursing' suggests a discordance between the multidisciplinary team and nurses. And this suggestion of discordance is located as a dilemma involving 'some culture within nursing itself' not 'valu[ing] itself enough'.

Her account can thus be understood as articulating a 'nursing dilemma' in which, first, the multidisciplinary team is construed as egalitarian and as inclusive and valuing of nurses as important. And yet, second, that there is a problem: that 'some culture within nursing doesn't value itself enough'. This problem suggests a lack of valuing, equality and inclusion for nurses but the lack is located squarely within 'some culture within nursing'; it is nurses' culture, not the team nor the institution of the hospital, which 'doesn't value [nursing] enough'. Significantly this nursing dilemma is not constituted as signifying

an increasing pressure within the nursing community for nurses to draw back from their 'handmaiden' relationship with doctors, and perform as an independent profession ... [or that] some doctors are very reluctant to relinquish traditional power (Leonard, 2003, p. 225).

Nor, is this dilemma of 'the culture of nursing' accounted for as occurring within the dynamics of gendered power relations in nursing where the 'context of patriarchal power' is both privileged and obscured (Evans, 1997, p. 230). Rather, Susan's
account represents an instance where the gendered position of the nurse is “completely omitted” in a consideration of ‘the culture of nursing’ (see Suominen, 1997, p. 188).

In the above quotes where Max, Delphi and Susan talk about the multidisciplinary team as egalitarian and inclusive, an uneasy space opens out in Susan’s account to suggest that perhaps the multidisciplinary team is less than wholly inclusive as pictured above. Her account certainly construes inclusion as somehow problematic for nurses. In these next accounts Lucy, Justine and Millie explicitly talk about problems of exclusion, they say:

Lucy: [you] have to be very mindful that the team isn’t um, isolating another core group of the team that’s vital … because some members of the team like to refer to themselves as a team and exclude the ward staff … it happens a lot and people need constantly be pulled into, to line about that. [Document 'Data - Lucy' Paragraph 31]

Justine: in it [can be] quite intimidating for the nurse that has to walk in and a lot of people don’t want to ever attend the case conferences, it’s like, ‘Who drew the short straw today?’ [Document 'Data - Justine' Paragraph 92 & 111]

Millie: The nurses are allowed in there as well. We’re allowed to go in at the team meeting. [Document 'Data - Millie' Paragraph 331]

For Millie exclusion is accounted for in the absence of ready inclusion as being permitted to join in the multidisciplinary teams. Being included is not a given for Millie when, she says: ‘The nurses are allowed in there as well’. This reference to ‘permission’ infers a position of favored subservience, not a position of entitled equality, and clearly constituting unequal relations of power between the multidisciplinary team and, in this instance, Millie.
These accounts explicitly constitute the multidisciplinary teams as less inclusive and less democratic than the broadly inclusionary title ‘multidisciplinary’ suggests. Lucy’s account also constitute the nurses’ role as an advocate for their colleagues to monitor and seek redress when the nurses are excluded from team, to ask for the ‘inclusion’ that nurses at one level are already constituted as possessing. Lucy constitutes this part of the nurses’ role when she says ‘people need constantly be pulled into … line’. This suggests that the nurses’ place on the multidisciplinary team is at best provisional despite the rhetoric of inclusion, and further that the nurses’ sustained inclusion on the multidisciplinary team is nurse-mediated. Without nurses ‘pull[ing the team] into line’ ‘some members of the team [would] exclude the ward staff’. Here, Lucy’s account resonates with Susan’s in that the nurse is constructed as needing to forge her own inclusion here. And this notion of the nurses’ place on the multidisciplinary team as provisional is consolidated in Justine account where she talks about the meetings as, at times, being intimidating to walk into, where the multidisciplinary team meetings are constituted as a something to be endured by the nurses, to the degree that the nurses ask each other ‘Who drew the short straw today?’ thus figuring these meetings as very uneasy, awkward spaces for the nurses.

Exclusion from the multidisciplinary team is also constituted in four other ways. These differing construals of exclusion are closely linked much like the rhyme This is the House that Jack Built that threads a concatenation of actions together portraying a wide picture of simultaneous and counterpoised events. In the accounts nurses exclusion from the multidisciplinary team is constituted where nurses’ work is valued but nurses’ knowledge is not; where nurses’ work is valued but nurses are constituted as ‘handmaidens’; and where nurses are constituted as ‘handmaidens’ and are thereby silenced but where nurses silences are constituted as ground for or explanation of their being excluded from the decision making process i.e. excluded from taking positions of authority.
4.3.2 Nurses’ Knowledge As Valuable Yet Marginalised

In Max’s second quote in section 4.3 he constitutes nurses’ knowledge as valuable because of the nurses’ pivotal role in caring for eating disorder patients when compared to other team members, whom Max says ‘do assessments and have a very valuable role but they don’t actually deliver the care. … their contact with the patients is fairly limited in comparison to the hours that are spent with the nursing staff’. Nurses’ knowledge is thus construed as valuable because of their encompassing role of anchoring the treatment programme. Nurses’ ‘knowledge’ is thus arguable also constituted as gendered ‘knowledge’ as a ‘feminised’ and therefore marginalised knowledge. It is (only) because of her constant caring (see chapter 2), not because of her professional status that her knowledge is valued. This is a highly and tightly incongruous construction where, in the process of ‘valuing’ the nurse, the carpet is pulled from under her feet because the role itself is systematically devalued in other ways, in other places such that the valuing of her knowledge cannot be sustained. As Max says later ‘[the nurses’] input is very valuable even if they [the nurses] raise an issue that they don’t get the outcome that they were really interested in, they’ve still raised that issue and some acknowledgement of it, and some change has occurred … it becomes part of the body of knowledge in the room’. And this is a quizzical appraisal of the knowledge of multidisciplinary team within which nurses are simultaneously constructed as ‘the hub’ of the therapeutic enterprise. As Ceci says:

essential incongruities persist in the discontinuities between nursing as taught and nursing practiced, between nursing experienced by others and nursing as perceived by others, and between nursing’s central role in health systems and our sustained marginalisation in determining how that role is to be realised. These discontinuities, which often seem to position nursing and nurses as simply incorrect in their understandings, must be taken up as meaningful, not as natural or inevitable. But as pointing to social structures and ways of thinking which privilege some perspectives and exclude others. [And while]
the marginal position of nurses is unquestionably related to the subordinate status of women and the aspersions cast on the value of what is called ‘women’s work’, nursing marginality is also specifically related to the subordinate status of nursing knowledge (Ceci, 2003, pp. 126 - 128).

The value of nurses’ ‘knowledge’ is constituted as accruing *because* they are the ‘crux’ of the treatment programme and is simultaneously devalued *because* it is nurses’ knowledge. This construction of nurses’ ‘knowledge’ can thus be seen to privilege the rest of the multidisciplinary team members’ ‘knowledge’ over that of the nurses. That is, the value of other team members’ ‘knowledge’ is not attached to their being ‘the hub of what’s happening’. It is the nurses occupy this position on the team. Rather, as Max says, the rest of the multidisciplinary teams’ ‘contact with the patients [being] fairly limited’, inferring then that other team member’s ‘knowledge’ is valued not in relation to the ‘size’ of their roles, but rather for the possible intrinsic value (guaranteed by their authoritative status) that their knowledge can contribute - but not so for the nurses.

This construction of the value of nurse’ ‘knowledge’ functions as a de-politicising conciliation of the nurses’ marginalised position and damps down the nurses implied ‘lack’ of valuable knowledge. For how is it that the nurses (who are, as Max explicitly says, ‘the hub of what’s happening’) are not therefore the centerpiece of these meetings where their knowledge and commentary is sought out and considered to be absolutely essential to treatment decision making? How is it that, in these accounts, when they do make a contribution to a team meeting they are construed as merely ‘rais[ing] that issue … [which then] becomes part of the body of knowledge in the room’?

4.3.3 Nurses’ Role As ‘The Hub’ Yet Nurses As Subservient

In constituting nurses’ knowledge as valuable (only) because of the value of nurses’ work, Max’s second quote explicitly constitutes the nurses’ role as being one that is
valued (and this has been discussed in chapter three where the nurses’ role is also constituted as ‘pivotal’ in her role as continually available ‘mother’) by ‘the more senior people [in the team who] see [the nurses’] role as valuable as anybody else’. Yet, at the same time he also says that ‘some people’ in the team are ‘a little bit ... reluctant to sort of treat [the nurses’] information as being valuable’ because of ‘the days when the nurses were seen as handmaidens’. This construal of nurses as ‘handmaidens’ slides between the past and present where ‘some people’ are reluctant to value nurses knowledge at this point in time and where nurses are positioned in a timeworn and tiresome position of ‘once-were handmaidens’. Here, with the past slipping effortlessly into the present, ‘some people’ appear exonerated from being accountable for their exclusion of nurses in a glossing over of relations of power, because of how nurses used to be viewed. In a curiously powerful construction of nurses any nurse is, then, somehow attached to the whole of nursing history, and in Max’s account this history still holds the nurses to ransom. And also, perforce this quasi-positioning of the nurses as (once-were) ‘handmaidens’, nurses ‘knowledge’ is marginalised in another way. The nurses’ place in these multidisciplinary team meetings is constituted as valuable, so to some degree powerful, but also as ‘once were handmaidens’ and therefore in subordination to the rest of multidisciplinary team and as relatively powerless.

Up to this point the above accounts constitute the nurses across multiple positions as the valued workers, as diffusely subjugated in being permitted to attend meetings, as intimidated when walking into meeting, as ‘once were handmaidens’, as one of the circle; as being equal, as being part of a culture that doesn’t value itself enough; as advocates for other nurses to ensure inclusion of all nurses; and as being the ones whose knowledge is valued in one way and abjured in another. This analysis thus reveals another layer of complexity (in addition to the complexities discussed in chapter 3) in the discursive construction of the nurses’ role. As well, these accounts show how rapidly power shifts in the nurse–multidisciplinary team relationship which, I have argued, up to this point, has been constituted as weighted in the favour
of the rest of the multidisciplinary team; ‘a team’ which in these accounts figures a still point of power around which the nurses spin.

Further to these accounts that track the relations of power, the participants also explicitly talk about lack of resources and poorly-coordinated timetabling of meetings as practical problems that inhibit equal nursing participation in multidisciplinary team meeting and so in decision making processes.

4.3.4 Nurses As Non-Participative In Decision-Making

Susan, Ramise and Justine talk about the practical difficulties involved in being active, participating multidisciplinary team members. They say

Susan: One of the constraints nurses have is …they are so under-resourced that it’s very hard for them to come to clinical meetings, it’s hard for them to be part of management decisions [Document 'Data - Susan' Paragraph 207]

Ramise: Actually in ten months, last week was the first one [team meeting] I went to. It was good. I liked it … actually the doctors actually given …feedback. And I didn’t think that happens, [in] the meetings that other people have gone to [Document 'Data - Ramise' Paragraph 88]

Justine: [the rest of the team could] check with the nurses when the case conferences are appropriate, like putting them on when they do sometimes just is not appropriate and I just can’t attend [Document 'Data - Justine' Paragraph 92 & 111]

Justine and Ramise above talk about the difficulty of attending meetings because of their work demands. Ramise says ‘[a]ctually in ten months, last week was the first one [team meeting] I went to’. Similarly Justine construes a lack of consultation with nurses as ‘[the team could] check with the nurses when the case conferences are appropriate, like putting them on when they do sometimes just is not appropriate and
I just can’t attend'. Coordinating regular multidisciplinary team meetings is no doubt difficult. Yet, Justine’s account infers the difficulty that the nurses’ experience in attending the meets is possibly constituted in broader material practices of exclusion where she suggests that the team could check with the nurses and this does not happen. Susan also talks about some of the problems that inhibit nurses’ participation in team meetings and, hence, in the decision-making process. Susan says that ‘it’s hard for [the nurses] to be part of management decisions [because the nurses] are so under-resourced that it’s very hard for them to come to clinical meetings’. So that from Justine, Ramise and Susan’s accounts it might be readily understood that the practical and pressing issues of timetabling meetings, work loads, and under-resourcing affects nursing staff and acts to impede full nursing participation in team meetings and management decisions, which are then therefore left to the rest of the multidisciplinary team to take up.

It is incongruous, therefore, that the nurses are not so ‘under-resourced’ that they are, as Max says in the first above quote in section 4.3, also constituted ‘really the hub of what’s happening’: they are ‘pivotal’ to the therapeutic enterprise and are constituted as the raison d’être for actually admitting eating disorder patients (discussed at length in chapter three concerning the constitution of the nurse at ‘mother 24/7’). That is, the very lack of resources, which stop at resourcing nurses being involved decisions, is constituted as a nursing problem. The exclusion of nurses from decision-making is constituted as a resource problem, which, at least implicitly, localises these resource problems as nursing resource problem. Raising these problems of nursing shortages and lack of nursing resources involves a conceptualisation of the current situation in nursing as:

principally a problem of mismatched supply and demand [which] is considered by some so self-evident that it is seldom discussed as merely a point of view ... the need and necessity of recognising the current situation in nursing as concerning matters open to question will be clear to all of us who understand nurses as something more than pairs of hands and nursing as
something more than ancillary technical support to the real work of providing medical care (Ceci, 2003 p. 122-125)

A series of impasses can be seen to shape the construction and regulation of the eating disorder nurse as a member of the multidisciplinary team member. The above accounts represent the nurse as a good and valued worker, who is simultaneously held at a distance from decision-making processes suggesting a multiplicity of possible tensions between the nurses and the multidisciplinary team, where what seems to be best maintained are patriarchal gender relations that are embedded in the institutional hierarchies of the hospital (see Evans, 1997).

4.3.5 The Silencing Of Nurses Within The Rhetoric Of Inclusion

Relations of power in the nurses-multidisciplinary team relationship are also constructed where the participants talk about not talking. In his second account Max talks about nurse not talking in the multidisciplinary team meetings. He says:

Max: sometimes you get people [nurses] going in there who aren’t prepared to really say what they’re thinking [and] the more junior [nurses] can be quite reluctant to actually say something. … … I went through a terrible time … I would go into the meetings and if somebody a bit louder than them was stopping them from talking, I’d actually stop that person and say ‘Look, can you finish what you’re saying?’ … I’d help them complete it and value what they’re doing because what they’re doing is really the hub of what’s happening.

Here Max constructs himself as another advocate assisting the inclusion of nurses into the meetings - this time the focus is the nurses’ voice. But as Max constitutes nurses as ‘quite reluctant to actually say something’, nurses are constituted as recalcitrant in being ‘unwilling’ to contribute in team meeting discussions. Moreover nurses are also constituted here as less powerful precisely because they themselves are reluctant to speak. That is, the nurses are construed as self-silencing
and the shifting forces that constitute the context of the nurses’ silence are dissolved, neutralised and thus rendered difficult to see as Max also constructs the team as ‘not very hierarchical. Like there’s not one person telling another person what to do [and where] everybody works together’. By constituting the context as largely egalitarian potential explanations of nurses’ ‘reluctance’ to actual say something’ in terms of power-relations are further marginalised to consolidate an explanation in terms of nurses’ ‘individual failings’. The eating disorder nurse is thus figured to hold a commission of authority in the work she does, but not the voice of authority.

Carol, Justine, Millie and Ula also talk explicitly about talking and listening in the meetings in ways that suggest that this matter is very problematic in the nurses relationship with the multidisciplinary team. They say:

Carol: Sometimes it’s OK. ... I would never go, I wouldn’t feel confident enough to say, ‘I don’t think this is the right way of going about it. ... I might make a suggestion

Ula: the nurses’ information/knowledge ... I don’t really think ... it’s listened to but I don’t think it’s ever acted on or considered. And um, it’s just like another bit of information now ... I don’t think it’s considered as essential as it used to be ... it seems to me, um, because I’m sure that if you asked the people that I feel aren’t ... kind of listening properly, if you asked them they would disagree with me ... it seems to me that regardless of what anybody says that the people that kind of run it have their agenda and that’s what they’ll do ... I feel generally [here] the nurses ... they’ve been devalued. And I think that generally they’re not listened to as much as they used to be in a different time and place. And I think generally that’s been very detrimental to the nursing teamwork. [Document 'Data - Ula' Paragraph 208

Millie: ...Lack of recognition is one instance .... the multi-disciplinary team they’ve only with the patients for a very short space of time. Whereas the nursing staff have got eight hours. [Document 'Data - Millie' Paragraph 99]
Justine: you walk into a room of probably about ten, twelve people that are laughing and sitting around cake and everything and it just seems to be ‘Hang on, this is a serious thing.’ … ‘Why do we bother coming in here?’ we say a little bit, that’s if we say anything, about the patients and your decisions are made [Document 'Data - Justine' Paragraph 92 & 111]

Carol, Justine, Millie and Ula explicitly construe their experiences of ‘talking’ and ‘not talking’ during the multidisciplinary team meetings as difficult and unpleasant, where Carol construes herself as lacking confidence and Ula construes herself as unheard. Ula additionally constructs a rebuff of her own construal of being unheard when she says ‘I’m sure that if you asked the people that I feel aren’t … kind of listening properly, if you asked them they would disagree with me’. This might be read as a qualification of her complaint, a suggestion that she may be wrong. Yet, in contrast, her statement can also be read as further consolidating a construction of unequal power relations. That is, here Ula’s account circumscribes a wholly limited position where not only are nurses not listened to, but their complaint of not being ‘listened to’ has no purchase. The nurses are left flailing in the absence of being heard – a different form of silence.

These above accounts disturb Max’s first construction of the multidisciplinary team as (almost) egalitarian. In Max’s account the team is ‘not very hierarchical … there’s not one person telling another person what to do … [e]verybody works together’, and ‘… the more senior people just see [the nurses’] role as valuable as anybody else’. Carol, Justine, Millie and Ula’s accounts do not constitute the team as equal or as receptive of the nurses’ presence at the meetings. Nor, in these accounts is the team constructed as seeing nurses’ ‘knowledge’ as valuable, rather the reverse. Carol says that she might ‘make a suggestion’ but ‘wouldn’t feel confident enough to say, ‘I don’t think this is the right way of going about it’’. Similarly, Justine says that when ‘we say a little bit, that’s if we say anything, about the patients … your decisions are made’; and Ula says that the nurses are ‘listened to but I don’t think it’s ever acted on
or considered. And um, it’s just like another bit of information now … I don’t think it’s considered as essential as it used to be’. These constructions of the multidisciplinary team as distinctly hierarchical (as well as constructions of the team as egalitarian) constitute part of the context in which the nurses work in the care of eating disorder patients. This context is marked out by divergent constructions of the team such that ‘the nurse’ is construed as pulling in at least two different directions: as equal but unequal and as the working ‘hub’ of the team and yet figured as unheard and reluctant to talk in a marginalisation of the role and the nurses’ knowledge. The multidisciplinary team is figured as a ‘deterministic framework [where membership constitutes] a painful obligation’ (Leonard, 2003, p. 220), when as Justine’s says about the team meetings that ‘about ten, twelve people … are laughing and sitting around cake and everything … [and] when they actually are in there for ages before a nurse walks in it’s quite intimidating for the nurse that has to walk in’. Her account thus suggests the possibility of social distancing practices that cull the nurses from this context (Evans, 1997, p. 229).

In the above accounts the nurse seems to keep rebounding off officially denied imperatives that have constituted the multidisciplinary team as a ‘big chief’, which makes the treatment decisions. Justine says ‘your decisions are made’ And Millie says ‘[:the doctors … and the psychologist sets a program. Not just the psychologist, the team’. There is an inference in both these accounts that the team has pre-empted the possible value of the nurses’ contribution and makes therapeutic decisions independent of nurses’ contributions. As Ula says, ‘the people that kind of run it have their agenda and that’s what they’ll do … I feel generally [here] the nurses … they’ve been devalued’. These accounts thus construct the nurse as substantively less powerful team members than Max’s above construction of the nurse as a valued team would presuppose.
4.4 The Nurse-Doctor Relationship

The above discussion has shown how the participants constitute the multidisciplinary team as inclusive and exclusive of nurses as team members. In these constructions where ‘inclusion’ is offset against being ‘not really included’ no clearly identified oppositions are formed. Rather, ambiguous boundaries surface and recede, suggesting that the nurses are positioned in roles that could arguably be said to be ‘frustrating’, and ‘challenging’. This ‘frustration’ and ‘challenge’ is resonant with the participants’ constructions of caring for eating disorder patients as ‘frustrating’ and ‘challenging’ (see chapter two). Suggesting that both the eating disorder patients and the nurses are hooked into a net of discourse and discursive practices that join them more closely than the traditional distinctions in their formal positions as ‘the nurse’ and ‘the patient’ might appear to allow.

Further to these above constructions of the multidisciplinary team as both inclusive of and exclusive of the nurses, the participants’ talk about the multidisciplinary team was spliced with talk about the doctors. This talk constituted ‘the doctors’ in different ways including the doctors as (1) ‘occasioning’ the ward with their presence, as (2) being both ‘supportive and non-supportive’ to the nurses, as (3) taking the lead when working with the nurses, as (4) being ‘male’ and lastly (5) as being a ‘law unto their own’. These five constructions are discussed below in the final section of this chapter, which is the last part of the analysis. The intention in this section is to show the density and overlap of the discursive relationships that constitute the nurses’ role in this area of care.

4.4.1 The Occasional Presence Of The Doctor

At times the participants talked about the doctors as if the doctors ‘occasioned’ the ward with their presence. This talk contrasts noticeably against the constructions of the nurses as capacious ‘mothers’ who are available ‘24/7’ discussed earlier in chapter three. Bridget and Phillipa say:
Bridget: Well, the psychiatrist and the psychologist ... breezed in once or twice a week ... the nursing staff did the bulk of the work [Document 'Data - Bridget' Paragraph 97]

Phillipa: Where I feel we [nurses] have more rapport with them [the eating disorder patients] than the doctors who come in and tell them [the eating disorder patients] what’s happening and then go back to their offices. [Document 'Data - Phillipa' Paragraph 84]

Here the doctors are constituted as ‘breezy’ and ‘occasional’ in how they attend to the eating disorder patients. This construction is opposite to how ‘the nurse’ is constructed as available ‘24/7’ as the constantly giving ‘mothers’ discussed in chapter three. As Bridget construes the doctors as ‘breez[ing] in once or twice a week’ the doctors’ consultative presence is casualised. And as Phillipa construes the doctors as ‘com[ing] in and tell[ing] them [the eating disorder patients] what’s happening and then go[ing] back to their offices.’ notions of an ‘ivory tower’ are also invoked.

Taken together these accounts construe the doctors as behaving in a quasi-aristocracy way. Yet, even this construction is ambiguous because both these accounts set up an image of a play with the doctors walking on and off the stage, with the nurses centre stage at all times – holding the fort so to speak.

As well as the construal of the doctors’ presences as ‘occasional’, for Bridget and Phillipa the nurses and the doctors also ‘work’ differently. Bridget says ‘the nursing staff [do] the bulk of the work’ figuring the nurses as ‘labourer’ against the doctors ‘breezy’ visits. And, for Phillipa, since nurses ‘have more rapport with them [the eating disorder patients] than the doctors’ and since rapport constitutes the heart of the therapeutic enterprise, Phillipa locates the nurses rather than the doctors at that heart.
These two accounts construct the nurse–doctor relationship as a relationship between two professional groups hinged to the same patient group thereby having the same curative goals for these patients. But, the two professions are constituted as being differently time-framed and as carrying different workloads. This is to be expected in the traditions of this relationship. Yet, these accounts also nuance these differences in professional availability and workloads as unequal demands and benefits. Again like the above constructions where the nurse is ‘included but not really included’ in the multidisciplinary team, what the doctors do is indistinct. Here anything else that the doctors may or may not do in relation to their work with the eating disorder patents, other than ‘drop-in’ occasionally or ‘come in and tell them [the eating disorder patients] what’s happening and then go back to their offices’ is curtailed off. This construction of the doctors’ limited, occasional but nonetheless pivotal presence positions the nurses as the ‘labour’ component in the relationship. One that simultaneously de-centres the doctor from the position of ‘cure’: Phillipa says ‘I feel we [nurses] have more rapport with them [the eating disorder patients] than the doctors’. More rapport perhaps, but (as discussed above) not more power. Indeed, this construction the nurse–doctor relationship might also be read to consolidate the marginalisation of nurse ‘knowledge’ discussed above, where the nurses provide the ‘labour’ and the doctors provide the occasional but ‘knowledgeable’ presence. (After all cleaners also ‘pop’ in and out of the ward areas.)

4.4.2 Doctors As Supportive And Non-Supportive Of The Nurses

The sense of inequality in the above accounts where the multidisciplinary team as a whole was discussed, also resonates in the following accounts where the doctors are constituted as at times supportive but as markedly unsupportive at other times. Phillipa, Loretta and Sandra say:

Phillipa: The nurses … get a lot of support … the doctors really do appreciate the work the nurses I feel there’s a lot of positive reinforcement given to the nurses, and the job they do. [Document 'Data - Phillipa' Paragraph 109]
Loretta: the doctors rely on us but then ... sometimes it’s not good enough, when we say things to them, that we suggest things to them sometimes you don’t get support from the doctors [Document 'Data - Loretta' Paragraph 162]

Sandra: there are times we feel we don’t get the support that we want ... and that’s usually the medical staff ... all I need to do is pass a comment [like] I think we could be doing it better and we could be getting a bit more support and then they all, they all sort of rally around again. [Document 'Data - Sandra' Paragraph 144]

These accounts construct support from the doctors/medical team in three ways: the ‘support’ is there and its marvelous; ‘support’ is available sometimes and is conditional; and ‘support’ ebbs and needs to be ramped up. In these accounts ‘support’ takes on a somewhat mysterious quality, much like the doctors ‘non-presence’. ‘Support’ is reified as ‘a something’ that is necessary or at least very helpful and ‘its’ absence is well noted. These accounts do not specify what constitutes ‘support’. Phillipa, Loretta and Sandra’s constructions of ‘support’ suggest that the notion of support is fluid and functions as a site where the differences in the nurses’ and doctors’ workloads might meet. Given that this concept that ‘support’, albeit poorly defined here, might function as a meeting point in the nurse-doctor relationship, the above accounts suggest that what ‘support’ exists in this relationship is mediocre. When the doctors do give a ‘lot of support’ it concerns appreciating the nurses for the work they do – but not helping the nurses, nor re-resourcing the nurses, nor rescheduling meetings to further incorporate the nurses. Rather the nurses are ‘appreciated’. For Sandra when the support isn’t there, she ‘pass[es] a comment ... then [the doctors] all sort of rally around again’. Here, also nurses are agentive advocates for other nurses (like Lucy in the above discussion who acts on behalf of other nurses to sustain nursing inclusion in the multidisciplinary team), to re-instate conditions of work that the nurses are at one level constructed to already have i.e. collaborative, egalitarian team relationships.
4.4.3 The Doctor And The Nurse Working Together

Further to the above constitution of ‘support’ as possibly operating as an index of both the quality of the nurse–doctor relationship and the practical work of partnership in the therapeutic enterprise, Charlie and Justine talk more explicitly about how nurses work alongside the doctors. They say:

Charlie: working within in a multidisciplinary team, the doctors would do the decisions and tell the patients of decisions with the nurse there and so you get that flow-on effect happening Um, so everyone knows what’s going on and having that is very helpful. [Document ‘Data - Charlie’ Paragraph]

Justine: Often the [the nurse is the] one that picks up the pieces after the doctors have been ‘round [Document ‘Data - Justine’ Paragraph 60]

For Charlie and Justine the nurse is constructed as the doctors’ ‘off-sider’ - the ‘one that picks up the pieces after the doctors have been round’, and as being there when the doctor-made decisions are told to the patients so that ‘everyone [including the nurses] knows what’s going on’. These slightly bitter sweet constructions of the nurses being present when the doctors hand out their decisions, and as picking up pieces’ allude to nurses’ ‘handmaiden-ship’. Max made explicit mention above (page 126) that nurses used to be thought of as ‘handmaidens’. However, Charlie and Justine’s accounts suggest that the nurse constituted as a ‘handmaiden’ is not remote in the history of nursing, but active in a different guise. A guise – (that is, ‘the nurse as a multidisciplinary team member who is too busy doing her essential work to participate in decision making’) that closets the sustained ‘feminisation’ of the role of the nurse in the rhetoric of egalitarian nurse-doctor relations.

In the following account Lucy ‘sexes’ up the nurse–patient-doctor relationship by explicitly construing the ‘male’ doctors on the team as having conventional ‘male’
egos. Lucy talks about the relationship between the teenage eating disorder ‘girl’ patients and the ‘male’ doctors she says:

4.4.4 The Doctors As ‘Males’

Lucy: we’re talking about teenage girls [the patients], predominantly, and their [the patients] main care-giver’s ah, on inpatient basis is from females [the nurses] and they[the patients] come up against the you know, male doctors and, honestly, you see them begin their flirtatious behaviour, their ah, games they play with these ah, you know, the male members of the team. And it’s, it’s for real, but they [the patients] get their way with them [the male doctors], they con them [the doctors] into changing decisions that have been made by the team and that is where the ward staff get irate [Document 'Data – Lucy’ Paragraph 84]

In this account Lucy talks about an alleged relationship dynamic between the doctors and the patients that figures the clinical doctor-patient relationship as influenced by a candid playing out of traditionally understood heterosexual(ised) ‘sex’ roles that the ‘male’ doctors are absurdly unaware of occurring. Of note, like the ‘feminised’ role of the nurse which is taken up by male as well as female nurses, so too the doctor’s role might be understood in these accounts as ‘masculinised’ despite the fact that female as well as male doctors take up that ‘gendered’ position. However, in the account above, Lucy is talking about ‘male’ doctors and the allegedly flirtatious ‘femme fatale’ teenage girl eating disorder patients ‘get[ting] their way’ with these doctors. In this account both patient and doctor are sexualised with the doctors figured as machismo bound and totally blinkered to (Lucy’s) understanding that their clinical decisions are most ‘unclinical’. The account thereby also undermines a construction of this relationship as clinical. Rather, in Lucy’s account, it is a farce.

Lucy’s construction of the doctors being ‘con[ned] ... into changing decisions that have been made by the team’ inserts an earthy ‘amusing’ quality into the nurse-patient–doctor relationship. Where ‘the doctors’, for all their authority, remoteness
and lack of efficacious support to the nurses are still figure as ‘mere males’ in reverse sexism. Yet, the ‘mere-ness’ of their ‘maleness’ – this whopping great blind spot of ‘the doctors’ in Lucy’s account, while somewhat amusing nevertheless figures as aversely impacting on the nurses who are disaffected by these decision changes, ratified purely by the doctors authoritative position. The constitution of the nurse-doctor relationship remains ambiguous and strained, thought not lacking in good will, but definitely a relationship of power asymmetries and access to rights.

4.4.5 The Doctors As A Law Unto Their Own

In the following and final account of this analysis Casey Anne talks further about how these ‘changes’ to the team-agreed-on treatment programme disaffects the nurses. Casey Anne says:

Casey Anne: I find it very frustrating at times when you know, we’ve got this level system …and you know, some parents will … talk to the team [the doctors] and get them to bend the rules in their [child’s] case … and it’s very frustrating in that you can’t know, you know, [the doctors] they’re not consistent with all the children that are going through and that’s depending on how much of a fight the parents kick up is how much they bend the rules and sometimes you feel like saying ‘Well, why do we have a level system if you’re not even going to … you know, stick to it? Shouldn’t it be that all of them, all, every child eh, should be treated the same and it’s not how much the parents … Um

Vicki: … do you have any redress about that?

Casey Anne: :I think we make it known, but they’re a law unto their own they you know [Document 'Data - Casey Anne' Paragraph 104]

In the above quote Casey Anne says that ‘its very frustrating’ when the doctors ‘bend the rules’ of ‘this level system’. The ‘level system’ that Casey Anne talks about is the eating disorder treatment programme. The treatment programme is structured so that the patients’ progress through the programme in stages where the patients’ gain
increasing privileges. These privileges include access to more activities, exercise, outings, and visitors. For example, a patient’s weight gain may mean that the patient moves to a level of increased privileges (according to the team’s joint decision), with the programme intended to progress all the patients in the same way, but not necessarily at the same time.

Given Casey Anne’s construction of nursing ‘frustration’ as the result of doctors’ allegedly random changes to the programme her deployment of the term ‘level system’ to mean the treatment programme, while clearly denoting patients’ progress can be read in this context of complaint to suggest evenness, fairness, equality and a level playing field – or lack thereof. Casey Anne construes the doctors as, at times, privileging some patients over others saying that some patients’ ‘parents will … talk to the team and get them to bend the rules in their [child’s] case … and it’s very frustrating in that you can’t know, you know, [the doctors] they’re not consistent with all the children that are going through and that’s depending on how much of a fight the parents kick up’. This alleged preferential treatment can be seen to not only be unfair to children not similarly ‘promoted’, but as also commensurably unfair to the nurses who are positioned as ‘keepers’ of the programme since they are with the patients twenty-four hours a day seven days a week (as discussed in chapter 3).

In Casey Anne’s account the boundaries between the nurse and the patient touch at this point where both patients and nurses are concurrently disaffected by the doctors – the nurses are frustrated, and the eating disorder patients as a group as Casey Anne says are not ‘be[ing] treated the same’. Her account thus figures the doctors to be, in a certain sense, aristocratic their actions. Casey Anne’s talk constitutes a specify problem in implementing the treatment programme as being rigged through implicit relations of power linking the doctors and the nurses in opposition. In this instance these power relations are asymmetric where the nurses are disaffected, and where the nurses’ challenge to the doctors on these matters seems impotent. Casey Anne says ‘I think we make it [our frustration] known’ adding that while the nurses make their frustration known ‘[the doctors] they’re a law unto their own they you know’. This
construction of the doctors as autonomous and powerful suggests that the doctors are non-innocent in these seemingly quasi-aristocratic actions, and figures the nurses as yielding to 'inevitable' frustrations.
4.5 Conclusion

The above discussion has considered the participants’ constructions of the nurses’ role in relation to the multidisciplinary team, and specially the nurse-doctor relationship. The participants’ differing constructions of power-relations are seen where nurses are multiply positioned as being valued for the work they do. Yet their faltering participation in the multidisciplinary team meetings, and thus their contributions at to treatment decisions, is construed as inhibited for a number of reasons. The nurses also positioned as neo-handmaidens, and ‘allowed’ into the meetings. While as Max clearly says that the nurses are encouraged to speak, and that what nurses have to say is valued by senior people on the team, nurses are also constituted as ‘reluctant of speak’, and as being wary of challenging treatment decisions. The multidisciplinary team is figured, as Ula says as ‘generally …not listening’, inferring that “the voices of nurses [are] largely … irrelevant” (Ceci, 2001, p. 125). The above accounts show a complex set of implicit tensions that structure nurse membership on multidisciplinary team, as nurses are positioned at one level to be ‘equal’ with all the team members, yet on another level not ‘equal’ simultaneously.

These accounts strongly suggest that it is difficult for nurses working within the multidisciplinary team. The participants’ accounts have centred on the explicit and implicit constructions concerning the (always-already gendered) position of the nurses in relation to the team, with, on one hand, the marginalisation of nursing ‘knowledge’, the subjugation implied in being ‘allowed’ to the meetings, and feelings of ‘intimidation’ when then joining the team meetings. Yet on the other hand, there are clearly articulated constructs of inclusion by the team and feelings of being equal with the team. These accounts have thus constructed the multidisciplinary teams as consultative of the nurses ‘knowledge’ and as, in the main, egalitarian. However, the accounts also clearly constitute the eating disorder nurse as subordinate to ‘the team’ and thus position ‘the nurse’ in continuous ‘role conflict’. A conflict between an idealised multidisciplinary team sustained in the rhetoric of inclusion and equality,
and that of the social distancing of the nurses such that the (gendered) power relations of inequality that are articulated in some accounts are obfuscated by gestures articulated in other accounts of team inclusion, support and equality of membership.

In this chapter the participant’s constructions of nurses’ relationships with the multidisciplinary team as a whole, and with the doctors in particular, have been shown to position nurses awkwardly between constructions of being included as team members but ‘not really’. Where nurses access to meetings is pinching off in construals that nurses the lack resources, not to do the work or be ‘the hub,’ but to access to positions of authority and decision-making.

At the same time the constructions of the nurse-doctor relationship shows that anything else that the ‘doctor side’ of the nurse-doctor relationship does is bracketed off, remaining invisible in these accounts. Much as there is a notable absence of ‘the father’ in accounts about ‘eating disorders’ and the ‘eating disorder patient’ (see chapter two), the doctors’ work in these accounts is slim reading. While the doctors’ work is scarcely talked about the participants nevertheless construe the doctors’ power as present. Exemplified in Casey Anne’s protest about the doctors as ‘a law unto their own’, which strongly suggests that this ‘doctors’ law’ rules everyone despite the rhetoric of equality; indicating that the ‘nurse-doctor relationship’ could be a profitable area for future qualitative research.

This concludes the analysis of the nineteen accounts. Chapter five offers a conclusion to the thesis.
Chapter Five
Conclusion

The following discussion is a summary of the three-analysis chapters, and concludes this thesis. This study is a project of feminist (poststructuralist), critical psychology that explores nurses’ accounts of nursing eating disorder patients. The methodology I used for this study is a qualitative, discourse analytic, semi-structured interview based methodology. The aim of the study has been to identify and analyse the discursive resources that participants draw on in framing and making sense of ‘eating disorder patients’, ‘eating disorders’, and their ‘nurse role’ in this area of care.

Principally, this project’s theoretical framework differs from a traditional, conventional approach to psychology (discussed in chapter one) in three important ways (among others): how ‘reality’ is understood, how ‘subjectivity’ is understood, and how ‘language’ and ‘discourse’ are understood. These three salient understandings can be summarised briefly. ‘Reality’, understood from this study’s perspective, is conceptualised as a ‘notion’, not as totalising and pre-given ‘fact’, albeit ‘a notion’ strongly held by many. Linked with this notion that there is ‘the real’ in which ‘we’ exist there is also an understanding of ‘rationality’ – that only one ‘rationality’ exists in the tyranny of objectivity (see Smail, 2001) which links ‘the real’ and the independent ‘I’. In this positivist perspective both ‘reality’ and ‘I’ are reified as separable ‘objects’ of investigation. ‘Objectivity’, assumed as possible, positions researchers as a neutral and unbiased, and research as reporting a one-to-one circuitous correspondence with ‘the real’ (see: Malson, 1998; Unger, 1996; Blaikie, 1993; Flax, 1991). All of which constitutes an exceedingly powerful and highly elaborate ‘reality principle’ (see Parker, 1997) on which understandings of ‘normality’ and ‘common sense’ are built, and which run like a fault lines through our socio-cultural relations.

This study contests this ‘reality principle’. Instead ‘the individual’ is considered to emerge and recede inseparable to and with encircling, overlapping socio-cultural
contexts (see Slobrouck, 2003). For this study ‘the individual’ is not singularly bounded by the locus of ‘a body’. Rather, in this study’s perspective, ‘the individual’ is conceptualised to consist precisely of “non-individual, social conventions, practices, meanings, and institutions we all share in common” (see Smail, 2001, p. 64). ‘The individual’, so-called, comes into sight across multiple discursively constituted positions that richly contour ‘subjectivity’ and ‘presence’ (see Davies & Harré, 1999; see also Hall, 1997). Language and discourse are therefore understood in this thesis as constitutive, not reflective, of ‘reality’ (see Malson, 1998, see also Burman & Parker, 1995). And further in this understanding, discourse is practice that systematically form[s] the objects that are spoken of (see Foucault, 1986, pp. 48 – 49). Hence, ‘the individual’ is conceptualised, not as the source of action and meaning (see Hall, 1997) as is the case in traditional, contemporary psychology. Rather, ‘subjectivity’ is revealed in the differing discourses and discursive practices that position us. Where, like fish in water, which both permits and resists ‘swim’, we too are discursively constituted as able or not able to act and speak, with the slew of analytic problems also forged in these conceptualisations of agency and determinism becoming mesmeric. For this research, therefore, an examinable ‘still point’ does not exist; rather this study concerns the ruck of the researcher-participant shared and co-implicative contexts of culture (see Bourke, 2002). This research does not offer a ‘true’ reflection of what the participants’ talk about (see Weatherall, 2002a), but a rigorous exploration of the ways that the participants’ represent the plurality of their competing ‘realities’.

From this theoretical perspective the aim of this study, put simply (and as discussed in chapter one), is to explore the participants’ representations of working as nurses - who care for eating disorder patients. Asking in this, how the participants understand and frame their work; the patients they care for; eating disorders; their own and other nurses’ work practices; and what it is like to work in a multidisciplinary team? The analysis involves (as also discussed in chapter one) a lengthy, detailed ‘sorting out’ of the participants’ accounts. A primary focus of the analysis is an examination of how the ‘relations of power’ are discursively ‘worked up’ in the accounts, and how ‘gendering’ is discoursed. Importantly the analysis also looks at coherencies and incoherencies in the
ways in which 'the nurse' and the 'nurse-doctor relationship' are constituted, and thus indicates the significance of the issues of 'care' and 'cure' (see Kottow, 2001) as they are located in these contexts. That is, with respect to 'care' and 'cure', contemporary Western medicine progressively seeks to 'cure' disease in particular ways, with this 'curative' mandate located in the traditional role of the doctor. The 'nurse role' by parallel is traditionally conceptualised as 'caring' (see Kottow, 2001). In the participants' accounts 'care' is seen to become 'cure', thus decentering the 'doctor', but not the doctors' power, thus ambiguating and problematising the nurses' role (discussed in chapter four).

Raising the theme of relations of power here, the possible issue of seeming 'fairness' and 'unfairness' of this analysis deserves acknowledgment. Much of what is talked about in the analysis chapters might be understood as a darker view of the nurses' complex work with these patients. In the main it is, but as taken only from the participants' accounts, and as what is most clearly in evidence in these accounts. Much emotional suffering is represented in these accounts concerning both the nurses and the eating disorder patients. Both are 'vulnerable' groups with one group caring for the other. This does not mean that the nurses' work is not veined with wry humour, great spontaneous kindnesses, sustained generosity of spirit, and frequent delight in their work. It is. But, this lighter 'esprit de corps' is only limitedly represented in their accounts; rather I observed this more so at the team meetings. So too, there is heavy work done in the constructions of the doctors in these accounts. The role of the doctor is benighted in these accounts. And again what I observed in the team meetings at times was the intense perplexity of these doctors, who are often 'stonkered' as to how best to help, showing in this, as with the nurses, their 'non-idealised' humanity. But, this too is scarcely carried over, if at all in the interview transcripts. This works back to postulating that there is a front room/back room vocabulary that may be operative here. Both are 'true' – the bright and dark of professional life. Yet one is seldom heard in a way that allows it to be coherent, and to show its provenance. I trust that I have been doing that in this analysis – despite the occasional awkwardness of the participants' candor. Here, a
case is made for further research into the discursive constructions (of multi-professional understandings) of multidisciplinary teams caring of eating disorder patients.

The analyses of participants’ accounts in chapters two, three and four considers the multiple, complex and often contradictory constructions of ‘the eating disorder patient’, ‘eating disorders’, the ‘role of the nurse’, and what it is allegedly like working in the multidisciplinary team. The accounts show a confluence of shifting discourses that consolidate the gendered ‘feminised’ positions both of these patients and of the nurses – a heavy flow of ‘the feminine’ - seemingly without release. The accounts constitute these nurses’ and patients’ subjectivities emerging in the ‘always-already feminine’, indicating that considerations of ‘gendering’ are inseparable from problems of pathologisation. And, as the nurses and patients are thus similarly ‘feminised’ they are linked in ways that belie the more crisp traditions of the formal nurse-patient relationship, showing further that an understanding of the processes of ‘gendering’ might illuminate the therapeutic liaison.

The accounts taken together also show constructions of power asymmetries between the doctors and the nurses (as might be expected), and between the nurses and the eating disorder patients. And these power-relations are themselves constituted in multiple often contradictory ways – for example, when, nurse-patient relations are constituted as disciplinary with ‘the nurse’ figuring as ‘warden’, when at other times the relations of power are constituted as ‘inverted’, figuring the eating disorder patient group as ‘controlling’ their nurses. And, similarly, as discussed in chapter four (‘Discursive constructions of the multidisciplinary team’) a rhetoric of ‘nurse inclusion’ on the multidisciplinary team functions in contradiction to discursive constructions of exclusion.

In chapter two (‘The discursive constructions of the eating disorder patient’) the participants’ accounts are seen to constitute ‘the eating disorder patients’ and ‘eating disorders’ across a plurality of positions. The accounts figure both this patient group, and ‘their’ eating disorders as ‘puzzling’, and as highly ambiguous, with the at times
uneasy contradictions, setting up tensions between the nurses and patients, and the nurses and doctors. In consideration of these tensions and ambiguities, what is seen to be indeterminate in the aetiology of eating disorders (discussed in the literature review in chapter one) might be read now as an intolerance of ambiguity in a logo-centric drive to isolate a cause and so a cure. Thus, what is so evident in the accounts is the construction of these patients and their disorder in a plurality of shifting, ambiguous and contradictory discourse – befitting the provenance of culture. That is, ‘the eating disorder patient’ is constructed in a nearly intolerable flux of ‘problematic identity’ and other issues. ‘She’ does not have the credentials of an ‘age appropriate’ identity; ‘she’ allegedly sees herself as ‘being different’, and is therefore seen as seeing herself as either ‘other’ or ‘better’ than her peers or the nurses; ‘she’ is pathologically intelligent, as well as almost darkly lyrical as La Donna e’ mobile; ‘she’ is alternately ‘normal but not normal’ and ‘mentally ill but not mentally ill’ - both simultaneously; and her family is allegedly ‘pathogenic’. And, within this ground swell ‘she’ is also ‘a lovely kid’ with a ‘great personality’, who has ‘gone off the track’. These constructions are among many other constructions, the discussion of which is limited by the scope of this thesis. It is no wonder that construals of ‘tension’, ‘challenge’, ‘conflict’ and ‘puzzlement’ pepper the participants’ accounts. Accounts where the medicalisation of eating disorders is not consistently supported, and where pathologisation of the eating disorder patient is ‘at best’ inconsistent. Thus neither, ‘these patients’ nor ‘eating disorders’ map neatly onto the disease model, within which the nurses are supposed to be developing the therapeutic liaison.

Chapter three (‘Discursive constructions of the nurse’) considered how the participants’ framed themselves in their role, and the work they did, and how they construed other nurses with whom they worked. Here, wide disparities in the construction of ‘the nurse’ are shown. The ‘feminisation’ of the nurses’ role is opened out to show ‘the nurse’ constituted as a Madonna - the generous, capacious ever-present mother. And, in a stark contrast, ‘the nurse’ is also constituted as ‘the warden’, who ‘doesn’t punish’ but who metes ‘consequences for actions’. These two constructions of ‘the nurse’ are discussed as taking shape in the patriarchal dichotomising fantasy of ‘the feminine’ as the good
nurturing woman – the bad avenging woman - age-old typifications that unite here in the nurses’ uniform. ‘The uniform’ that signifies care and love of the mother is also ‘the uniform’ constituted as endorsing oppressive power. It is not at all surprising that ‘the nurse’ is constructed as ‘the dichotomised feminine’, but simply how powerful these constructions remain – revealing the power of the dominant ideal, and how well the svelte medical jargon and manner obfuscates this idealisation/divesting of ‘the feminine’.

As well in this chapter the participants’ constructions of their work as ‘battle’, ‘force’ suggests that the tensions between these principal constructions might be understood in many ways. They might for example, be viewed as an explanatory context prefacing nursing ‘burnout’ in this area of care, as well as showing why nurses may be reluctant to work with eating disorder patients. This is possibly another area that might reward a more concentrated exploration of the discourses and discursive practices that constitute and regulate an ‘eating disorder ward’.

The final chapter of the analysis, chapter four, considers how the participants constituted their experiences of working with other professionals in the implementation of the treatment programme. And, this is another area of great discomfort that I mentioned in the introduction. Talking about this was uneasy for many of the participants. There are two aspects of these constructions that are highly problematic, and again this area deserves closer research attention. Firstly, the accounts constituted an enveloping construction of the multidisciplinary team as both egalitarian and inclusive. But this account of inclusive egalitarianism was also repeatedly disrupted by accounts in which the nurses are excluded and their knowledge repudiated. And, secondly the accounts constitute the nurses’ relationship with the multidisciplinary team as a site where nurses are (near) silent or silenced. So that the conflicting constructions of the nurse as equal and/or subordinate are consolidated, in the shifting of accounts in which nurses’ ‘lack of voice’ in decision making is constituted as a problem of individual nurses’ lack of confidence, and, (more implicitly) as a systematic exclusion that expresses the (always/already gendered) hierarchies of ‘the multidisciplinary team’ and ‘the nurse-doctor
relationship’. Together the constructions discussed in this chapter reveal profound and complex issues of power imbricated in ‘the multidisciplinary team’, which itself constitutes an important part of the context of work for the nurses.

This last problem presented in this analysis is a part of the complexity of the relations of power. This problem of power may well not be ‘solved’ through this (or any other) discourse analysis. However, by analysing participants’ accounts, by exploring the ways in which ‘the nurse’, ‘the patient’ and ‘the working environment’ of ‘the multidisciplinary team’ are constituted, this thesis has sought to elucidate the multiplicity of often contradictory ways in which this field of ‘the eating disorders nurse’ is constituted and regulated, and to illustrate the multiple ways in which gender is imbricated in this discursive field. And by explicating some of the complexities and ambiguities of this gendering, and the power relations that are woven through these accounts, the analysis presented in this thesis might, perhaps make some redress of power and gender issues more possible or probable. These workings of gendered power might profitably be viewed to represent broader issues involving the ‘lost promises’ of the ‘logocentric’ medical model, wherein intolerance of ambiguity, ‘cure’ mandated over ‘care’, and the repudiation of the ‘feminine’ dissolve access to power, and where studies such as this one, which privileges representations of experience at point black range, offer a purposeful re-ambiguation of this complex territory.
Appendix 1
INTERVIEW SCHEDULE

Title of Research Project:
Nurses’ experiences of nursing eating disordered patients.

Can you tell me about your nursing background?

How did you come to care for eating disordered patients?

How would you characterise eating disordered patients?

In your experience what is it like to nurse eating disordered patients?

What is your understanding of eating disorders?

In what ways is nursing eating disordered patients the same as and/or different from your other nursing experiences?

How do you feel when you are nursing eating disordered patients?

How does nursing eating disordered patients affect you?

What kind of service do you consider that you offer these patients?

In your experience what is it like working as the nurse member of the multi-disciplinary team who cares for the eating disordered patients?

What are some of the positive benefits you get out of nursing eating disordered patients?

What sort of challenges have you experienced in nursing eating disordered patients and how do you manage them?

What kind of qualities do you think it takes to work in this area?

What kind of support do you get and what other sorts of support could be offered?

Would you care to add anything?
Appendix 2
PARTICIPANT INFORMATION SHEET

A qualitative research project to investigate nurses’ experiences and perceptions of caring for eating disordered patients in hospital contexts, in order to better understand what is involved for nurses in this area of work.

Investigators
Ms Victoria Ryan
Research student – School of Psychology
University of Western Sydney - Penrith Campus, ph: 02 47360294

Dr Helen Malson
Senior Lecturer School of Psychology
University of Western Sydney - Penrith Campus, ph: 02 47360294

We would like you to consider participating in a research study that will be conducted (across your hospital campus).

What is this study about?
In this study we aim to develop an understanding of the experiences and perceptions of nurses who care for eating disordered patients in a hospital context, this includes inpatient or outpatient services. The intention of interviewing nurses directly is to find out what it is actually like for nurses working in this area of care, what sorts of challenges arise for you, and what sort of support you need. Despite the extensive amount of research which has been carried out on eating disorders - very little research has focused on the role of the nurse in caring for eating disordered patients, yet nurses spend a considerable amount of time with eating disordered patients and provide a diverse range of support, which requires special skills and knowledge. The study is not an evaluation or assessment of you as a nurse or your nursing practices on the ward or in outpatient services. Instead the project is concerned with developing a contemporary knowledge base of what is involved in nursing eating disordered patients as a unique area of care.

Who can take part in the study?
Any nurse who has cared for eating disordered patients.

What will happen if you decide to participate in the study?
The interview will take approximately an hour, the interview questions are attached. The interview questions are intended to guide the interview and are not a test. The interview will take place in a private office within the Hospital at a time convenient to you and will comprise part of your shift. The interviews will be audio-recorded. The tape recorder will be in full view at all times and will be manually operated by the interviewer. The audiotapes will be transcribed in full by an independent, professional transcriber.

If you agree to participating in this research study, please telephone Victoria Ryan on 02 47574438 this is a direct contact number with password protected voice mail, all messages will be returned or send an email to Victoria Ryan: v52@hermes.net.au.
Are there any risks involved in participating in this study?
We do not expect there to be any side effects from this study. Sharing your experiences and perceptions might be uncomfortable. You are free to interrupt the interview at any time. A Clinical Nurse Consultant phone number xxxx on page xxxx is available for confidential debriefing at participants’ request. This Clinical Nurse Consultant will not be present at interviews nor will they have access to the audiotapes, or full interview transcripts.

Other information
The audiotapes and transcripts will be kept in a locked filing cabinet and erased and destroyed under supervision when the study is completed. Pseudonyms will be used during the interview and all names and personal details will be changed, including references to staff members and patients. The full interview transcripts will be viewed by only by Dr Helen Maison and Victoria Ryan both of University of Western Sydney, other research team members, and any ensuing publications will view only certain excerpts from these transcripts. It will not be possible to trace interview material back to any individual. Participation or non-participation in this study will not be monitored or documented in any staff files.

What to do you if decide to participate in the study?
Participation in this project is voluntary and if you decide not to take part or to withdraw at any time you not are required to offer an explanation and withdrawal is without penalty or prejudice.

If you have any concerns about the conduct of this study, please do not hesitate to discuss them with the investigators listed or with the secretary of the Ethics Committee, which has approved this project (telephone: 02 xxxxx xxxx),
Appendix 3
CONSENT TO PARTICIPATE IN RESEARCH

Title of Research Project:
Nurses' experiences and perceptions of nursing eating disordered patients

Names of Researchers
Ms Victoria Ryan  Research student – School of Psychology
    University of Western Sydney - Penrith Campus, ph: 02 47360294
Dr Helen Malson  Senior Lecturer School of Psychology
    University of Western Sydney - Penrith Campus, ph: 02 47360294

1 I understand that the researcher will conduct this study in a manner conforming with ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.

2 I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by Victoria Ryan ("the researcher") and I, being over the age of 16 years, acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

3 I acknowledge that I have been given time to consider the information and to seek other advice.

4 I acknowledge that refusal to take part in this study will not effect my employment status.

5 I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

6 I acknowledge that this research has been approved by the Western Sydney Area Health Service Human Research Ethics Committee.

7 I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

Before signing, please read 'IMPORTANT NOTE' following.

Name of participant __________________________________________ Date of Birth ____________

Address of participant: (all the participants' addresses were reordered as care of the ward area in which they worked)

Signature of participant __________________________________________ Date: ____________

Signature of researcher __________________________________________ Date: ____________

Signature of witness __________________________________________ Date: ____________
CONSENT TO PARTICIPATE IN RESEARCH

Title of Research Project:
Nurses’ experiences and perceptions of nursing eating disordered patients

IMPORTANT NOTE
This consent should only be signed as follows:

1. Where a participant is over the age of 16 years, then by the participant personally.

2. Where the participant is between the age of 14 and 16 years, it should be signed by the participant and by a parent or guardian.

3. Where the participant is under the age of 14 years, then the parent or guardian only should sign the consent form.

4. Where a participant is under a legal or intellectual disability, e.g. unconscious, then particular consent should be sought from the Human Research Ethics Committee as to whether the person should take part in the research.

INDEPENDENT WITNESS:
I, _____________________________ (name of independent witness)

of _____________________________ hereby certify as follows:

1. I was present when _____________________________ ("the participant") appeared to read or had read to him / her a document entitled Participant Information Sheet; or I was told by _____________________________ ("the participant") that he/she had read a document entitled Participant Information Sheet (*Delete as applicable)

2. I was present when Victoria Ryan ("the researcher") explained the general purposes, methods, demands and the possible risks and inconveniences of participating in the study to the participant. I asked the participant whether he/she had understood the Participant Information Sheet and understood what he/she had been told and he/she told me that he/she did understand.

3. I observed the participant sign the consent to participate in research and he/she appeared to me to be signing the document freely and without duress.

4. The participant showed me a form of identification, which satisfied me as to his/her identity.

5. I am not involved in any way as a researcher in this project.

Name of independent witness

Address

Signature of independent witness Date: __________

Relationship to participant of independent witness

______________________________

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Appendix 4

Transcription Conventions

= indicates an overlap or the absence of a gap between two consecutive

// indicates an interjection. For example, ‘I think yeah /\: mm/ I could be like her.’

(.) indicates a pause.

Italics indicate where words or phrases are stressed.

... indicates where part of the transcript has been omitted.

(inaud.) indicates where a part of the recording of the interview was inaudible.

( ) brackets surround words where the accuracy of transcription is in doubt because of the poor
quality of the recording.

[] brackets surround explanations that are not part of the transcript but are added to clarify the
meaning of an utterance. For example, ‘It’s [eating disorders] not just about food.’

[] are also used where extracts are quoted in the text to indicate where words have been altered.

‘ ’ are used in the analysis where extracts from the participants’ account are quoted.

“ ” are used in the report to quote extracts from the reference list.

All quotes from the reference list over fifty (50) words are indented and italicised and no quote
marks are used.

Sounds such as ‘mm’ and uhr’ are transcribed phonetically, as are colloquialisms, abbreviations,
stutters and half-said words. Where utterances are not grammatical, punctuation is used so as to
make the transcript as readable as possible.
Appendix 5
Index of categories (N-Vivo)

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A critical psychological investigation of nurses’ experiences, understandings and perspectives of nursing eating disordered patients.

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Masters (Hons.)

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PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
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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, either in full or in part, for a degree at this or any other institution.

[Signature]

16.12.24

Victoria Ryan
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Abstract

This study is a critical, feminist psychological investigation of nurses' experiences, understandings and perceptions of nursing eating disorder patients. Specifically nineteen (19) in-depth semi-structured interviews were conducted at a large metropolitan Australian hospital complex with nurses who care for eating disordered patients. A qualitative discourse analytic methodology was used to analyse the data. The interviews sought to elicit responses from the participants that would permit the identification and examination of the ways in which nurses i) construe their professional identities in the context of nursing eating disordered patients; ii) construe the identities and behaviours of the eating disordered patients they nurse; iii) frame and make sense of their therapeutic relationships with these patients; iv) frame and make sense their experiences of the various aspects of the hospital-based therapeutic interventions for eating disorders with which they are involved; v) frame and make sense their particular contribution as nurses to patients' care; vi) identify the challenges and benefits specific to nursing this patient group and vii) identify the support they do and could receive in providing optimally effective nursing. The analysis investigates the different ways that the eating disorder patients and the nurses are constituted in a web of explicit and implicit discursive constructions and discursive practices. The analysis also considers how relations of power between the nurses, the patients, and the doctors and other health care workers are constituted in discourse and practice, as well as exploring how the eating disorder patient group and the role of the nurse is ‘feminised’.
Introduction

This study concerns nurses’ therapeutic relationships with hospitalised eating disorder patients and so concerns the highly patterned phenomena of eating disorders (anorexia and bulimia nervosa). In shaping this complex subject area into a coherent research problem, I initially considered the status of anorexia and bulimia nervosa (referred to as eating disorders hereon) as psychiatric disorders. Put broadly and simply, eating disorders are primarily considered from a conventional psychology and medical perspective to be psychiatric disorders (DSM IV, 1994). They are ‘disorders’ which primarily and predominantly involve young girls and young women (Emans, 2000; Laurie & Mitan, 2002; Smith, 2002; Steinberg, 2003; Rosen, 2003; Treasure, & Schmidt, 2001). Eating disorders can thus be considered as gendered issues and as youth issues as well as psychiatric disorders. I wondered why is it that eating disorders are constituted as psychiatric disorders when many other health problems that are also gendered and/or youth problems are not?

In bald terms eating disorders can be said to involve behaviours concerning food and food issues that impinge on an individual’s nutritional status and which can render individual sufferers medically compromised (Emans, 2000; Laurie & Mitan, 2002; Smith, 2002; Steinberg, 2003; Rosen, 2003; Treasure, & Schmidt, 2001). These medical complications of eating disorders are often presented as the explanation and rationale for the ways in which individuals diagnosed with eating disorders are treated. Yet, by comparison, heart disease (for example) is also associated with behaviours around food (as well as smoking and exercise) such as over-consumption and ‘poor’ food choice. And, as with eating disorders, these behaviours are seen to impinge on an individual’s nutritional status (malnutrition and obesity) in ways which can often render individual sufferers medically compromised. And, just as with ‘eating disorders’, ‘heart disease’ is also gendered. While the incidence of heart disease is falling markedly in Australia (Mathur, 2002), men are still twice as likely to be hospitalised for heart disease as women. Yet individual sufferers of heart disease or potential heart disease are not diagnosed as having a psychiatric disorder.
The presence of their blocked arteries, high cholesterol or angina is not viewed as evidence of psychopathology. Nor are such individuals commonly put into hospital to lose weight in order to decrease the possibility of medical compromise. In contrast, low body weight, the absence of menstruation, and the possibilities of osteoporosis in those diagnosed as ‘eating disordered’ are often presented as evidence of the necessity of hospitalising these individuals, often against their wishes.

Like eating disorders, heart disease is constituted as a serious disease. [In Australia between 1999 – 2000 there were reportedly approximately 44,000 coronary events in Australia - as many as 132 per day (Mathur, 2002).] Yet, in contrast with eating disorders, heart disease is not construed as a ‘disorder’ involving inherent flaws in the individual sufferer’s psyche. Those suffering from heart disease are not generally stigmatised. Rather, heart disease is much more readily understood as a medical condition, and as a regrettable contemporary Western socio-cultural phenomenon. Despite an astounding amount of public education about the ‘best’ sorts of food choices, and exercise choices to make to circumvent possible ‘life style’ diseases, many individuals appear to ‘choose’ life styles that lead to cardiac problems and other health problems. But, where heart disease is diagnosed, these apparent ‘choices’ do not carry the same psychiatric valency that the ‘choices’ of self-starvation or of binging and purging carry for eating disorder patients. The predominantly masculine health problem of heart disease – involving ‘unhealthy’ food ‘choice’ and eating behaviours, and the possibilities of alarming and urgent medical problems – is constituted and regulated in ways which are very different from the ways in which those diagnosed as ‘eating disordered’ are understood and treated.

Both heart disease and eating disorders are serious and significant problems that need to be addressed urgently. What I am suggesting in drawing this comparison between these two problems is that while these ‘health problems’ are very different in many ways they can also both be understood as (gendered) disorders of socio-cultural process. They can also be understood as sites where questions about ‘choice’ arise; where conventional understandings of ‘choice’ as individuals’ autonomously made
and hence accountable decisions are in evidence; where a “poverty of individualism” (see Smail, 2001) begins to become apparent. That is, in briefly considering and comparing ‘eating disorders’ and ‘heart disease’ I have sought, amongst other things, to indicate some of the limitations in conventional individualistic perspectives on these health problems and to suggest that neither eating disorders nor heart disease (or other ‘health problems’) can be adequately understood without attention to cultural context and to gender issues. Nor, I would argue, can they be adequately understood without a non-individualistic re-theorisation of personhood because “what an ‘individual’ consists of is precisely non-individual, social conventions, practices, meanings, and institutions we all share in common” (Smail, 2001, p. 64). And this, I would argue, is not accounted for nor seemingly acknowledged in the medicalisation and psycho-pathologisation of eating disorders. The “institutions we all share in common” that arguably function as ‘gendered’ institutions are not accounted for in how we make sense of these ‘health problems’.

In this study I will explore what seems to be a near-devotional attention given to eating disorder patients. In researching the nursing of eating disorder patients I will be questioning what constitutes this fixed gaze on ‘starving’ girls (see Malson, 1998) and will explore the ways in which eating disorder patients are constituted in nurses accounts of nursing of eating disorder patients. Given the often-noted complexity of ‘eating disorders’, their much-debated complex aetiology (Treasure & Schmidt, 2002) and the clearly gendered nature of this problem (Gaskill & Sanders, 2000; Steiner & Lock 1998; Redenbach & Lawler, 2003) many questions arise concerning the therapeutisation of eating disorders. These questions include questions about the (discursively constituted and regulated) relationships between the eating disorder patients, who are ‘feminised’, and the nurses, who as the principle agents of the therapeutic enterprise, themselves work in a feminised role (Davies, 2003; Farrell, 2001; Suominen et al., 1997; Evans, 1997). Moreover these questions also include questions about how the medicalisation of eating disorders seeks (or fails) to sort out the therapeutic overlap of ‘care’ and ‘cure’ (Kottow, 2001) when the aetiology of eating disorders remains undetermined.
'Care' and 'cure' are of interest because as the literature on nursing suggests (Ramjan, 2004; King & Turner, 2000; Grothaus, 1998; Garrett, 1991; Newell, 2004; Anderson, 1997), 'caring' and 'curing' seem to be consistently fused in the therapeutisation of eating disorder patients, and to be located in the role of the nurse. The concepts of 'care' and 'cure' provide a way of exploring the processes of therapy. In contemporary medicine 'care' and 'cure' have become inextricably interwoven in the fulfillment of "the therapeutic mandate" and can be considered to be "nondispensable aspects of the clinical encounter" (Kottow, 2001, pp. 53 – 54). Yet, as Kottow (2001) suggests, contemporary medicine pursues the curative effort in "indifference of the lived body … transform[ing] it into an object-body [so that] [p]atients may feel more threatened by therapeutic propositions than from the underlying disease" (Kottow, 2001, p. 59). The notions and practices of 'care' and 'cure' are thus dominant but potentially highly problematic and distinct features of contemporary therapeutic mandates. Moreover,

If curing and caring in medicine are two distinct, perhaps independent and even hierarchically ordered areas of therapy, the question arises if they are served by different kinds of health care providers and if the classic distinction holds true [then] physicians are preferably engaged in curing where as the nursing profession is more attuned to caring. (Kottow, 2001, p. 59).

The distinction between 'caring' and 'curing' is thus useful in the analysis presented in this thesis (chapters two, three, and four) where at many points 'care' is explicitly and implicitly talked about in the participants' accounts as 'curative' in their nursing of this patient group.

Given the above types of questions and interests that motivate this study, the feminist, critical psychology framework (discussed in chapter one) that has been adopted enables a set of analytic distinctions to be formulated concerning eating disorders and the nurses' role in the therapeutisation of eating disorder patients that a traditional
psychology approach would not allow. This includes being able to question the ‘gendering’ and ‘medicalisation’ of eating disorders, and the ‘gendering’ of the nurses’ role, rather than assuming these elements are objective pre-existing facts. This theoretical framework supports the interview-based, discourse analytic methodology taken up in my empirical research (discussed in chapter one). Within this framework the questions and interests discussed above can be investigated in the discourses that the participants draw on in making sense of their work. In that sense the research might be viewed as democratic in that it privileges the participants’ account in their own right as the object of investigation.

This thesis has been organised into five chapters: In chapter one I discuss the study’s feminist, critical psychology theoretical framework. I offer a broad overview of the elements of a feminist, critical psychology epistemology and ontology. These are considered against a positivist conventional mainstream approach to psychology. In this discussion I also define the major terms used in this thesis including ‘subjectivity’, ‘discourse’, ‘culture’ and ‘context’. I then briefly review the differing approaches to feminism, discussing, in particular, the feminist post-structuralist Foucaultian-informed approach that I have taken. This approach allows an examination of how “social and political relations are embedded in the ways of thinking and talking about the world” (Weatherall, 2002a, p. 79). It thereby allows consideration of the different ways in which the subject is constituted in discourse and of how gender is constituted and regulated in discourse (see Malson, 1998). In the second section of chapter one I review the relevant current literature on eating disorders. This review provides a discussion of research and theory on eating disorders and their aetiologies, on current approaches to the treatment of eating disorders and research into how nurses are related to those treatments. In the third section of chapter one I provide an account of the research methodology used in this thesis and discuss how the specific aims of this study are related to the qualitative; discourse analytic, interview-based methodology adopted.
Chapters two, three and four present the discourse analysis of the nineteen (19) interviews transcribed verbatim that are participants’ accounts of their experiences, understandings and perceptions of nursing eating disordered patients. The chapters have been organised along the analytic path of three broad questions addressing: (1) what the participants say about ‘eating disorders’ and ‘the eating disorder patient’, (2) what they say about themselves in ‘the role of the nurse’, and (3) what they say about how nurses ‘fit’ into the multidisciplinary team in order to do the work they are auspiced to do.

In chapter two I discuss the participants’ discursive constructions of ‘eating disorders’, and ‘the eating disorder patient’. In this chapter consideration is given to six themes in the participants’ discursive constructions of these patients: (1) the problematic identity of the eating disorder patient; (2) alleged self-perception - how the eating disorder patients are constructed to perceive themselves; (3) deviancy - the eating disorder patient constructed as ‘deviant’, and ‘deviacy’ as feminised; (4) normality - the eating disorder patient constructed as ‘normal’ and ‘not-normal’ at the same time; (5) the eating disorder patients’ families constructed as pathogenic; and (6) mental health - the participant’s constructions of eating disorders as a ‘mental health issue’ and ‘not a mental health’ issue at the same time. In chapter three I discuss the participants’ discursive constructions of themselves as eating disorder nurses and their work. Here constructions of (1) the nurse as ‘mother’; (2) the nurse as ‘warden’, (3) nurses’ work constituted as ‘battle’ and ‘force’; and (4) the participants’ constructions of ‘other’ nurses are discussed. And lastly in chapter four I discuss the participants’ constructions of (1) the multidisciplinary team, and (2) their constructions of their relationships with the doctors. Each chapter is summarised at the end of the chapter whilst chapter five presents the concluding discussion to the thesis.
Codicil

Prior to commencing chapter one, I want to make a few less ‘lineal’ points concerning this thesis. The above introduction explains the motivations, intentions and shape of this study. Yet in writing this way a part of this study is left unvoiced. The following few ideas are taken from my notebook that I kept while interviewing, during the process of analysing participants’ accounts, and later when I was writing.

In engaging in this project I feel as though I have entered an insoluble problem. I feel as though I have sat in a two-year deliberation that principally concerns how impossible it is to be a woman. While I have used the terms ‘gender’, ‘gendered’, the ‘feminine’ and ‘feminisation’ throughout this study, these powerful terms do not serve up that whole complexity of ‘woman’. They do not lift the heavy presence of humanity into view and oddly these terms seem to further the ‘sanitisation’ of ‘woman’ and this is part of the insoluble problem – the analytic conundrum.

The terms of this study and the analysis also do not fully address what I saw during the times I was on the wards and in the multidisciplinary team meetings. What I saw were young women who looked as though there were ‘walled-in’, ‘bricked-in’ - brick by brick, and left to starve – much as we hear those terrible stories about how young women in ‘other’ cultures are allegedly sentenced to death for matters of family honour, cemented into walls and left to die horrible deaths. I know so much is done to try and stop this starvation in these young women in our hospitals. It was obvious that there was a profound and dedicated sense of care and compassion in the nurses, doctors and the many other professional people who worked in the multidisciplinary teams. Knowing that this care was there ‘the walls’ still came into my view when I saw ‘the thin anorexic body’ walk with rigid steps.

It seemed that this ‘walled in-ness’ was what was meant about eating disorders being a psychiatric disorder, that the medical profession saw ‘the walls’ as some sort of inner mental state. But I did not and I still do not. This metaphor of ‘walls’ may be
understood as the density and plurality of discourses that constitute confusing entrapment, with these discourses being like a Sargasso Sea - a vast mat of entangle bull seaweed the size of a sea, a sea growing in a sea. The analysis of the data explores some of this entanglement.

When I conducted the interviews to ‘obtain the data’ much else happened in each interviews than is attested to in the transcriptions. That is the participants’ words do not capture all the nuances of their talk. Some of these nuances in the interviews occurred when the participants talked about ‘the programme’. When the participants spoke about ‘the programme’ - the eating disorder treatment programme - I sensed a shift of ground occur between us. The texture of conversation altered at these points in each interview, often marked by a change in tone of voice or a shift in facial expression. And without exception the participants changed how they sat: they re-seated themselves – quite discreetly, but in a way that suggested to me that they were uncomfortable. Something happened when the participants started to discuss ‘the programme’, which I watched with increasing attentiveness as each interview progressed. Or at least that is what I first thought was happening - that the participants were becoming uncomfortable when they talked about the programme, and that ‘I’, the astute interviewer and researcher, was noticing this happen.

In the first few interviews when I noticed this particular shift I thought that I would later use this as a ‘marker’ for my analysis because when ‘the programme’ was discussed a badge of authority flashed. But then I noticed that what I took to be the participants’ discomfort was also my own - that as the participants talked about ‘the programme’ a sense of alarm and suffocation gained on me as the small interview rooms filled with a silent water. I found it harder to breath out as I saw the sleek precision of a dark fin rise in our talk and swim toward us. The participants, I realised humbly, were not experiencing something within them that I had intuited. Rather ‘the programme’ breathed behind each participant and I was witness to this. And I began to wish I were that anaemic, empiricist phantom of neutrality and objectivity - a
conventional researcher - as I realised that I suddenly but obscurely became complicit in this process of ‘making visible’ in each interview.

As I analysed the participants’ accounts and wrote up this thesis I worked so that the analysis concerns only the text. Yet, truthfully the analysis is also textured through the above sorts of long moments that I spent with the participants and in the team meetings. Also in analysing and writing my analysis I have considered that the ‘thin feminine body’ is an implied presence in the participants’ accounts resting in what they say. This ‘body’ is not the explicit ‘object’ of investigation in this study but it nevertheless figured as an implied presence, as the reason why the participants are doing their work. This ‘thinness’ – so present but not mentioned. The ‘thin feminine body’ seemed to be like the last doll in a stack of those beautifully painted, wooden Russian dolls that can be packed one into the other, in diminuendo, so that there is finally only one beautiful doll housing all the others. The ‘thin feminine body’ - the identified anorexic body of all the young women who are metaphorically packed one into another in the process of their diagnosis seemed to be one of the many givens in our talk in the interviews.

In this introduction and ‘overture’ to this thesis my researcher response may be seen as deeply ambiguous. I consider that this study hopefully offers a purposeful re-ambiguation of ‘eating disorders’ and of the nurses’ role in the therapeutisation of this patient group.