



**DISCIPLINING THE FEMININE:
THE REPRODUCTION OF GENDER CONTRADICTIONS IN MENTAL HEALTH CARE**

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ABSTRACT

This thesis makes an original contribution to knowledge about the way in which gendered assumptions operate within health care interventions for women with eating disorders. The thesis is based on an interview study with a wide cross section of Australian mental health workers and uses discourse analysis, informed by post-structural feminist theory, to uncover the discursive dynamics and power relations characterising health care workers' knowledge and practice. A series of gendered contradictions are revealed in the psychological discourses used by health workers to construct selfhood in eating disorders, which have the effect of rendering anorexic and bulimic women deficient through the idealisation of masculinised autonomy and control over feminised connectedness and emotion. While these discourses are shown to be profoundly gendered, the operation of gender is effectively masked through subscription to an ideology of gender neutrality. Gender is further obscured through the employment of a wider multidimensional explanatory framework that reduces gender to 'sex', and works in concert with reductionist biomedical and psychological discourses to individualise eating disorders. In examining clinical practitioners' constructions of psychiatric intervention, the thesis argues that a contradictory positioning of the anorexic woman as simultaneously autonomous/in control and non-autonomous/out of control reproduces a paradoxical approach to autonomy and control in practice. More specifically, the pursuit of autonomy through psychotherapy is shown to be augmented by peculiarly gendered, controlling practices that operate to de-power women, re-inscribing rather than challenging the discursive 'double-bind' of femininity implicated by post-structural feminists as causing eating disorders in the first place. The thesis also offers the first critical analysis of approaches to the prevention of eating disorders, contributing new and original insights into dilemmas associated with the application of health promotion theory and practice in a program addressing body image and disordered eating. The thesis argues that because of a reliance on social marketing and an uncritical perspective on the extent to which health promotion is complicit in wider cultural processes, the program also inadvertently reproduces the gender-double bind structuring female body management practices, dissipating the possibilities for resistance. Lastly, the thesis undertakes a critical examination of the potential of alternative practice paradigms informed by feminism and post-structuralism for redressing the gendered contradictions and individualised focus of psycho-medical and health promotion approaches.

SIGNED STATEMENT

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference is made in the text.

Date: 1.1.6.2004

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

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PUBLICATIONS

Two academic papers based on the research carried out for this thesis have been published in peer-reviewed international journals:

1. Moulding, N. (2003). Constructing the self in mental health practice: identity, individualism and the feminization of deficiency. *Feminist Review*, 75, 57-74.
2. Moulding, N. & Hepworth, J. (2001). Understanding body image disturbance in the promotion of mental health: a discourse analytic study. *International Journal of Community and Applied Social Psychology*, 11, 305-317.

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Chapter 1

Introduction: Gender and Health Care Intervention

While psychological theories and associated interventions used to explain and treat 'mental disorders' make pretensions to gender neutrality, they are known to be based on profoundly gendered assumptions about mental health and illness in women and men (Broverman et al, 1972, Chesler, 1972, Ussher, 1991). Eating disorders provide a potentially powerful illustration of the specific ways in which assumptions about gender might structure contemporary theories and practices in the mental health arena because they are disproportionately diagnosed in women and girls (American Psychiatric Association, 2000). More than this, though, post-structural feminists have shown that the pursuit of thinness which characterises anorexia nervosa is symbolic of the conflicted and contradictory nature of 'femininity' in western culture, where a hierarchical dualism constructs an uncontrolled, "dangerous, appetitive, bodily female principle" in opposition to a controlled, "masterful male will" (Bordo, 1990: 105). Thus, eating disorders, particularly anorexia nervosa, are understood within contemporary feminism as playing out fundamental contradictions about femininity in western culture. Taking as its starting point an understanding of eating disorders as reflective of wider cultural contradictions about gender, this thesis explores the related question of how health care knowledge and associated interventions which aim to treat and prevent eating disorders approach the construction of gender within the health care context.

The extent to which gendered assumptions underpin health care interventions for eating disorders has particular implications for the ways in which individuals come to understand and experience themselves. Various forms of psychotherapy represent the dominant mode of intervention and because these are intrinsically language-based, they offer particular forms of subjectivity to women as their usual subjects. However, psychiatry, as the main professional discipline involved in the treatment of eating disorders, presents women with extremely problematic conceptualisations of their subjectivities and experiences because in addition to defining eating disorders as inherently psychopathological, the nature of this pathology is portrayed in fundamentally contradictory ways. In particular, anorexic women are paradoxically characterised as both highly controlled *and* out of control (Anderluh et al, 2003; Steiner et al, 2003; Karwautz et al, 2001; Williams, Chamove and Millar, 1990; Bruch, 1978). While such conflicted portrayals resonate with the gender contradictions that feminists theorise as operating within eating disorders, psycho-medicine fixes contradictory characteristics deeply within the individual woman rather

than the culture. It is this theme of contradiction and duality in psycho-medical constructions of eating disorders that constitutes one of the central objects of inquiry for this thesis.

Contestation and Contradiction: Contemporary Psychiatry and the Enigma of Eating Disorders

Since the medical identification of anorexia nervosa over one hundred years ago, eating disorders continue to be primarily understood through psycho-medical knowledge as distinct forms of psychopathology (Malson, 1998; Hepworth, 1999), exemplified through their inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (see Appendix 1 for definitions and prevalence). However, self-starvation among women was documented in the medieval period as a religious rather than psychopathological practice, and the women involved were known as 'fasting saints' (Brumberg, 1988). The conceptualisation of eating disorders as psychopathological conditions is, therefore, a relatively recent phenomenon that brings practices such as self-starvation within the realm of psycho-medicine, and positions women involved in them as subjects within specific health care interventions (Hepworth, 1999).

While eating disorders have been largely understood and treated from within the disciplinary confines of psychiatry since becoming the objects of medical attention (Hepworth, 1999), there are, nevertheless, many competing explanations of their origins within contemporary psychological medicine. A multidimensional model that posits cause as a combination of biological, psychological, familial and social factors (Gamer and Garfinkel, 1980) is clearly dominant at the current time, however, there is continuing debate about the relative contribution of the different factors, and none of the research has been able to determine aetiology (Gremillion, 2001). Theoretical understandings of eating disorders therefore remain contested within psychiatry and anorexia nervosa, in particular, continues to be characterised as enigmatic in this sense (Bruch, 1978; Sohlberg and Strober, 1994). In addition to the conflicted nature of psycho-medical explanations, common health care interventions used in the treatment of eating disorders involve central tensions and dilemmas. More specifically, psychiatric treatment in this area is consistently associated with poor outcomes (Ben-Tovim et al, 2001; Steinhausen, 2002; Keel and Mitchell, 1997; Keel et al, 1999) (see Appendix 1 for more detailed information on treatment outcomes). In the case of anorexia, failure to recover is often blamed on patients themselves, who are variously described as "frustrating" (Vitousek, Watson and Wilson, 1998: 391; Fairburn, Shafran and Cooper, 1999: 2), "resistant" to treatment (Vitousek, Watson and Wilson, 1998: 391) and "recalcitrant" (Fairburn, Shafran and Cooper,

1999: 2). Eating disorders therefore continue to elude psychiatry to some extent, both in terms of agreement about their specific causes, as well as the development of effective forms of treatment.

It is within this wider context of contestation and frustration that conflicted depictions of eating disordered women emerge. This extends beyond the idea that anorexic women are both highly controlled and out of control to the notion that they are also independent *and* dependent (Basseches and Karp, 1984; Felker and Stivers, 1994; Smolak and Levine, 1993; Bruch, 1978), as well as 'compliant' *and* 'resistant', 'manipulative' and 'deceitful' (Sohlberg and Strober, 1994; Bruch, 1978; Vitousek and Watson, 1998). Moreover, in direct opposition to the supposedly controlled 'asexuality' of anorexic women (Bruch, 1978; Crisp, 1980), bulimic women are depicted as 'promiscuous' and uncontrolled (Tice et al, 1989; Kaltiala-Heino et al, 1994).

As noted earlier, this theme of contradiction within psycho-medical accounts of eating disordered women resonates with post-structural feminist theorisations which suggest that contradiction is a central organising principle in eating disorders themselves. Rather than fix contradictory characteristics in individual women, these look to the cultural meanings of food and the slender female body in western culture, drawing attention instead to the conflicted and contradictory nature of 'femininity' and its symbolisation in the pursuit of thinness (for example, Bordo, 1990; 1993; Lester, 1997; MacSween, 1993; Malson, 1998). Most well known is the work of Bordo (1990), who argues that anorexia is symbolic of the conflicted and contradictory nature of 'femininity' in western culture. Bordo (1993) suggests that anorexia nervosa symbolises resistance to the maternal body and its associations with powerlessness, and the pursuit of its binary opposite in the thin body is understood as a rejection of "a reproductive destiny and a construction of femininity seen as constricting and suffocating" (Bordo, 1993: 209). MacSween (1993) argues that the body practices associated with anorexia nervosa can be understood as "an attempt to resolve at the level of the individual body the irreconcilability of individuality and femininity" in western culture, that is, the inherent contradiction between male-defined individuality and femininity (MacSween, 1993: 252). Also elaborating the theme of contradiction in eating disorders, Malson (1998) demonstrates that women's accounts of anorexia encapsulate a multiplicity of contradictory femininities, including femininity as fragile and heterosexual, *and* a rejection of traditional femininity. Furthermore, sociologist Bryan Turner (1992) argues that contradiction is a distinguishing feature of contemporary expectations of

adult women more generally, who are required to be at once “autonomous” and “compliant”, “independent” and “dependent”, “sexualized” and “androgynous” (Turner, 1992: 6).

While the theme of contradictory femininity is central within feminist and sociological analyses of eating disorders themselves, there has been little attention to the operation of gender discourses within contemporary health care interventions in this area. This thesis is concerned with examining the ways in which eating disorders, as well as women as subjects of eating disorders, are constructed within health care, and with theorising the relationship between these constructions and wider social relations and cultural processes. In particular, the thesis attempts to account for contradictory portrayals of eating disordered women as, for example, highly controlled and out of control, through exploration of the particular categories of psycho-medical and cultural knowledge that informs them, and considers the ways these might operate within contemporary health care intervention. This is based on the premise that, like eating disorders themselves, health care interventions are also culturally situated, and reflect wider cultural processes (Parker et al, 1995; Gremillion, 1992). The thesis is therefore concerned with interrogating what Gremillion (1992) calls the ‘dialogue’ between culture and contemporary health care interventions for eating disorders – that is, the way that culture is present within different forms of health care intervention - and with examining the possibilities for challenging gendered contradictions and dilemmas through alternative interventions. Thus, health care intervention is understood to be imbricated in culture, rather than a supposedly impartial activity that occurs in isolation from culture.

Discourse, Subjectivity, Power and Knowledge

Much of the plethora of psycho-medical research into eating disorders seeks to identify cause and examine the effects of intervention from within a positivist, medico-scientific epistemological paradigm, based on the assumption that anorexia and bulimia constitute real, distinct entities that can be quantified and known in an objective sense. Through an interview-based study with contemporary health care practitioners, this study places health care knowledge and intervention at the centre of inquiry, rather than women with eating disorders. However, there is recognition that women’s experiences are affected in multiple ways by the nature of the interventions in which they participate. In this sense, then, health care intervention, and the knowledge through which it is structured, becomes imbricated in the individual’s actual experiences of an ‘eating disorder’. This alludes to the role of the human sciences, and the

associated practice disciplines, in constructing the very 'conditions' they seek to quantify, explain and treat (Parker et al, 1995; Garrett, 1994; Malson, 1998; Hepworth, 1999).

In line with an awareness of the socially constructed nature of social reality, this analysis takes as its epistemological starting point the post-structural ideas of the French philosopher, Michel Foucault, which emphasise the role of language in the discursive production of reality (Foucault, 1972). 'Post-structuralism' refers to the philosophical movement that is associated with the writings on language, discourse and texts produced initially by French cultural analysts such as Derrida, Lyotard and Foucault in the late 1960s, 1970s and 1980s (Parker, 1992). For Foucault (1972), language is comprised of historically specific discourses described as "practices that systematically form the objects of which they speak" (Foucault, 1972: 49). Thus, for Foucault, discourse does not simply reflect social reality, but is constitutive of it (Henriques et al, 1984; Parker, 1992; Burman and Parker, 1993). This is a radically different view of language as bringing objects into meaning, rather than conveying a meaning that precedes language (Foucault, 1977b).

The idea that discursive practices form the objects of which they speak extends to a concern with how individual subjects are constructed in discourse (Parker, 1992; Burman and Parker, 1993). Thus, language is understood as

...the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested...it is also the place where our sense of ourselves, our subjectivity, is constructed.

(Weedon, 1987: 21).

Subjectivity is seen as produced in a range of discursive practices and the meanings of these are understood as "a site of struggle over power" (Weedon, 1987: 21). Furthermore, the subject positions produced through discursive practices are multiple and shifting, and often contradictory, challenging the humanist assumption of a fixed and stable self (Parker, 1992). The notion that discursive practices involve

a struggle over power is based on the idea that power and knowledge are intrinsically linked and “directly imply one another” (Foucault, 1977a: 27). Thus,

..... there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.....

(Foucault, 1977a: 27)

In elaborating this point, Foucault describes his overall objective in examining the way in which power is installed in particular institutions and cultural practices as to

..... discover the point at which these practices became coherent reflective techniques with definite goals, the point at which a particular discourse emerged from these techniques and came to be seen as true, the point at which they are linked with the obligation of searching for the truth and telling the truth.

(Foucault, 1980, cited in Rabinow, 1984: 7)

For Foucault, then, discursive practices are intrinsically tied up with power and knowledge, and the point at which discourse emerges is synonymous with the production of truth (Foucault, 1982). Thus, “ways of knowing are equated with ways of exercising power over individuals”, where disciplinary power is understood to be written on the body and soul of the individual (Sawicki, 1991: 22). The discursive practices that constitute interventions for eating disorders, and the field of psycho-medical knowledge that structures them, can therefore be understood as involving power relations, where truth and subjectivity is at stake. While mental health interventions represent only one of many contexts in which the subjectivities of those diagnosed with eating disorders are produced, it is particularly significant because of the power dynamics involved. The freedom to position oneself in discourse is contingent upon access to power (Parker, 1992), and health workers have differential access to the power to position subjects within the discourses which structure health care interactions by virtue of their status as professionals with access to expert knowledge (Harper, 1995). Thus, health intervention is understood as a localised form of power dynamics which offers individuals participating in these interventions particular forms of subjectivity.

Foucault's work also involves a focus on the body as discursively produced through historically specific power relations, rather than as a pre-existent or natural entity (McNay, 1992). Foucault understands the body to be "produced through power", and as a historically specific and "cultural rather than a natural entity", and while Foucault does not elide the corporeality of the body, his perspective represents a radical departure from conventional and scientific assumptions about the body (McNay, 1992: 3). Foucault describes the way in which discourse becomes inscribed on the body, producing subjected and practised "docile" bodies reflective of, and constitutive of, wider social relations (Foucault, 1977a: 138). This notion of the body as caught up in wider power relations is important to this investigation because it draws attention to the way in which health care practices, which commonly centre the body as the object of intervention, might be understood in terms of Foucault's concept of 'governmentality of the body' as disciplinary practices that have the potential to circumscribe women's experiences of eating disorders in particular ways (Turner, 1984; Gremillion, 1992). While Foucault examines the disciplinary effects of power on subjectivity and the body, his view of power does not involve a notion of a universal, sovereign entity, though:

This form of power applies itself to immediate everyday life which categorises the individual, marks him by his own individuality, attaches him to his identity, imposes a law of truth on him which he must recognise and which others have to recognise in him [sic]. It is a form of power which makes individuals subjects.

(Foucault, 1982: 212)

Thus, power is conceived of as diffuse, and is exercised rather than possessed (Sawicki, 1991), while power relations are decentred (Foucault, 1978). Furthermore, while power is understood as operating through discourse to regulate and discipline individuals (Foucault, 1977a), it is also understood to be productive and positive, not merely repressive and negative, and as producing resistance to its disciplinary effects (Foucault, 1978; McNay, 1992). Foucault (1980b) defined resistance as arising where the operation of power is most repressive, and this idea is therefore closely linked with the notion of productive power (McNay, 1992).

Foucault's notion of discursive practice also eschews the traditional distinction between theory and practice and, instead, discourse emerges from social practices that have become "coherent reflective

techniques with definite goals” (Foucault, 1980a, cited in Rabinow, 1984: 7). In line with this, Foucault describes discourse as practices, and Parker (1992) elaborates this point further,

.....for Foucault, discourse and practice should be treated as if they were the same thing, and it's true both that material practices are always invested with meaning (they have the status of a text) and that speaking or writing is a 'practice'.

(Parker, 1992: 16)

Foucault therefore presents the relationship between discourse and practice as dynamic and intertwined, in contrast to the traditional distinctions drawn between the ideological and material, or theory and practice, where one determines the other (McNay, 1992). In line with this, discourse has been described as surrounded by social practices (Rabinow, 1984), or as playing functions within the social practices that give rise to them (Burman and Parker, 1993). This point is relevant to this thesis, concerned as it is with examining the operations of power/knowledge within health care disciplines which commonly distinguish between theory and practice. In line with Foucault's ideas, both theoretical explanations of eating disorders and associated health care interventions are understood as discursive practices. However, this does not necessarily mean that they are qualitatively the *same*. While it is acknowledged that theory and practice each have particular power/knowledge effects, health care intervention denotes a space where *action* occurs, a material realm in which women participate. In contrast, theoretical explanation denotes a symbolic realm and, as is noted by McNay, the relation between “symbolic codes and concrete practices is not isomorphic” (McNay, 2000: 159). Nevertheless, in drawing this distinction I open up the opportunity to explore the ways in which theoretical discourse and practice discourse relate to each other, where they converge and where they depart from each other, bringing an additional layer of understanding and insight into the ‘discursive dynamics’ (see Parker, 1992) and contradictions that infuse health care knowledge and practice in this area.

In his later work, Foucault (1988) shifted his focus from techniques of domination to the operations individuals perform on themselves, known as ‘technologies’ or ‘practices’ of the self. In her appropriation of Foucault's later ideas, Probyn (1993) describes the idea of technologies of the self as “the relation of the self with self and the forming of oneself as a subject” (Probyn, 1993: 121), while Lester (1997) describes practices of the self as the way individuals produce themselves through “the conscious and

deliberate shaping of the self according to a particular philosophy of living and through a given set of culturally meaningful bodily practices" (Lester, 1997: 482). Through the idea of practices of the self, Foucault (1988) therefore explores the ways in which individuals exercise a measure of autonomy and agency in fashioning themselves within social constraints (McNay, 1992). Thus, while this thesis is concerned with examining the operation of power within contemporary health care, it is tempered by the awareness that women's experiences of health care intervention are not wholly reducible to the effects of power.

Feminism and Post-Structuralism

Feminists have drawn on post-structural ideas to emphasise the ways in which gender inequalities are reproduced in the structuring of explanations of women through historical, social and political discourse (for example, Weedon, 1987; Sawicki, 1991; McNay, 1992; Butler, 1993). Thus, feminist engagement with post-structuralism has extended understandings of the way bodies and subjectivities are produced in discourse by acknowledging the "gendered character" of many of the disciplinary techniques that circumscribe the female body (McNay, 1992: 11). These ideas have been usefully employed by feminists, such as Bordo (1988; 1989; 1990; 1993), MacSween (1993), Gremillion (1992) and Malson (1998), in examining the meanings of the thin female body in western culture, and in elaborating the gendered nature of disciplinary practices associated with female body management.

A feminist engagement with post-structuralism is also relevant to an analysis of health care interventions used for eating disorders because it brings with it sensitivity to the potentially gendered aspects of the discursive practices that structure health care, as well as female body management practices. Feminist analyses have shown that psychological theory, which informs much of contemporary psychiatry, psychology and other disciplines involved in the treatment of 'mental illness', is itself intrinsically gendered. Western thought is underpinned by a series of core dichotomies, in particular, the association of 'male' with reason, culture, the universal and the public, and 'female' with the irrational, emotion, the physical, nature, the particular and private (Jaggar, 1989; Lloyd, 1989). These ideas are also linked to Cartesian dualism, where the mind is seen as synonymous with the self and superior to the physical body (Lloyd, 1989). These assumptions also structure psychological knowledge, so that the idealised model of the "thinking, reasoning individual" is a model of man, made possible by the subordinate positioning of women in gender power relations that result in "male-defined criteria of normality" (Burman et al, 1996: 3).

Gendered ideas about 'mental health' have particular effects within contemporary mental health care practice more generally, most clearly illustrated in a now famous study conducted in the 1970s by Broverman et al (1972). Mental health clinicians were shown to perceive socially acceptable 'feminine' characteristics, such as dependency and emotionality, as conflicting with notions of mental healthiness because they are at odds with notions of instrumentality and adulthood (Broverman et al, 1972). Conversely, 'masculine' characteristics were unproblematically understood as marks of mental health in men (Broverman et al, 1972). Thus, notions of mental health in women are inherently conflicted and contradictory because they operate around "a double standard of mental health" (Chesler, 1974: xxi).

This thesis is particularly interested in investigating the gendered aspects of contemporary knowledge used to delineate and explain eating disorders, and the way these might manifest in practice. Because eating disorders are associated with a marked gender asymmetry, they provide a particularly useful opportunity to examine the operation of gendered knowledge and assumptions in the context of health care, and the gendered nature of subjectivities offered to women within specific interventions. However, while I acknowledge the existence of unequal power relations between health professionals and 'patients', I do not assume that women are the mere docile bodies or passive subjects of intervention. Rather, women are actively involved in the processes of subjectification, including the potential to resist the subjectivities they impose (Foucault, 1978). In fact, the concept of resistance is particularly relevant to an analysis of health care interventions for eating disorders because, as was mentioned earlier, women with anorexia nervosa have been typically characterised within psycho-medicine as 'resistant' to psychiatric efforts to 'cure' them. More than this, though, I see women as actively engaged in the production of their own subjectivities within the context of health care through Foucault's notion of 'practices of the self' (Foucault, 1988). Some feminist theorists have utilised the later ideas of Foucault to show that dominant constructions of gender are oppressive but do not completely determine women's experiences and actions (for example, McNay, 1992; Probyn, 1993).

Feminist theorists have also drawn on a range of other ideas to elaborate the idea that discourse is not completely determining. Perhaps most well known is the idea of 'embodiment' (for example, Butler, 1993; Braidotti, 1994; Grosz, 1994), which has been used to emphasise the unstable aspects of corporeality and the idea of 'mutual inherence' between psyche and body, inside and outside (McNay, 2000). Thus, while the constraining effects of discourse are acknowledged, the concept of embodiment leaves "a moment of

indeterminacy where the embodied subject is constituted through dominant norms but is not reducible to them" (McNay, 2000: 32). Butler's (1993) notion of gender as "performative" has also provided a way of thinking about gender identity not as entirely determined or constructed, but as "a regularised and constrained reiteration of norms" (Butler, 1993: 94-95). Butler (1993) emphasises the temporal nature of performativity, where "sex is both produced and destabilized in the course of [...] reiteration" (Butler, 1993: 10). The reiteration of sexual norms is seen as indicative of their instability, and of the possibility for change through the creation of "a potentially productive crisis" (Butler, 1993: 10) and the "re-signification of the symbolic domain" (Butler, 1993: 22), leaving space for the exercise of individual agency.

While this thesis involves an analysis of health care intervention from 'the perspective of power', drawing on Foucault's concept of disciplinary power, I take a cautionary approach to assumptions of power's effectivity, informed by my awareness that women are also actively involved in processes of self-production, albeit it within social constraints. This suggests the *inter*-subjective realm (Stanely, 1990; Olesen 1994), and involves acknowledgement of the fact that health care interventions involve exchanges between individuals that are not one-directional and wholly determining of women as subjects, leaving possibilities for resistance and agency. I am therefore interested in the ways in which power seeks to co-opt women, without assuming that it is always successful in doing so.

A central criticism of some forms of feminism is the tendency to focus on questions of gender to the exclusion of other forms of oppression, particularly class and race (Stanley and Wise, 1990; McNay, 1992), and sexuality (Stanley and Wise, 1990). Over the past two decades black women, in particular, have pointed out that it is only for privileged, white western women that gender is the central form of oppression, and that dominant forms of feminism generalize these experiences to all women (McNay, 1992). Thus, power differences *between* women can be great, and have far reaching implications for the struggle against gender oppression (McNay, 1992). This point is relevant to this thesis because eating disorders have traditionally been associated with white, middle and upper class women (Bruch, 1978). However, there is evidence that eating disorders increasingly affect all socio-economic and ethnic groups (Miotto et al, 2003; Dolan, Lacey and Evans, 1990). Feminist research is needed into the specific experiences of black women and women from lower socio-economic groups (c.f. Witt, 1994) so that critiques emanating from analysis of the experiences of white middle and upper class women are not generalized to other groups. This thesis does not specifically examine how questions of class and race

influence health care intervention because of a specific concern with analysing gender. However, I am aware that class and race are also relevant here, and that the forms of psycho-medical knowledge and practice that have been applied to eating disorders are not only gendered, but also developed out of inherently western traditions of thought and assumptions about selfhood which do not take into account the experiences of other groups. Furthermore, the perception that eating disordered women are from privileged backgrounds persists (c.f. McClelland and Crisp, 2001), so that the experiences of women from other socio-economic backgrounds are likely to be marginalised within current approaches to health care.

Women, Mental Disorder and the Emergence of Eating Disorders as Psychiatric Conditions

Before exploring the gendered aspects of contemporary health care interventions used for eating disorders, it is useful to briefly summarise the historical links between notions of femininity and mental disorder in western culture, and the role of psychiatry in the treatment of 'mental illness'. Feminists have specifically applied themselves to analysis of the gendered aspects of mental illness in an effort to explicate the historical associations between women and 'madness' (Showalter, 1985; Ussher, 1991). As has been widely argued, the eighteenth and nineteenth centuries saw a feminisation of 'nervousness', epitomised in the idea of hysteria as an intrinsically feminine condition (Showalter, 1985). At the same time, a male-dominated medical profession strengthened its hold over health and healing with the rise of scientific discourse, while the rapidly growing discipline of psychiatry extended its control over the definition and treatment of 'madness' (Ussher, 1991). Foucault (1978) shows how the medical technologies of this period "hysterized" the female body, producing it as "thoroughly saturated with sexuality", and how this was tied to the regulation of reproduction and sexuality in the Victorian era (Foucault, 1978: 104). Thus, women's nervous, hysterical nature was linked to their reproductive function (Showalter, 1985). This process of hysterization also coincided with women's demands for suffrage, and Sayers (1982) has argued that patriarchal institutions used the idea of women as inherently unstable to exclude them. Thus, in their analyses of what has been termed "the golden age of hysteria" (Showalter, 1985), feminist scholars demonstrate a dialogue between psychiatry and culture that played a part in the "regulation of gender" (Malson, 1998: 59), and the attempt to retain women in the private, domestic space.

As was noted earlier, eating disorders have only been understood as forms of mental disorder since the late nineteenth century. While it is not my intention to provide a detailed history of eating disorders as psycho-medical categories, it is important to outline some key points about the medical 'discovery' of

anorexia nervosa to serve as a backdrop to an examination of contemporary discursive practices. In particular, I later draw attention to some of the continuities and disruptions between earlier discursive productions of psychopathology and later ones. Drawing on Foucault's genealogical method (1977a; 1977b), Malson (1998) and Hepworth (1999) demonstrate the emergence of 'anorexia nervosa' through the medical and cultural discourses of the late nineteenth century, arguing that it is within these that the origins of anorexia are constituted, rather than within the 'anorexic' body itself. Malson (1998) argues that nineteenth century medical discourse did not

.....describe a 'reality' that existed independently beyond it. Rather, medical discourse in dialogue with the wider culture was 'inscribed' on the (female) body that which could be diagnosed as anorexic.

(Malson, 1998: 49)

Malson (1998) and Hepworth (1999) demonstrate that anorexia emerged as a medical category in the context of the wider hysterization of women in the nineteenth century. The Victorian physicians, Gull and Lasegue, are credited with the 'discovery' of anorexia nervosa (Malson, 1998; Hepworth, 1999). Originally, these two physicians described anorexia as having an organic origin, but came to emphasise its psychological nature through the idea 'hysterical anorexia' (Malson, 1998; Hepworth, 1999). Because anorexia was predominantly identified in women and girls, hysteria presented itself as a self-evident explanatory framework with wide currency at the time (Hepworth, 1999). Anorexic women and girls were therefore understood as inherently irrational and, in common with hysteria, irrationality and instability in anorexia were understood as intrinsically feminine (Hepworth, 1999). In this way, then, anorexia nervosa came to be understood, in essence, as a form of quintessentially feminine psychopathology, where "the discursive construction of 'woman' is at once medical and social" (Malson, 1998: 65). Of particular interest in view of contemporary constructions of anorexia nervosa and other eating disorders identified later in this thesis, anorexic young women were not separated out from other young women, but were pathologised specifically *in terms* of their gender (Malson, 1998). Furthermore, this was achieved in a very overt way in these early medical texts, for example, through the description of young women as "specially obnoxious to mental perversity" (Gull. 1874: 25, cited in Hepworth, 1999: 29).

Bulimia nervosa was described and distinguished from anorexia much later, with bingeing and purging identified by Bruch (1974a) as eating problems in the 1970s. These practices were initially defined as variants of anorexia (Beumont, George and Smart, 1976). Russell (1979) was the first to use the term 'bulimia nervosa' and it was included as a distinctive category of eating disorder in 1980 (American Psychiatric Association, 1980). Bulimia has not received the levels of attention directed at anorexia, neither within psycho-medicine nor from feminist scholars, however, it is often brought into explanations of anorexia. There is a fascination with anorexia nervosa within both feminist and medical circles, perhaps related to the 'spectacle' of the thin body (Spitzak, 1990) and to the fact that anorexia is associated with a high mortality rate (American Psychiatric Association, 2000), with the result that in each realm the more common disorders receive limited attention.

Critical Analyses of Mental Health Intervention

Only a small number of previous studies critically explore mental health care practitioners' approaches to intervention. For example, Harper (1994) examines the ways in which a psychiatric diagnosis of paranoia is accomplished through language. Barrett (1988) shows how transformations are effected in patients' identities through psychiatrists' practice of clinical case note writing. While not empirically based, Parker et al (1995) use Foucauldian ideas to deconstruct 'psychopathology', showing that 'mental illness' has become divided from 'mental health', and illustrating the ways in which contemporary health professionals are involved in 'dividing practices'. More specifically, many feminists have used post-structural ideas to examine contemporary psychiatric approaches to the treatment of anorexia nervosa through critical reviews of the psycho-medical literature, each noting the emphasis on the individual as the source of eating disorder psychopathology, and the failure of psycho-medical approaches to incorporate awareness of the role of gender and socio-cultural context (Gremillion, 1992; 2001; MacSween, 1993; Russell, 1995; Lester, 1997; Malson, 1998; Hepworth, 1999). The only other empirical study of health care professionals' approaches to eating disorders was undertaken by Hepworth (1999), who interviewed a multidisciplinary sample of eleven health care workers in the United Kingdom as part of examining the way anorexia nervosa is constructed as a contemporary health problem. Hepworth's (1999) study demonstrated that health professionals individualised anorexia, and also showed that the diagnosis of males results in a discursive dilemma because of the historical links between anorexia and femininity.

Other feminist analyses of health care interventions used for eating disorders have drawn attention to the inherently gendered nature of contemporary psychiatric knowledge and practice (MacSween, 1993; Lester, 1997; Gremillion, 1992; 2001). In line with arguments made earlier about the gendered nature of psychological theory, Lester (1997) argues that while traditional psychotherapies used to treat eating disorders claim to be gender-neutral, they actually reinscribe traditional gender assumptions covertly because the self to which they aspire is "a barely concealed masculine one" (Probyn, 1993: 2, cited in Lester, 1997). Gremillion (1992) shows how contemporary psychiatric conceptualisations of anorexia nervosa and associated treatments reproduce a host of gendered dualisms, particularly mind-body dualism, which she argues are central in sustaining anorexic practices. In later ethnographic fieldwork in an inpatient eating disorder treatment unit in the United States, Gremillion (2001) examines the way medical practitioners and psychiatrists "actively craft the particular kinds of bodies that they claim merely to describe, diagnose, and normalize", showing that psychiatric intervention is "embedded in contemporary discourses of feminine 'fitness' that help cause anorexia in the first place" (Gremillion, 2001: 383-384).

This thesis extends previous feminist analyses of health care interventions used for eating disorders by specifically attending to the gendered nature of the contradictions that distinguish contemporary psycho-medical explanations of eating disordered women, and by exploring the ways in which these might operate in practice. As was noted earlier, eating disordered women are often described in contradictory ways in the psycho-medical literature as independent and dependent, and as controlled and out of control. Such paradoxical portrayals are founded on particular assumptions about individual autonomy and control, and this thesis seeks to examine and explicate the gendered nature of the knowledge which informs them, and the gendered assumptions which are at work. In order to examine in some depth the formal theoretical knowledge and informal assumptions about women with eating disorders that underpin contradictory constructions of subjectivity in eating disorders, a series of in-depth interviews was undertaken with a multidisciplinary sample of health care workers, and discourse analysis was used to reveal the discursive dynamics and power relations operating within health care workers' explanation of eating disorders and health care practices. In a break with other feminist research in this area, this investigation focuses on health care workers' approaches to eating disorders in general. Most feminist research in this area concentrates specifically on anorexia nervosa (for example, Malson, 1998; Garrett, 1995; Gremillion, 2001; Hepworth, 1999), and there has been little examination of interventions used for

bulimia nervosa or 'sub-clinical' eating disorders, despite the fact that these are far more common and women do not necessarily fall into distinct groupings in practice, moving between the different diagnostic categories (Vaz, Guisedo and Penas-Lledo, 2003). This thesis takes a broader approach, and while this recognises that women's experiences are not as distinctive as psycho-medicine might draw them, it also allows for examination of the ways practitioners distinguish between and divide women, adding a further layer of analysis and interpretation.

Alternative Practice Paradigms

A further distinction between this thesis and previous feminist analyses of health care interventions used for eating disorders is that I also attend to the possibilities for overcoming the individualising tendencies and gendered assumptions structuring psycho-medical intervention through alternative approaches to health care. Historically, health care intervention for eating disorders has been dominated by an almost total emphasis on treatment. However, the past decade has seen increasing calls for prevention, matched by a growing interest in the contributory role of socio-cultural context (for example, Hsu, 1996; Striegel-Moore and Steiner-Adair, 1998). This is linked to the idea that the marketing of the thin female body ideal in western cultures has contributed to widespread 'body image dissatisfaction' and dieting practices among women, constituting a backdrop for the development of eating disorders (Thompson, 1992; Wade et al, 1996; Silverstein and Perdue, 1986). In tandem with this, there are a growing number of programs that identify with the concept of 'health promotion', and seek to address social conditions understood to give rise to eating disorders (c.f. Neumark-Sztainer, 1996). As yet, there has been little critical examination of approaches to the prevention of eating disorders, so the analysis undertaken in this thesis represents the first contribution to critical insights in this area.

Health Promotion

Health promotion defines itself as concerned with a social view of health, and the idea that health is more than the absence of disease, in line with international policies such as the Ottawa Charter for Health Promotion (OCHP) (World Health Organization, 1986). Through this emphasis on the socio-cultural rather than the individual and pathological, health promotion offers some potential to advance new understandings and practice approaches to eating disorders. Furthermore, because treatment outcomes associated with psychiatric intervention in this area are poor, the need for effective forms of preventive intervention is particularly significant.

The application of health promotion theory and practice to the prevention of eating disorders involves a number of potential contradictions, though. Firstly, while health promotion claims to be empowering of individuals and groups in line with principles enshrined in international policies (World Health Organization, 1986), in practice its approach can be controlling (Grace, 1991). Secondly, while concepts such as community participation are emphasised in theory, in practice health promotion often operates within the context of ideas derived from marketing, which can lead to paternalism (Grace, 1991). Thirdly, while the social aspects of health problems are emphasised, health promotion has been criticised for focusing on the individual as responsible for change in practice (Wikler and Beauchamp, 1995). Some forms of health promotion also enshrine 'healthy lifestyle' as a moral virtue, and this has come to be associated with concepts of youthfulness and vitality (Burrows, Nettleton and Bunton, 1995; Wikler and Beauchamp, 1995; Bunton and Burrows, 1995; Glassner, 1995). This association is particularly significant in cultural assumptions of women's health, where aesthetic concerns have permeated cultural ideas of women's health to the extent that 'healthful' appearance, in terms of slenderness and youthfulness, has become synonymous with 'health' (Spitzak, 1990). The specific application of health promotion to the prevention of eating disorders will therefore be examined against the backdrop of these potential dilemmas, and an assessment will be made of its capacity to challenge cultural processes implicated in eating disorders. While such an analysis is based on the assumption that health promotion, like therapeutic intervention, is a culturally situated activity, it is also premised on the idea that health promotion offers a transformative potential through its emphasis on the socio-cultural rather than individual origins of health problems, and on principles of empowerment and participation (World Health Organization, 1986).

Feminist Health Care and Narrative Therapy

A further source of alternative approaches to eating disorders can be found in feminist models of health care, and in the development of politically informed psychotherapies such as feminist therapy, narrative therapy and other discursive forms of psychotherapy. In Australia, the women's movement of the 1970s led to the establishment of government-funded women's health centres in most Australian states (Broom, 1991). While diverse in their emphases, each centre is an initiative of local communities, and the centres are united in their aim of extending women's control over their bodies and health, based on the view that mainstream medicine is male-dominated and often insensitive to women's needs (Broom, 1991). In line

with their feminist origins, the centres are based on the philosophy that women have distinctive health needs related to the positions accorded to them in gender power relations, and the centres usually have a broader change agenda to transform patriarchal values and structures of society (Broom, 1991). As the only distinctively feminist forms of health care in Australia, this thesis also examines the approach of the women's health centres for its transformative potential in this area.

More recently, there has been a growing interest in the "narrative turn" in psychotherapy based on the post-structural ideas of Foucault and, to a lesser extent, Jacques Derrida (Parker, 1999: 1). Most well known of these therapies is the narrative approach developed by the Australian psychotherapist Michael White and his New Zealand colleague David Epston (White and Epston, 1989). Their approach has been enthusiastically adopted in Australia by psychotherapists working in some government-funded counselling services, women's health centres and certain private psychotherapy practices. Because of the enormous impact of narrative therapy within contemporary psychotherapy, and its attempt to engage with post-structural ideas in practice, I also explore this approach to intervention in this thesis as another alternative to dominant treatment paradigms.

Summary and Overview of the Thesis

This chapter has offered a background to the thesis as a whole, highlighting central tensions and dilemmas within psycho-medical approaches to eating disorders, particularly the contradictory ways in which women are portrayed. The chapter also situates the thesis epistemologically within a post-structural feminist paradigm, with its acknowledgement of the gendered character of disciplinary power, as well as individuals' active role in self-production. Within this conceptualisation, health care intervention comes to be understood as a site of 'struggle over power' where subjectivity is at stake. More specifically, the chapter draws attention to the peculiarly gendered nature of supposedly gender-neutral psychological and psycho-medical discourses more generally. Chapter 2 continues analysis of this theme through examination of contemporary psycho-medical theories used to explain eating disorders and associated interventions used to treat them. Chapter 3 examines theory and practices associated with approaches to the prevention of eating disorders, including an exploration of the application of the theory and practice of health promotion in this area. These two chapters serve as backdrops to the field research with health care practitioners.

Chapter 4 moves into outlining the research methods used in the interview study with health care practitioners, situating these within a feminist approach to social inquiry. It describes in detail the process of undertaking the research, and the discourse analytic method of data analysis that was used, tying this to the post-structural feminist epistemological perspective of the thesis as a whole.

Chapters 5 and 6 introduce the first discursive themes to emerge from analysis of health care practitioners' interviews. These chapters explore the main psycho-medical discourses of 'autonomy' and 'control' used by health care workers to explain eating disorders, and examine the ways in which these ideas are used to re-inscribe gender contradictions. Chapter 5 examines the discourses associated with the construction of anorexia nervosa as a problem of deficient identity, while Chapter 6 examines the related construct of 'control' through health care workers' explanations of sexuality and emotion in eating disorders.

Chapter 7 examines the ubiquity of multidimensional explanations of eating disorders, and the way in which these work in concert with discourses of autonomy and control to displace gender within explanatory frameworks. The chapter shows how the assumption of a supposedly 'gender-neutral' individual cannot account for the specifically gendered nature of subjectivity and how this might influence health, so that an ideology of gender neutrality actually works to erase gender as a cause of eating disorders.

Chapters 8 and 9 critically examine health workers' explanations of their approaches to psycho-medical therapeutic intervention, paying particular attention to continuities and discontinuities between explanatory and practice discourses, and the ways in which gendered contradictions are reproduced in practice. Chapter 8 examines interventions that centre the body as the object of intervention through an emphasis on weight gain, while Chapter 9 examines psychotherapeutic interventions that focus on the mind.

Chapters 10 and 11 examine approaches to preventive practice, exploring the application of health promotion theory and practice in the specific example of an Australian body image dissatisfaction program, exploring its potential for overcoming the hierarchical dualisms and gendered contradictions structuring psycho-medical intervention.

Chapter 12 examines the theoretical and practice approaches of health care practitioners working with feminist ideas and post-structural-informed approaches such as narrative therapy, and examines their potential for providing alternative approaches that challenge some of the contradictions associated with psycho-medical and health promotion practice.

Chapter 13 provides an overview of the main arguments outlined in the thesis, and points to recent post-structural feminist theory and research which offers potentially fruitful directions for the re-conceptualisation of feminist-informed health care practice that addresses both individual experiences of eating disorders and social change.

In the next two chapters, I now turn to the 'official account' (Malson, 1998) of eating disorders in the literature, mapping the key discourses and paying particular attention to the ways gendered forms of knowledge underpin central assumptions and approaches to practice.

Chapter 2

Mapping Contemporary Discourses of Eating Disorders and Approaches to Therapeutic Intervention

Introduction

In this chapter, the main contemporary theoretical explanations of eating disorders and associated therapeutic interventions are critically examined. The psycho-medical literature on eating disorders is vast, and this review therefore only focuses on mapping the dominant approaches and themes, paying particular attention to those which continue to exert the greatest influence on contemporary approaches to practice. The chapter also examines early feminist theorisations and their approach to therapeutic intervention with women experiencing eating disorders, attending to where they converge with, diverge from, dominant conceptualisations. As noted in Chapter 1, narrative therapy has been used more recently with individuals diagnosed with eating disorders. Because narrative therapy does not involve a general theorisation of eating disorders *per se*, discussion focuses on the theoretical assumptions which underpin the approach to intervention. This and the following chapter, which reviews socio-cultural theories and preventive practice, serve as backdrops to an analysis of the discursive dynamics characterising health care practitioners' explanations of eating disorders and their approaches to practice.

The main theoretical explanations of anorexia nervosa and bulimia nervosa in the medical and psychological literature range across a number of perspectives and include psychoanalytic and psychodynamic theory, cognitive and behavioural theory, family systems theory and biological theories. Associated therapeutic interventions include psychotherapy, cognitive-behavioural therapy, behaviourist treatment programs, family therapy and pharmacological therapy. In spite of the higher prevalence, theorisations of bulimia continue to be secondary to anorexia (Cooper, 1987), and while there have been attempts to explain bulimia through each of the major theoretical perspectives applied to anorexia, it is most commonly theorised and treated within a cognitive-behavioural approach. Following this, cognitive-behavioural theory and practice is the focus of discussion of approaches to bulimia in this chapter. Because the psycho-medical literature on eating disorders is large, this review will concentrate, where possible, on seminal texts that provide more detailed explanations of underlying theoretical perspectives and interventions.

Psychoanalytics and Psychodynamics

Psychoanalytic explanations of anorexia, based on Freudian notions of sexual conflict and repression, were common from the 1930s to the 1950s, but are less so now (Gremillion, 1992), and therefore will not be covered in great depth here. In brief, psychoanalytic theorists view anorexic symptoms as indicative of unresolved sexual conflict, where food refusal is characterised as 'oral ambivalence' related to the unconscious association of food with oral impregnation, while bulimia is theorised as a breakthrough of unconscious desires for oral gratification (Bemis, 1978). Psychodynamics developed out of Freudian psychology, and places an emphasis on the conscious 'ego' rather than the unconscious (Erikson, 1980). It is psychodynamics that has perhaps had the greatest influence on contemporary theorisations of eating disorders, particularly anorexia nervosa. Hilde Bruch is credited with first elaborating the psychodynamic approach to anorexia nervosa, based on her work as a psychiatrist in the US during 1960s and 1970s (Bruch, 1974a; 1978), and these ideas continue to exert a strong influence on contemporary approaches (for example, Polivy and Herman, 1987; Yager, 1994; Hartman, 1996; Horesh, Zalsman and Apler, 2000). Bruch defines anorexia as a "developmental crisis" (Bruch, 1978: 169) involving "a desperate struggle for a self-respecting identity" (Bruch, 1974a: 250). She identifies three areas of psychological dysfunction: disturbed body image; misinterpretations of "internal and external stimuli", including inaccurate perception of hunger cues; and "a paralysing underlying sense of ineffectiveness" and of being out of control of one's life (Bruch, 1978: x). Bruch also characterises anorexics as seemingly "defiant and stubborn" and "strong and vigorous", however, this is revealed to be a façade for 'real' underlying 'ego' deficiencies in the form of a lack of identity, autonomy and control. (Bruch, 1978: 39). She argues that anorexics gain a sense of having a core to their personality through control of their eating (Bruch, 1978), which is part of a "struggle" for identity and effectiveness (Bruch, 1974a: 251). Bruch (1974a; 1978) also characterises much of the cognitions and behaviour of anorexics as the consequence of the cognitive dysfunction that accompanies starvation, particularly pre-occupation with food and eating, "narcissistic self-absorption" and "infantile regression" (Bruch, 1978: 9).

Within the psychodynamic framework, the families of anorexics are described as achievement-oriented, with mothers 'over-valuing' their anorexic child, that is, mothering 'too well' (Bruch, 1978). Anorexics are understood to have been 'compliant' children who, while cared for well physically, educationally and materially, are deprived of independence because their individual needs and desires were not taken into account, resulting in a lacking sense of identity and an inability to express their needs (Bruch, 1978). This

includes inappropriate feeding by the mother that either neglects "child-initiated clues" or is "oversolicitous", the child failing to learn to discriminate hunger from satiety or hunger from other feelings (Bruch, 1978: 41). The 'pre-anorexic' comes to feel 'unbounded' from the external world, cannot distinguish whether impulses originate from inside or outside, does not feel "truly separated from others" (Bruch, 1978: 40), and lacks awareness of their own feelings, thoughts and bodily cues (Bruch, 1974: 255). Anorexia is also seen as emerging in the face of challenges that accompany adolescence, so that control of the body becomes the only area of control and effectiveness for individuals deficient in these respects (Bruch, 1978). Bodily changes associated with puberty, such as menstruation and increased body fat, are also said to be accompanied by anxiety because they are interpreted as loss of control and with being required to be more independent (Bruch, 1978).

Because many of the psychological features of anorexia are consequences of starvation, Bruch (1978) argues that the underlying psychological problems can only be expressed and addressed after there is an improvement in nutrition. Treatment involves establishing normal nutrition, changes to patterns of family interaction, and correcting and maturing the "undifferentiated slave-like self-concept" (Bruch, 1978: 90). Psychotherapy is aimed at developing the personality so the individual can separate from parental enmeshment (Bruch, 1978: 90), and increasing weight in an "integrated treatment approach" (Bruch, 1978:93). Family therapy involves getting parents to admit there are problems in family functioning, and redress them through granting their children greater autonomy and independence. The goal of individual psychotherapy is to help "develop a valid self-concept and the capacity for self-directed action" by assisting patients in discovering their abilities for "thinking, judging and feeling", so that they can then re-evaluate their rigid, rule based system of values (Bruch, 1978: 123).

While Bruch (1974; 1978) attempts to account for some of the contradictory social pressures placed upon contemporary young women in terms of career aspirations and traditional feminine roles, anorexia nervosa is nevertheless presented primarily as a problem of individual psychopathology rather than gendered experience. Most significantly, the ostensibly gender-neutral assumption of personality development within psychodynamics is based on a male model that idealises autonomy and control, and a masculinised idea of the body as a "self-contained" system of self-directed needs and desires owned by the self (MacSween, 1993: 43). As is argued by MacSween, physical, sexual and psycho-emotional receptiveness, while not valued, are central requirements of women (MacSween, 1993: 43). The

psychodynamic approach, epitomised in the work of Bruch, therefore pathologises characteristics such as dependence and compliance typically associated with the "feminine", while the cultural origins of this contradiction remain obscured. Lester (1997) highlights the ways in which gendered contradictions can be used to undermine patients within psychodynamic therapy by pointing out that when some of Bruch's female patients assert that their eating disorder arises from "conflicts of gendered selves", these are "turned back on them and used as evidence of their 'childlike' and 'illogical' (i.e. 'female') reasoning, as compared to the 'scientific' and 'logical' reasoning of the (male) medical establishment" (Lester, 1997; 481).

In common with psychoanalytic theory, psychodynamics places a particular emphasis on the role of mothers in the genesis and maintenance of anorexia. For example, Bruch (1978) describes one mother as "childish" and "submissive", while another is characterised as domineering, and much emphasis is given to the role of the early mother-child relationship in causation (Bruch, 1978: 110). There is, therefore, an "over-implication" of the mother in this approach, while fathers play a far less prominent part (Malson, 1998: 89). This results in a gendered approach to the family where primary responsibility for, and influence upon, children lies naturally with the mother. Thus, anorexia becomes a problem peculiar to *female* patterns of interaction, in spite of the fact that Bruch (1978) repeatedly notes critical comments from fathers to daughters about their increasing weight immediately prior to the development of anorexia nervosa. Horsfall (1991) argues that the patriarchal nature of psychiatry makes it possible to ignore the role of the father in the parthenogenesis of psychiatric disorders, and asks "what equally charming qualities these invisible fathers would manifest should we look for them" (Horsfall, 1991: 233, cited in Hepworth, 1999: 51).

The psychodynamic explanation of anorexia, through focusing on the idea of underlying psychological disorder, also fails to acknowledge the meanings of food (MacSween, 1993), bodily practices (Gremillion, 1992) and the female body (MacSween, 1993). Most critically, psychodynamics does not explain "how the transformation from asexual child's body to ambiguous icon of female body is experienced" (MacSween, 1993: 42), leaving unanswered one of the central processes of engendering. Furthermore, because gender roles are taken to be natural, the question of why eating disorders are disproportionately diagnosed in women is not answered (MacSween, 1993). Thus, while Bruch (1978) called anorexia nervosa a 'socio-cultural epidemic' promoted by the cultural emphasis on thinness for women, anorexia is

nevertheless conceptualised as an essentially individual problem that is merely 'triggered' by socio-cultural factors. Because the relationship between the individual and society is understood in a dualistic way within psychodynamics, while society's norms and values are seen as internalised, the individual is understood to be, at the same time, separate from the socializing effects of the wider collective rather than part of an interrelated realm (Davies, 1991).

The Psychobiological Model of Anorexia Nervosa

The psychobiological model of anorexia was first proposed by British psychiatrist Arthur Crisp (1979; 1980), and continues to be extremely influential within contemporary theory and practice (for example Yager, 1994; Horesh, Zalsman and Apler, 2000; Polivy and Herman, 2002). Crisp (1979; 1980) describes anorexia nervosa as "a psychologically adaptive stance operating within biological mechanisms", where "the thrust of puberty" introduces body weight and shape as "a new, meaningful and threatening experience" (Crisp, 1980: 5). Food therefore gains its meaning because of its significance to body weight and shape, rather than its symbolic association with the mother-child relationship (Crisp, 1980). More specifically, Crisp (1980) argues that it is the changes in "fatness" that accompany female puberty, such as breast development and rounding of hips and thighs, which become associated with food (Crisp, 1980: 50). He suggests that some girls feel a loss of autonomy and control, a sense that they do not "own" their own bodies, and this "may compound previous passivity and dependency feelings of childhood" (Crisp, 1980: 51). Adolescence is characterised as a tumultuous period, and failure to negotiate this phase of development results in the failure to achieve a stable and mature sense of self (Crisp, 1980: 58). Biological sexuality is seen as a pivotal aspect of this process because biological weight determines the threshold at which sex hormone activity is "switched off", so that regression through food avoidance and weight loss becomes possible (Crisp, 1980: 84). The anorexic regression to childhood is seen as providing the individual with a sense of increased autonomy and "renewed control" over her life, the chaos of adolescence having been avoided (Crisp, 1980: 85). Avoidance of adolescent conflict therefore results in the anorexic's adoption of a "sustained phobic avoidance of herself at a post-pubertal weight" that is seen as adaptive (Crisp and Fransella, 1972: 395), and the biologically determined nature of this is presented as indicative of the psychosomatic nature of the disorder (Fransella and Crisp, 1979).

Within this approach, therapeutic intervention is seen as enlarging the anorexic's experience of herself, with family encouragement, and as providing opportunities for personal growth and skills to cope with

biological maturity (Crisp, 1980). Thus, the task is to "grow up" biologically and psychologically through psychotherapeutic intervention (Crisp, 1980: 103). This is achieved through a combination of one-to-one psychotherapy, family therapy and support groups. The aim of intervention is to encourage personal growth and new coping styles in the individual, sharing of feelings and examination of patterns within the family unit, and sharing of problems with fellow patients. For the avoidance of maturity to cease, though, the necessary psychological change can only occur if weight gain proceeds to "normal adult levels" because, otherwise, the young woman is "biologically incomplete" (Crisp, 1980: 103-104). Thus, weight gain is a prerequisite for the development of psychological maturity based on the assumption that increasing weight will bring with it a re-emergence of the avoided adolescent turmoil related to control, dependence/independence and identity formation (Crisp and Fransella, 1972). Weight gain is achieved through a program of bed rest and prescription of a 'normal' diet and target weight (Crisp, 1980).

While Crisp locates the maturational crisis of adolescence within the context of the changing demands of contemporary society, it nevertheless remains unclear why it is female sexuality in particular that is so peculiarly problematic (MacSween, 1993). Crisp (1980) suggests that changes such as breast development can result in a girl's realisation that she is "destined to grow like her mother and all that that implies" (Crisp, 1980: 51), however, precisely *what* dilemmas or conflicts are implied in the development of an adult female body are not elaborated. Thus, as MacSween (1993) argues, the psycho-biological explanation offered by Crisp cannot analyse the socio-cultural processes of engendering because becoming an adult is viewed as a primarily biologically determined process that is universal, ahistorical, natural and achievable. In this context, then, for those who 'fail' to negotiate this process it *must* be individual psychological deficiencies that come into play. Once again, an aura of gender-neutrality leads to a lack of recognition of the gendered nature of sexual norms, or why the transition to adult female sexuality might be particularly problematic. Furthermore, the idea that anorexic girls and women need to gain a sense that they 'own their own bodies', and that their needs are valued by others, is a masculinist conception of individuality that is at odds with an 'open' concept of the body that is part of 'femininity' (MacSween, 1993). It is also at odds with the idea of femininity as self-sacrificing, subsuming needs to those of others, as well as the idea of the female body as a sexual object that is available to others (Orbach, 1986). Crisp's biological determinist approach to the body means that while social influences interact with biology at the point of crisis, the cultural meanings of the female body and practices of food restraint are not elaborated and gender is equated only with sex.

Much of the contemporary research into the psychopathology of eating disorders takes as its objects of inquiry constructs originally defined in psychobiological model of anorexia and in psychodynamic theorisations based on Bruch's work. For example, psychological assessment tools used in eating disorder research, such as the EAT (The Eating Attitudes Test; Garfinkel and Garner, 1979), and EDI (The Eating Disorders Inventory, Garner, Olmstead, and Polivy, 1983; Garner and Olmstead, 1984) claim to measure the psychological and behavioural features of eating disorders such as personal "ineffectiveness" (Garner, Olmstead and Polivy, 1983: 15). Earlier theoretical works such as Bruch's and Crisps' therefore remain influential, and current treatment protocols in Australia, as well as overseas, continue to recommend a two-pronged approach to treatment involving both psychotherapy and weight gain (Gilchrist et al, 1998; Hay et al, 1998).

Family Systems Theory and Family Therapy

Family systems theory developed out of psychoanalytics and psychodynamics, and focuses on the whole family rather than the individual *per se*, involving a shift to the systems of relationships in which individuals are involved as the source of dysfunction (Palazzoli, 1974). Once again, there is an emphasis on anorexia rather than bulimia in this literature. Mara Selvini-Palazzoli of the Milan School of systemic family therapy was the first to apply systems theory to an understanding of anorexia nervosa, and to the development of therapeutic interventions. Anorexic families are described by Palazzoli as having dysfunctional patterns of communication characterised by enmeshment, conflict between parents and coalitions between different members, and the anorexic's behaviour is understood as a way of managing family conflict and as a form of "self-sacrifice" within the family unit (Palazzoli, 1974: 234). The aim of family therapy is to identify dysfunctional patterns that sustain anorexia, and help the family transform them (Palazzoli, 1974). Interestingly, with its shift in emphasis away from the intra-psychic to dynamic forces outside the individual, family therapy has been associated with better outcomes than other forms of psychotherapeutic intervention based on psychopathological models (Gremillion, 1992). While not as widely cited as psychodynamic or psychobiological approaches, family therapy continues to be included as one element of many contemporary treatment protocols (Le Grange, Lock and Dymek, 2003).

While family theorists identify inter-subjective forces outside the individual as fundamental to the maintenance of eating disorders, they do not explain the origins of family dysfunction. Instead, the family

is treated as if it were a discrete system, divorced from wider socio-cultural processes (Malson, 1991; Gremillion, 1992). As in psychodynamics, family systems theory also pathologises 'feminine' characteristics, such as connected-ness to others, so that the resolution of 'enmeshment' becomes the anorexic's achievement of independence from other family members (Gremillion, 1992). Thus, family systems theory also devalues the 'feminine', and values masculinized ideas of independence and autonomy. In a further similarity with psychodynamics, systems family theory is characterised by a focus on mothers rather than fathers. For example, Palazzoli (1974) argues that the families of anorexics are distinguished by the "conspicuous figure" of the mother, while the father is an "emotional absentee" who is undermined by his wife (Palazzoli, 1974: 39). Mothers are portrayed as controlling and 'two-faced', feigning traditional devotion to the family and submission to their husbands, and as particularly controlling of their daughters, who become "the model children of a domineering, intolerant and hypercritical woman" (Palazzoli, 1974: 39). Anorexia nervosa, indeed all forms of mental illness, therefore become products of families with a "pathogenic mother" (Palazzoli, 1974: 194). Within this approach, anorexia becomes defined as a female problem located in the feminised domestic space of the family, rather than the masculinized public realm, and the solution for the anorexic girls is to 'individuate' and separate from the home and its suffocating relationships (Gremillion, 1992). Family therapy is therefore based on profoundly gendered assumptions about women's role in the family, while its ostensibly gender-neutral stance at the same time obscures the operation of gender power relations within the family unit.

Biological Theories and Treatments

Biological theories of eating disorders appear to be gaining ground in the more recent psycho-medical literature, particularly genetic theories (Schmidt, 2003), which are enjoying a more general ascendancy in medicine at the current time through the Human Genome Project (see Willis, 2002). More specifically, following the discrediting of the 'non-scientific' basis of psychoanalysis, psychiatry has found it necessary to cement its credentials as a medical science (Russell, 1995), and this in part explains the rise in biomedical theory and research within the mental health field.

Chemical/hormonal theories, those pertaining to brain structure and genetic theories have all been used to explain eating disorders, however, these are no longer as discrete as they once were. Chemical theories suggest that eating disorders reflect chemical imbalances in the body. For example, the hypothalamus has been implicated through its role in the control of appetite, satiation, sexuality and emotion, and it has

been shown that women with anorexia have abnormal levels of hypothalamic hormone (Russell, 1977). It has also been suggested that low serotonin levels may affect satiety cues in bulimia (Abraham and Llewellyn-Jones, 1992). However, these theories often suffer from problems of temporality, and Russell (1995) points to other evidence indicating that when weight is restored and the diet is nutritional, hormone levels return to normal. Certain structural changes in the brain have also been observed in individuals diagnosed with either anorexia or bulimia (Laessle et al, 1989) but, again, there is dispute as to whether these changes are the result of starvation or causal (Russell, 1995). Until recently, the observation of an increased incidence of anorexia in family members, particularly twins, provided the basis on which a genetic component to eating disorders was argued. For example, Wade et al (2000) studied the incidence of the 'phenotype' of anorexia in twins, and argue that genetic factors significantly influence risk, with 58 percent attributed to heritability. However, the statistical significance of these findings is questionable, and the authors state that they are unable to completely rule out the contribution of a shared environment (Wade et al, 2000), a chief weakness of family and twin studies.

More recently, there has been a drawing together of chemical, structural and genetic research in this area, principally through examination of the role of the neurotransmitter, serotonin, in brain function. Recent research demonstrates imbalances in serotonin in individuals with anorexia, which have also been associated with other conditions such as obsessive-compulsive disorder (Barbarich, 2002). Further to this, newer studies using brain imaging show that alterations in brain regions, specifically changed serotonin neuronal pathways, persist after recovery and it is hypothesised that these might contribute to traits such as anxiety that result in a genetic vulnerability to eating disorders (Barbarich, Kaye and Jimerson, 2003). However, other research shows that brain structures, such as changes in serotonergic function, can be altered by traumatic experiences such as child sexual abuse (Bremner et al, 2003), which is common among women diagnosed with eating disorders (Leonard, Steiger and Kao, 2003). Thus, changes to the brain present after recovery are not necessarily genetic in origin. Examination of the genome through DNA sampling represents another recent development in genetics-based research into eating disorders that also links chemical, structural and genetic theories. For example, Devlin et al (2002) studied the psychiatric, personality and temperament 'phenotypes' of anorexics and affected siblings through DNA sampling. They conclude that there are links between these phenotypes and genes, and point to serotonergic regulation as the likely genetic candidate (Devlin et al, 2002). However, there is no

examination of the genetic links between anorexics and non-affected siblings, so there is no comparison group.

Genetic research based on identification of phenotypes and DNA sampling is still relatively new, and yet to be fully evaluated. In addition, its claims are sometimes grandiose. For example, one yet to be published study by Australian researchers was reported in the press as having discovered the 'anorexia gene' (Newby, 2003). However, on closer examination, findings suggest that anorexics are twice as likely to carry a gene theorised as implicated in anxiety, but 70 per cent of the general population also carries this gene (Newby, 2003). Furthermore, unlike research into more clearly defined and observable disease entities such as diabetes, the establishment of the anorexia 'phenotype' involves extrapolating socially constructed, self-reported measures of 'invisible' psychopathology, such as 'obsessionality' (Devlin et al, 2002), to the presence of particular genes. The question of *what* the studies are measuring is therefore open to question, and the fact that 'anorexia genes' emerge into an already established psychopathological model limits understandings of their potential operation in other socio-cultural contexts.

The practical value of knowledge about whether individuals carry 'anorexia genes' remains at best unclear. Because of the lack of research into, and understanding of, the role of non-individual factors in causation, it is not clear how an eating disorder could be prevented from developing in individual identified as 'at risk' because of their genetic make-up. Most importantly, genetic research locates the causes of eating disorders as deeply internal to the individual, potentially ignoring the role of culture and context. This research cannot, therefore, answer why eating disorders are more common in women because of its exclusive focus on the question of why *individual* women become eating disordered. Moreover, Willis (2002) argues that too heavy an emphasis on genetics can deflect attention away from social aspects of causation and collective intervention, instead individualising disease and deploying biotechnology as an instrument of social control. He suggests that genetic research into 'mental illness', as well as 'homosexuality' and other areas of human behaviour, are particularly problematic because they legitimise an individualistic approach to health and illness by going beyond crude notions of 'innateness' to the notionally more sophisticated idea of 'genes' (Willis, 2002).

There are a number of psychiatric treatments for eating disorders that fit within the biological paradigm, although some, such as electro-convulsive shock therapy and brain surgery, are no longer common. Most significantly, and in line with the emphasis in recent research on the role of serotonin, there is an increasing emphasis on the use of antidepressants, particularly selective serotonin re-uptake inhibitors (SSRIs), in the treatment of eating disorders (Crow and Mitchell, 1994; Stokes and Holtz, 1997; Bacaltchuk et al, 2000). This in part reflects the view that 'depression' is reaching epidemic proportions in western societies (Clearihan, 1999). Feminists have expressed disquiet about increases in the prescription of SSRI antidepressants such as Prozac to women over the last decade (for example, Gardiner, 1995). The increased emphasis on the use of antidepressants in the treatment of eating disorders is associated with a number of potential dilemmas. Firstly, antidepressants are recommended in the absence of medium- or long-term outcome data about their efficacy in the treatment of eating disorders, and this is inconsistent with the current emphasis on evidence-based approaches in medicine (Evidence-based Medicine Working Group, 1992). While some studies report that a combination of cognitive-behavioural therapy and antidepressant therapy is the most efficacious for bulimia nervosa, these involve only short follow-up periods (for example, Bacaltchuk et al, 1999).

Secondly, there has been little attention to the issue of side effects for individuals diagnosed with eating disorders. This is despite the fact that according to the 'Mims' guide used by Australian medical practitioners for prescribing, the commonly used SSRIs are known to cause weight loss, weight gain, increased appetite and 'anorexia' (Mims Australia, 2003). It is conceivable that these side effects might be experienced as distressing by individuals already anxious about body weight and food, and may lead to additional adverse effects. There is evidence from a systematic review that the use of antidepressant medications significantly reduces the acceptability of treatment in clinical trials with eating disorder patients, increasing rates of withdrawal from treatment (Bacaltchuk et al, 1999). There has, however, been little examination of the factors leading individuals to withdraw from treatment, or the impact of this on future recovery. Lastly, without wishing to dismiss some individual's reports that antidepressants have helped them, a growing reliance on their use in treatment potentially confirms to the individual that they are indeed out of control and require externally administered solutions to their internally located illness.

Another treatment that fits within the biological model because of its exclusive focus on weight and malnutrition is nutritional re-feeding. The treatment of severely underweight anorexic patients has typically

involved some form of re-feeding, typically nasogastric feeding (NGF) (Larocca and Goodner, 1986). This involves the insertion of a tube into the stomach of the individual via the nose and the introduction of a nutritional formula or, alternatively, individuals might be fed nutrients directly into the bloodstream (Gilchrist et al, 1985). The practice of NGF has been controversial over the years both within and outside psychiatry. Vandereycken and Meeman (1984) argue that NGF has come to be seen in a similar way to electro-convulsive shock therapy as "an emotionally controversial symbol of so-called repressive psychiatry" (Vandereycken and Meeman, 1984: 92). While these authors defend the practice, NGF has been criticised on a number of specific grounds, including the idea that it is unethical because it constitutes an intrusion into patient autonomy (Lewis, 1999); is ineffective and even harmful (Lewis, 1999), and specifically leads to bulimia (Palazzoli, 1978), chronic anorexia and suicide (Dresser, 1984). It has also been suggested that that NGF has been used prematurely and punitively (Andersen, 1984). The intrusion into autonomy for individuals already defined as lacking autonomy within psycho-medical discourse clearly presents a dilemma for the psychiatry use of NGF.

Behaviourist Theory and Treatment

Behaviourist treatment for anorexia nervosa became common in the 1960s because of frustration with the long-term nature of psychoanalysis and its lack of success (Gremillion, 1992). The shorter duration of the behaviourist approach, and positive reports about its effects, made it an attractive alternative (Bemis, 1978). Within the behaviourist approach, restricting food intake is seen as a learned behaviour that is reinforced by environmental stimulants, such as attention, however, behaviourist approaches are characterised by an emphasis on the design of treatment programs, and a lack of detailed attention to theorisation (Bemis, 1978). Behaviourist treatment programs are still commonly used, in Australia and worldwide, to bring about weight gain in the treatment of anorexia nervosa (for example, Touyz, Beumont and Dunn, 1987; Gilchrist et al, 1998; Hay et al, 1998). These programs typically involve the confinement of anorexic patients to bed or to their rooms, a controlled diet, regular weighing and the use of positive and negative reinforcement based on the behaviourist theory of operant conditioning (Bemis, 1978). Within this approach, weight gain might be reinforced through increased physical activity, visiting privileges and social contact (Halmi, Powers and Cunningham, 1975), while negative reinforcement historically involved the restriction of toilet facilities and isolation (Dally, 1969).

While behavioural theory identifies the causes of anorexia nervosa as environmental, treatment responses focus exclusively on the individual who must re-learn more 'appropriate' responses (Gremillion, 1992). This is based on a very mechanistic model of human behaviour, where the mind is conceived of as little more than "a privatised, internal 'processing centre' [...] between external 'input' and behavioural 'output'" (Gremillion, 1992: 62). Most particularly, the mechanistic conceptualisation of the individual and an emphasis on the outcome of weight gain in treatment means that there is no elaboration of the meanings of eating disorder practices within this approach. While behaviourist approaches continue to be central within contemporary treatment protocols, they have been attracted criticism over the years from those who maintain that it is a simplistic approach that is dangerous (Bemis, 1978). Indeed, Bruch (1974b) documented extremely negative reactions of anorexic patients to behaviour modification programs, while Bemis (1978) points to an "officially endorsed bulimia" associated with programs that emphasise rapid weight gain, some patients later going on to become obese (Bemis, 1978: 604). Many feminists have also openly criticised treatment programs based on reward and punishment, characterising them as inhumane and controlling (see MacLeod, 1981; Lawrence, 1984), and as involving a power struggle between practitioner and patient for control (see Orbach, 1986). Since the 1970s, there is evidence of a relaxation in approach so that, for example, Touyz, Beumont and Dunn (1987) characterize their behavioural program as "lenient" and "flexible" in comparison to other more rigid treatment regimes of the 1970s (Touyz, Beumont and Dunn, 1987: 151).

Cognitive-Behavioural Psychology

Both anorexia and bulimia have been explained through ideas from cognitive-behavioural psychology. It was Bruch (1978) who first articulated the idea of ineffective thinking patterns in anorexia nervosa. As in behaviourism, the theory of causation in cognitive-behavioural theory is implicit, and is based on the assumption that anorexic and bulimic individuals have learned to think and behave in particular ways, although personality characteristics such as perfectionism, ineffectiveness and low self-esteem are also emphasised (Fairburn, Shafran and Cooper, 1999), while bulimics are particularly characterised as 'impulsive' (Penas-Lledo et al, 2002; Kaltiala-Heino et al, 2003). Also in common with behaviourism, there is a focus on how symptoms are maintained, rather than cause, within this approach, and on the development of treatment programs, rather than the development of a theoretical explanation of eating disorders. Within the cognitive-behavioural approach, anorexic and bulimic symptoms are seen as maintained by an over-valuing of body shape and weight (Fairburn, Shafran and Cooper, 1999). In

anorexia, Fairburn, Shafran and Cooper (1999) suggest that three feedback mechanisms reinforce restricted eating: control over eating enhances sense of self-control; weight loss encourages further dietary restriction; and, extreme concerns about shape and weight encourage restricted eating. In bulimia, low self-esteem is seen as leading to extreme weight and shape concerns, strict dieting, bingeing, followed by purging, which further reinforces low self-esteem and the development of a "vicious circle" (Fairburn, Marcus and Wilson, 1993; 370).

Cognitive-behavioural therapy (CBT) is particularly emphasised as the 'treatment of choice' for bulimia (Hsu et al, 2001). The approach outlined by Christopher Fairburn and colleagues has been particularly influential on practice and is widely advocated in the psycho-medical literature for the treatment of bulimia and binge eating (Fairburn et al, 1995; Fairburn, Marcus and Wilson, 1993; Waller et al, 1996) and, more recently, for anorexia nervosa as well (Fairburn, Shafran and Cooper, 1999). Fairburn, Marcus and Wilson (1993) state that CBT involves a focus on the "thoughts, beliefs and values" that maintain eating disorder practices, with a particular focus on concerns about size and shape (Fairburn, Marcus and Wilson, 1993: 365). Within this approach, the therapist needs to "persuade patients that their form of dieting is a problem", and should be "firm and authoritative" (Fairburn, Marcus and Wilson, 1993: 368-369). A central aspect of treatment includes addressing concerns about shape and weight and other "cognitive distortions" through "cognitive restructuring" (Fairburn, Marcus and Wilson, 1993: 381). This involves the self-monitoring of problematic thoughts, and the use of questioning that challenges their validity. For example, the thought "I feel fat" would be challenged with questions about whether other people would think the individual was fat, whether they are confusing "subjective impression" with "objective reality", or whether the individual is using illogical "dichotomous reasoning" (Fairburn, Marcus and Wilson, 1993: 386). Having analysed the "appropriateness of the thought", the patient then decides what is "reasonable" to think in the given context (Fairburn, Marcus and Wilson, 1993: 386). This includes demonstrating to patients where they "misperceive" the size of their body, encouraging them to defer to "the opinions of trusted others" rather than themselves (Fairburn, Marcus and Wilson, 1993: 390-391).

CBT is based on a very rationalistic approach to the individual which has no place for the concept of the unconscious, and leaves little room for exploring the meaning of eating disorder practices. This is made possible by the assumption of an objectivist ontology, which posits 'reality' to be 'out there', stable and accessible to the individual (Sarantakos, 1998). An objectivist ontology also assumes reality to be

perceived uniformly by all, and defined in one way only, because all members of a society are presumed share the same meanings (Sarantakos, 1998). Thus, eating disordered individuals' perceptions, thoughts and feelings become fundamentally *wrong* within this formulation. Furthermore, the emphasis on rational, objective thinking privileges masculinized rationality while the body and emotions, historically associated with the feminine, are relegated to the periphery in terms of their explanatory power and meaning (Jaggar, 1989). CBT is therefore premised on gendered assumptions about the superiority of masculinised rationality over feminised irrationality and emotionality. In line with the emphasis on rationality within CBT, the approach to therapy is characterised by a subtle undermining of the individual's subjectivity so that others are positioned as more rational and as having a firmer grip on reality, evidenced by the idea that other people's assessments of the individual's body size are more reliable and should be deferred to. Thus, the individual is invited to distrust the most central dimension of selfhood – the reliability of her own perceptions and experience and, instead, to see herself as others do. Ironically, over-concern with the opinions of other people is identified as central to the psychopathology of the eating disordered woman in psychodynamic conceptualisations of eating disorders.

CBT also focuses almost exclusively on the individual, giving little attention to the social context in which eating related problems develop. For example, while Fairburn and colleagues make mention of the origins of 'dysfunctional' attitudes, including "family and peers, and the role of social pressures to be thin", emphasis is placed on the individual factors that maintain the problem rather than those likely to have contributed to it (Fairburn, Marcus and Wilson, 1993: 389). Thus, cognition, emotion and behaviour are not explicitly linked with their social contexts in which they occur, producing an essentially asocial, privatised approach to the individual (Crawford et al, 1992). This dislocation of eating disorder practices from their social context is demonstrated through the suggestion that strategies to address concerns about size and shape should include encouraging patients who avoid exposure of their bodies to others to "seek out opportunities to reveal themselves", for example, by going to the swimming pool (Fairburn, Marcus and Wilson, 1993: 390). This completely fails to acknowledge the high levels of scrutiny women's bodies come under in this context, producing women's size and shape concerns as personal problems of adaptation. While CBT may provide specific techniques for 'managing' eating and body concerns, like behaviourist approaches, it does not seek to explore the meanings of food and the body, and this is because the practitioner knows, *a priori*, that they merely signify irrational thought processes.

Multidimensional Models of Eating Disorders

Within each of the above theoretical positions, eating disorders are constructed as pathological states and the causes are located within the individual. Even when it is suggested that socio-cultural factors play a role in causation, specifically the pressure on women to be thin, there is an under-theorisation of how this might occur, and the focus remains on questions of individual dysfunction. A 'biopsychosocial' theory of anorexia and bulimia, which takes a 'multidimensional' approach to causation, is widely advocated in the contemporary medical and psychological literature (Garfinkel and Garner, 1982), and has become dominant in the last two decades (Garrett, 1994). This position argues that there is no one cause of eating disorders, but that they are the result of a combination of biological, psychological and social factors (Garfinkel and Garner, 1982). Thus, the multidimensional model attempts to unite the different theoretical perspectives on eating disorders in an overarching explanatory framework. The multi-causal model of eating disorders is also reflected in multidimensional approaches to treatment in Australia and elsewhere, which commonly recommend a mixture of psychological therapy (particularly cognitive-behavioural therapy and psychotherapy); psychotropic pharmacotherapy, and in-patient re-feeding programs based on behaviour modification (Touyz et al, 1987; Gilchrist et al, 1998; Hay et al, 1998).

While a multidimensional theory of eating disorders appears to give added credence to the idea that socio-cultural context plays an important role in causation, the relationship between the individual and society is, once again, under-theorised and the focus remains on the internal psychological and physical processes of the individual (Garrett, 1994). The concept of 'risk factors' determining the likelihood of whether disease emerges is central to this approach (Krieger, 1994). While an emphasis on individual psychopathology is characteristic of psycho-medical explanations more generally, a focus on individual risk factors in contemporary multidimensional explanations is also reflective of two key limitations with multifactorial models of disease causality in particular. Firstly, multifactorial models focus on the identification of specific causal factors to enhance epidemiological research, rather than elaborate a theoretical explanation of the origins of causation (Krieger, 1994). Secondly, they "inevitably focus attention on those risk factors 'closest' to the 'outcome' under investigation", that is, the individual (Krieger, 1994: 891). For example, Leon et al (1997) argue that since culture does not identify which individuals will develop eating disorders, individual factors should be the focus. One consequence of this narrow focus on the individual is that the social realm is not addressed in any depth. In particular, the social construction of gender is ignored, and the potentially complex and dynamic realm of culture and its relationship to the

individual is reduced to simplistic and limited measurement categories such as 'age', 'sex' and 'class'. Furthermore, socio-cultural context is not perceived to be a 'true' cause of eating disorders because '[c]ulture is mediated by the psychology of the individual' (Vandereycken and Meerman, 1984: 194). This view is again based on a dualistic notion of the individual in society, where the individual pre-exists, and is separate from, the socialising effects of the wider collective (Davies, 1991). The role of socio-cultural context, then, is generally under-theorised and under-explored in this literature.

Early Feminist Theories and Therapies

In contrast to psycho-medical explanations, feminist theories of eating disorders attempt to account for the socio-cultural context of eating disorders. A number of seminal works exploring eating disorders from a feminist perspective were published in the early to mid-1980s. The most well known of these is Susie Orbach's *Hunger Strike* (Orbach, 1986), while the other feminist texts from this period include Kim Chernin's *The Hungry Self: Women, Eating and Identity* (Chernin, 1985), as well as Sheila MacLeod's (1981) *The Art of Starvation* and Marilyn Lawrence's (1984) *The Anorexic Experience*. Orbach's (1986) and Lawrence's works (1984) include a focus on feminist therapeutic intervention and, in line with the emphasis of this thesis on analysis of discourses in the context of health care intervention, it is their work that is the focus of discussion and analysis here, while the work of Chernin (1985) and MacLeod (1981) are outlined more briefly. Because more recent post-structural feminist theory on eating disorders is not explicitly linked with specific approaches to health care intervention, these texts are not examined here but are drawn on at other relevant points in the thesis.

Each of these feminist texts locates eating disorders as products of patriarchal societies and while they have different emphases, they share many features. Each account is thoughtful and sympathetic, and attempts to situate women's experiences in a wider social context, rather than focusing only on individual factors. MacLeod's (1981) and Chernin's (1985) insights are derived in part from their own experiences of anorexia. For MacLeod (1981), anorexia "is not a matter of slimming which has somehow or other got out of hand" but, like other "psychoneurotic syndromes", anorexia is "a positive strategy aimed at establishing autonomy and resolving what would otherwise be unbearable conflicts" (MacLeod, 1984: 10-11). This is situated against the backdrop of a society in which women are devalued and used as commodities, but where it is hypocritically claimed that they are equal (MacLeod, 1981). Drawing on the identity theory of Erikson (1968), MacLeod (1981) asserts that the development of a complete adult identity involves the

development of autonomy. MacLeod (1981) argues that anorexia becomes a metaphor for the autonomous identity that the individual lacks because others, particularly family, have controlled them. She specifically places an emphasis on the negative meanings attached to the beginning of menstruation and female pubertal development as a trigger (MacLeod, 1981). She characterises anorexia as a largely unconscious form of "passive resistance", a symbol that the only thing owned and controlled by the individual is her body, and a rejection of womanhood as passivity and loss of self in the face of the demands of others (MacLeod, 1981: 66). Chernin (1985) also sees eating disorders as reflective of the struggle for female identity in the face of social changes that have extended women's role. In particular, she focuses on the mother-daughter relationship, and the way that daughters are required to "surpass" their mothers in contemporary western society (Chernin 1985: xi). She draws on psychoanalytic ideas of the early mother-child relationship to argue that food comes to be symbolic of the child's feelings of both rage and guilt at the mother, preventing women from truly individuating (Chernin, 1985).

Based on her work as a psychiatric social worker with anorexic women, Lawrence argues that the need for control over eating and the body is tied to "a sense of a lack of control in other areas of life", situating this against the backdrop of changes to women's role and the difficulties of being both successful and feminine (Lawrence, 1984: 22). Anorexia is seen as protective, involving the creation of a "false self" that protects the vulnerable "true self". The thin anorexic body is paradoxically seen as projecting the idea of self-control and success, and the sub-text of worthlessness and weightlessness, denying and masking the individual's true needs (Lawrence, 1984). Lawrence (1984) also draws on ideas very similar to those of Bruch (1978) and Crisp (1980) when she suggests that the emergence of anorexia at adolescence reflects a struggle for identity, autonomy and independence with which the individual is unable to cope because of a family background encouraging compliance and self-denial (Lawrence, 1984). However, unlike psycho-medical theories, there is an acknowledgement by Lawrence that girls in general are expected to be compliant and obedient, so that these behaviours are normalised rather than pathologised (Lawrence, 1984). While Lawrence claims to be cautious about avoiding mother-blame, though, she nevertheless adopts Bruch's (1978) theory about inappropriate feeding by mothers as central to the genesis of anorexia (Lawrence, 1984). The aim of psychotherapy is for women to discover themselves and their needs, where the therapist provides opportunities for examination of feelings. Traditional psychotherapies that involve interpretation by practitioners are seen as damaging because they tell women what is 'wrong' with them

and who they are (Lawrence, 1984). Because anorexia is understood as a quest for autonomy and a cover for a lack of identity, Lawrence (1984) argues that such interpretations will be rejected.

Orbach's (1986) work developed from, and informed, her practice as a feminist psychotherapist at the well known Women's Therapy Centre in London, which she and Lawrence co-founded. Anorexia is defined by Orbach as "an expression of a woman's confusion about how much space she may take up in the world", where control of the body is symbolic of emotional neediness (Orbach, 1986: 14). Thus, anorexia involves a negation of a self who is "needy, hungry, angry, yearning" and replacing this self with someone more acceptable, while deriving strength from ignoring these needs (Orbach, 1986: 14). Orbach (1986) suggests that the smaller female body size was proposed at the same time as women were demanding more space in the world, so that their concerns were deflected into body maintenance. Anorexia is set against the backdrop of western consumerism, where the female body is an object of "alienation, fascination and desire" and, for women, the object with which they negotiate the world (Orbach, 1986: 36). Because of this, women are understood not to have an "unmediated or purely physical relation to their bodies" (Orbach, 1986: 36).

Orbach (1986) focuses on the mother-daughter relationship and argues that raising daughters is presented as inevitably ambivalent for mothers because it involves educating them to also live "a circumscribed life in patriarchy" (Orbach, 1986: 43). Orbach (1986) argues that because contemporary young women must learn self-denial, they do not develop "an authentic sense of their needs or a feeling of entitlement for their desires" resulting in "a shaky sense of self" (Orbach, 1986: 43). She uses object-relations to describe how individuals gain a corporeal sense of self, beginning with the recognition that the mother is separate from oneself. Because of mothers' ambivalence towards daughters, feeding is not so responsive to their needs and, as in Bruch's thesis, internal hunger cues come to be misinterpreted (Orbach, 1986). When girls reach adolescence, their "struggle for an identity separate from the family is made of fairly shaky foundations" because dependency needs conflict with the wish for separation, and widely promoted dieting and body control become attractive solutions (Orbach, 1986: 46). Like MacLeod's (1981) idea of resistance, Orbach sees food refusal as an unconscious protest, a 'hunger strike' that is a symbolic language for a needless self that is a solution to "being in a world from which at the most profound level one feels excluded" (Orbach, 1986: 103). While focusing on anorexia, Orbach (1986) also

gives some attention to bulimia, describing bingeing as the use of food to repress feelings, and purging as a way of cleansing oneself of feeling and therefore a defence against buried problems.

The aims of therapy are described as creating an understanding of food refusal, focusing on the body, and recommencing self-development (Orbach, 1986). The approach involves acknowledging the woman as "the keeper of her food" rather than taking control away, thus, there is not a focus on weight gain but on understanding the meaning of food refusal as "the gagging of desire" more generally (Orbach, 1986: 140-141). In focusing on the body, there is the goal of gaining a sense of the body "as an integrated aspect of self" rather than an object of self-hatred and control (Orbach, 1986: 149). The development of self in therapy involves the re-starting of "nurturance" of the "embryonic self behind the defence structure" by relating to the more developed cognitive abilities of the person as a way of accessing the hidden inner self that is frightened of losing control (Orbach, 1986). Through this process, the woman "achieves a psychosomatic unity" because "she can give and receive from a position of having" (Orbach, 1986: 165) and "becomes a person with legitimate desires and demands which she can now openly express" (Orbach, 1986: 180). Orbach (1986) also argues that political struggle is necessary to change the social structure that produces eating disorders, although the focus of her discussion is upon individual psychotherapy.

While these early feminist accounts utilise the psychodynamic idea of anorexia as an attempt to forge an autonomous identity, they attempt to place the dilemmas faced by girls in achieving autonomy in the context of wider patriarchal gender relations. Thus, female psychology is understood as socially created and gendered, rather than as a gender-neutral process of development. However, early feminist theorisations nevertheless retain a male-defined notion of the ideal self as autonomous and self-contained. Thus, while there is acknowledgement of the inherently gendered nature of experience, the aim of the works is to explain why women *fail* to reach a masculinized ideal of selfhood in patriarchal culture. While patriarchal culture is ultimately to blame, psychosocial experiences leave women in general, and anorexic women in particular, intrinsically lacking and deficient. Without eliding their many important insights into some of the gendered meanings of female practices of body management, because these authors retain ideas from psychoanalytics and psychodynamics, a feminist understanding is simply overlaid onto theories that are based on gendered assumptions about selfhood (MacSween, 1993). Thus, characteristics such as connection to others remain forms of weakness and vulnerability that carry with

them potentially catastrophic results. Furthermore, as is argued by MacSween (1993), the ideal of achieving through therapy a body that is a self-contained psychosomatic unity is a masculinized one. Thus, only women's psychology is socially constructed in these early feminist theorisations, while "the masculine self remains the invisible and unanalysed standard against which the 'problems' of the insecure female self are measured" (MacSween, 1993: 85). Orbach (1986), Chernin (1985) and Lawrence (1984) also centre the role of mothers in the genesis of anorexia. This reflects the psychoanalytic and psychodynamic underpinnings of these accounts, which place a premium on the role of the mother-child dyad in development. While these feminist readings position mothering within a gendered social context, like psycho-medical accounts, they nevertheless result in laying a certain amount of blame at the feet of mothers as the prime source of gendered deficiencies of identity in adulthood.

Orbach's (1986) and Lawrence's (1984) approaches to psychotherapy differ in important respects to dominant psycho-medical interventions with their emphasis on providing space for women's own interpretations of their feelings and behaviour, and the avoidance of attempts at controlling women and their weight. However, because of the retention of a masculinized concept of selfhood, women are nevertheless encouraged to see themselves as needy and deficient in important respects, albeit in a more understanding way that takes account of the socio-cultural factors that impact on their lives. Therapy becomes, then, an attempt to resolve a problem that is conceived of as a gendered identity problem based on similarly gendered assumptions about identity and selfhood.

Narrative Therapy

More recently, there has been a growing interest in narrative therapy as an alternative form of therapeutic intervention among some health care workers, particularly women's health workers and social workers. The approach of White and Epston (1989) has been specifically utilised by practitioners working with women experiencing eating disorders (see Epston and White, 1992). White and Epston (1989) utilise the idea of 'stories' or 'narratives' around which individuals organise their lives, that give meaning to their experiences and through which they interact with others. People are understood to experience problems and seek help "when the narratives in which they are 'storying' their experience....do not sufficiently represent their lived experience" because much of it contradicts the "dominant narratives" (White and Epston, 1989: 22). White and Epston (1989) draw on the Foucauldian concept of power as productive, as inseparably tied up with knowledge and as producing truth. In particular, they adopt the Foucauldian idea

of the normalising judgement of modern power to explain individuals' engagement in their own subjugation (White and Epston, 1989). They also utilise the idea of "subjugated knowledges" that are "exiled from the legitimate domain of the formal knowledges" whose "insurrection" can provide a platform for resistance to dominant discourses and their power/knowledge effects (White and Epston, 1989: 30-31). These ideas are brought to the therapeutic 'conversation' by encouraging individuals in the identification of the "truth discourses" that are subjugating them, and by "resurrecting the subjugated knowledges" about the person and instances where they have resisted subjugation (White and Epston, 1989: 34).

As mentioned above, White and Epston have utilised the narrative therapy approach with a host of different problems faced by individuals, including eating disorders (Epston and White, 1992). In one case vignette, White (1992) describes working with a young woman to externalise the problem, so that it is 'anorexia' that has her comparing herself to others, isolating her from others and "requiring her to watch over herself" (White, 1992: 113), recognising the Foucauldian concept of self-surveillance in anorexia nervosa. It also had her "engaging in operations on her own body, attempting to forge it into a shape that might be considered acceptable – a 'docile body'" (White, 1992: 114). White (1992) describes a process of working with a young woman to identify the way she was "recruited" into such practices, the woman herself identifying family, cultural and social influences, where 'anorexia' comes to be seen as the "embodiment" of these (White, 1992: 114). Thus, 'anorexia' is "unmasked" through therapy, and there is a focus on identifying "resistance" where, in this particular case, the young woman behaved in ways that were "anti-anorectic" and these came to be the preferred version of herself and more available to her through the process of therapy (White, 1992: 114).

Clearly, the narrative approach to working with women with eating disorders is markedly different from psycho-medical approaches, as well as early feminist therapies, with its embrace of post-structural ideas of the production of subjectivity in language, and its eschewing of humanist assumptions of selfhood. As such, it is the only practice approach that is not based on a reification of masculinized notions of selfhood. It is also the only approach that attempts to draw the socio-cultural influences on subjectivity into the therapeutic process, rather than focus only on the individual and the intrapsychic. This approach therefore offers some potential for addressing the gendered nature of the experience of eating disorders at the level of individual intervention, and its possibilities in this regard are examined later in interviews with health workers utilising a narrative approach in practice.

Summary

This chapter has mapped the dominant contemporary approaches to eating disorders outlined in the therapeutic literature, paying particular attention to the gendered nature of many of the theoretical concepts used, and the gendered contradictions which result when conflicted notions of selfhood that idealise the 'masculine' and pathologies the 'feminine' are applied to eating disordered women. The chapter also points to the individualising tendencies of psycho-medical theories and the individual-society dualism that underpins this. While early feminist approaches extend understandings to include an awareness of the socially constructed, gendered nature of women's psychology, their reliance on psychoanalytic and psychodynamic theories results in an uncritical retention of masculinized notions of idealised selfhood and a continued emphasis on the intrapsychic rather than the social, both in theory and practice. Only the newer narrative therapies, based on post-structural ideas of the socially constructed nature of subjectivity in language, offer conceptualisations that potentially avoid the gendered contradictions structuring other approaches. However, like all the practice approaches documented in this chapter, they also tend to focus on the individual level of intervention. The following chapter examines approaches to the prevention of eating disorders, paying particular attention to those that attempt to challenge the social conditions thought to give rise to eating disorders.

Chapter 3

Mapping Approaches to the Prevention of Eating Disorders

Introduction

Despite the historical emphasis on treatment in this area, the prevention of eating disorders has received increasing attention over the past two decades (for example, Hsu, 1996; Huon, 1994; Shisslak et al, 1987; Striegel-Moore and Steiner-Adair, 1998; Vandereycken and Meerman, 1984). Attention to the question of prevention is important because treatment outcomes in this area are relatively poor (Schoemaker, 1998; Ben-Tovim et al, 2001), and eating disorders have significant short- and long-term consequences for the physical and mental health of individuals (Rosen and Neumark-Sztainer, 1998). While many argue that eating disorders are preventable because socio-cultural factors and related dieting practices are implicated in causation (Button and Whitehouse, 1981; Katz, 1985; Levine and Smolak, 1998; Shisslak et al, 1987; Striegel-Moore and Steiner-Adair, 1998), there has been little critical examination of current practice approaches to prevention.

Two main approaches to the prevention of eating disorders can be identified in the literature, the first focusing on secondary prevention through early detection and intervention, the second addressing primary prevention through the application of the theories and practices of health education and health promotion. This chapter examines both levels of prevention in terms of the extent to which they offer alternative practice approaches, their implications for the construction of gender and the extent to which they engage with the socio-cultural, rather than individual, aspects of eating disorders.

Early Detection and Intervention: Prevention as Surveillance and Control

There is a heavy emphasis on the importance of early detection and intervention in the literature addressing the prevention of eating disorders. In common with the therapeutic literature in this area, a multidimensional model of cause is also widely proposed (for example, Crisp, 1979; Vandereycken and Meerman, 1984), and the tendency to focus on individual factors to the exclusion of social factors also persists. For example, in their discussion of the possibilities for the prevention of eating disorders, Vandereycken and Meerman (1984) propose a multidimensional model of eating disorders that essentially focuses on psychopathological factors in the individual (Vandereycken and Meerman, 1984). The idea that anorexia nervosa is socially caused by "the culture of slenderness" is rejected and it is argued that

anorexic patients “display essential psychological differences”, limiting food intake “to gain a sense of psychological organisation and self-control” (Vandereycken and Meerman, 1984: 193). Thus, psychodynamic ideas about deficient identity and control clearly inform the authors’ understandings of anorexia nervosa. It is concluded that since it appears “almost impossible for health care professionals to change [...] socio-cultural influences”, preventive measures should be directed at the identification of individual risk factors and the early recognition of individuals at risk (Vandereycken and Meerman, 1984: 196).

Risk factor research on eating disorders ostensibly addresses the issue of prevention, particularly early intervention, and here again there is a focus on individual factors. Research into the development of measurement instruments to assess the psychological and behavioural features of eating disorders, such as the Eating Attitudes Test (EAT; Garner and Garfinkel, 1979) and the Eating Disorders Inventory (EDI, Garner, Olmstead, and Polivy, 1983) are seen as having the potential to identify individuals at risk of, or in the early stages of, eating disorders (Vandereycken and Meerman, 1984, Garner, Olmstead and Polivy, 1983; Garner et al, 1987; Vandereycken, 1992; Black and Wilson, 1996; Wade et al, 1997). While multidimensional models of eating disorders are usually subscribed to, there is an emphasis on measuring individual psychopathology, rather than other pre-disposing factors. For example, the EDI is described as “a multidimensional inventory for anorexia nervosa and bulimia”, however, it focuses on measuring psychopathological constructs such as “perfectionism” and “ineffectiveness” (Garner, Olmstead and Polivy, 1983: 15). Other research in this area is also distinguished by a preoccupation with identifying individual factors (for example, Leon et al, 1997, Leung, Geller and Katzman, 1996). Leon et al (1997) define risk factors as “personality, attitudinal, biological, family, cultural and other features impinging on the individual” (Leon et al, 1997: 405). However, it is argued that while exposure to general cultural factors play a role in the development of eating disorders, culture “does not specifically identify which adolescent will develop an eating disorder”, and the authors emphasise the importance of personality characteristics such as negative self-esteem (Leon et al, 1997: 405). While risk factor research is often presented as relevant to both primary and secondary prevention, its emphasis on the identification of intrapsychic factors in individuals inevitably lends itself to the latter.

Numerous authors advocate the use of screening instruments to identify individuals at risk of eating disorders (Vandereycken and Meerman, 1984; Garner et al, 1987; Vandereycken, 1992; Black and

Wilson, 1996; Wade et al, 1997), and others emphasize the need for health care practitioners to screen patients for eating disorders as a routine part of consultations (Freund, 1993; Melve and Baerheim, 1994; Muscari, 1998; Vandereycken and Meerman, 1984; Wilhelm and Clarke, 1998). For example, Vandereycken and Meerman (1984) recommend the use of a clinical interview involving parents, spouses and friends in addition to the potential patient, while Muscari (1998) suggests taking a history of frequency of weighing practices, anxiety levels regarding weight, dieting practices, and making an assessment of "psychological manifestations" such as perfectionism and depression (Muscari, 1998: 24). Freund et al (1993) suggest that primary care practitioners screen women as part of taking a routine medical history by asking questions about satisfaction with eating patterns and secretive eating.

Despite the fact that it is widely advocated, early detection through the different forms of screening is also presented as difficult. For example, in discussing early recognition by health care professionals, Crisp (1979) suggests that "the person concerned, for whom [the eating disorder] is adaptive, will conceal it so far as she (and occasionally he) is able" (Crisp, 1979: 394). Crisp (1979) clearly employs his psychobiological theory of anorexia in his perception of the eating disorders as adaptive and therefore likely to be denied. Vandereycken and Meerman (1984) identify barriers to early detection and intervention in the form of patients who "frequently conceal their aberrant eating behaviour", who "frankly deny the symptoms", and those cases whereby "the surreptitious anorectic or bulimic vomiter is unveiled by the dentist" (Vandereycken and Meerman, 1984: 199-200). Interviewing parents and spouses is recommended to identify cases and overcome the problem of denial (Vandereycken and Meerman, 1984). In these examples, the chief barriers to early detection are seen to reside with the eating disordered individual themselves. A more compassionate approach to early detection in primary care is presented by Noordenbos (1998). She emphasizes that negative attitudes of health care professionals towards patients with eating disorders, gender differences between practitioners and patients and inadequate intervention on the part of practitioners contribute to individuals' unwillingness to discuss their eating behaviour (Noordenbos, 1998). Schoemaker (1998) argues that the value of screening in schools "may be seriously damaged by denial, non-attendance, and refusal to do an interview' on the part of young women (Schoemaker, 1998: 200). On this point, Rathner (1992) recommends not announcing the day of screening in schools to prevent "selective absenteeism", as well as cross-validation of information with third parties such as relatives, GPs and hospital records (Rathner, 1992, cited in Schoemaker, 1998: 300).

While "denial" and "refusal to do an interview" are presented as potentially undermining the value of early detection efforts, the possibility that screening may be experienced as an unwelcome intrusion into privacy by women and girls is not addressed. In fact none of the literature advocating the early detection of eating disorders addresses potential ethical dilemmas associated with screening. The ethics of undertaking unsolicited population screening with young women and girls in schools, or the practice of questioning patients about conditions and behaviours other than those for which they have attended a health service, or questioning third parties about eating practices, are not examined. Instead, women and girls are positioned as subjects of surveillance, and difficulties are usually seen as arising from their 'resistance' to the efforts of health care practitioners to help them, rather than from the health care workers' approach or the intrusiveness of the method. This has some thematic similarities with the way in which anorexic patients become the subjects of surveillance in eating disorder treatment clinics where weight gain is the goal of treatment, often creating antagonist relationships between patients and health care workers (Hepworth, 1999). In a similar vein, employing surveillance in the prevention of eating disorders is likely to be experienced as invasive and controlling, and is therefore likely to be counter-productive.

While early intervention is generally recommended for individuals at risk of, or in the early stages of, an eating disorder, there is no discussion in the literature of what this intervention should entail. It is implicitly assumed, therefore, that early intervention should involve the provision of conventional psychiatric treatments commonly used for eating disorders. There is, however, little evidence that psychiatric treatment is beneficial in bringing about recovery from an eating disorder, irrespective of whether it is offered early or not, recovery being largely due to 'patient variables' such as age of onset (Schoemaker, 1997). Thus, the premise on which early intervention is based, that is, that it maximises the effectiveness of treatment, is not substantiated. Advocating the extension of interventions with no demonstrated benefits to a wider section of the female population therefore represents a major ethical and practical dilemma.

In summary, conceptualising the prevention of eating disorders as early detection and intervention with 'at risk' individuals leads somewhat inevitably to the conceptualisation of prevention as the early identification of psychopathological vulnerability and the provision of psychiatric treatment. This reproduces psychopathological explanations of eating disorders within the realm of prevention, and potentially extends the gendered contradictions around autonomy and control identified in dominant therapeutic interventions in the previous chapter to a wider population of women. Early detection is also structured

around techniques of surveillance, where ethical questions about invading individual autonomy are left unexplored, and efforts are therefore likely to be counter-productive.

Primary Prevention of Eating Disorders

Socio-cultural Explanations and Body Image Dissatisfaction

Literature addressing the primary prevention of eating disorders is more explicitly based on the view that eating disorders are preventable because socio-cultural factors and related dieting practices are implicated in causation (Button and Whitehouse, 1981; Katz, 1985; Levine and Smolak, 1998; Shisslak et al, 1987; Striegel-Moore and Steiner-Adair, 1998). In particular, socio-cultural explanations emphasise the idea that the marketing of the thin female body ideal in western cultures has contributed to widespread 'body image dissatisfaction' and dieting practices among women, which are seen as constituting a backdrop for the development of eating disorders (Thompson, 1992; Wade et al, 1996; Silverstein and Perdue, 1986). It has been well established that dieting is often a precursor to the development of eating disorders (Patton et al, 1990; Sundot, 1994; Huon, 1994). Patton, Johnson-Sabine and Wood (1990) estimate that women who diet are eight times more likely to develop an eating disorder.

Many studies report body dissatisfaction among women as extremely high. For example, in an Australian study by Wade et al (1996), 43 per cent of women reported concerns about their weight or shape, and in another by Tiggeman and Pennington (1990) it is suggested that up to 56 per cent of women are dissatisfied with their bodies. A study by Paxton et al (1991) states that up to 76 per cent of high school girls reported a thinner ideal than their current body size, and that 35 per cent are very much preoccupied with their weight. On the basis of figures such as these, it has been argued that 'feelings of fatness' predominate among women, regardless of their actual weight (Ben-Tovim and Walker, 1991). Involvement in dieting and other forms of weight control are also reported to be high among women in western societies. For example, Wade et al (1996) estimate that one-third of Australian women have used binge-dieting, vomiting and diet pills. Numerous other studies also suggest that weight loss practices such as fasting, binge-dieting and purging are widespread among women (Chesters, 1994; Jacobovits et al, 1977; Mintz and Betz, 1988), with some even referring to such practices as 'normative' in women and girls (Polivy and Herman, 1987).

In the face of reports that body dissatisfaction and dieting are common among women in Western societies, and that these often precede the development of eating disorders, several authors have suggested that a 'continuum' of disordered eating exists, with clinical eating disorders at one end and 'normal' concerns with food and weight at the other (for example, Nylander, 1971). While many others do not accept this conceptualisation because eating disorders are seen as involving distinctive personal psychopathology (for example, Bruch, 1978; Polivy and Herman, 1987), 'normal' dieting and body dissatisfaction are still often understood as likely to be causally linked and therefore relevant to the question of prevention (Polivy and Herman, 1987).

Within socio-cultural explanations of eating disorders, there is a particular emphasis on the concept of 'body image' and how this is negatively affected by the promotion of the thin body ideal for women. 'Body image' has been theorised as the mental picture the individual holds of their body, involving perception, judgements about size, shape, weight and other aspects of appearance, an emotional response to these judgements (for example, satisfaction/dissatisfaction) and behavioural components such as dietary restraint (O'Dea, 1995). Thus, body image is generally presented as involving an internal mental representation that has perceptual, cognitive, emotional and behavioural elements, and this is essentially a cognitive-behavioural theorisation. Numerous studies demonstrate that idealisations of thinness in women have become increasingly prevalent in western societies (Garner and Garfinkel, 1980; Silverstein, Peterson and Perdue, 1986). Garner et al (1980) compared the sizes of *Playboy* models and Miss America contestants during the 20-year period from 1959 to 1978, finding that both groups significantly decreased in weight over this period. Silverstein, Peterson and Perdue (1986) found that while the women's magazines in their survey sample contained ninety-six articles about body shape or size, there were only eight in the men's magazines. Because the female body ideal has become increasingly thin over the past three decades, it is theorised that many women and girls came to hold inaccurate pictures of bodies as larger than they actually are (Crisp and Kalucy, 1974; Casper et al., 1979; Button, Fransella and Slade, 1977; Ben-Tovim, Whitehead and Crisp, 1979; Probst et al, 1992).

The idea of 'distorted body image' has a long history in the psychiatric and psychological literature. It has been widely argued that anorexics and bulimics have distorted perceptions of their bodies, because of the observation that they over-estimate their weight (for example, Halmi, 1983; Mizes, 1988; Gardner and Bokenkamp, 1996; Cachelin et al, 1997). In the earlier literature, this was discussed as a defect related to

cognitive and perceptual development (Halmi, 1983). However, 'perceptual distortion' has come to be seen as associated with 'affective factors', that is, that body dissatisfaction causes over-estimation of weight (for example, Gardner and Bokenkamp, 1986). The findings of research studies into body image distortion are notoriously contradictory, with some suggesting it is more common in eating disordered individuals (Slade and Russell, 1973; Garner and Garfinkel, 1981; Horne, Van Vactor and Emerson, 1991), while others report that body image distortion is also present in non-eating disordered individuals (Crisp and Kalucy, 1974; Casper et al., 1979; Button, Fransella and Slade, 1977; Ben-Tovim, Whitehead and Crisp, 1979; Probst et al, 1992). Indeed, it has been reported that 'normal' women sometimes overestimate their body size more than women with anorexia (Casper et al, 1979; Button Fransella and Slade, 1977), while others argue that body image distortion has become a normative feature of the female population (Powers and Erickson, 1986, cited in O'Dea, 1995). When body image distortion is discussed in this way, the causes are generally held to be socio-cultural, that is, the result of the promulgation of a thin ideal for women in western culture rather than individual psychopathology. Nevertheless, women's perceptions are construed as 'inaccurate' and the argument can be made that this, to some extent, pathologises most of the female population as having 'cognitive dysfunction'. Indeed, there have been calls for the creation of the new psychiatric diagnostic condition 'body image disorder' to be included in the DSM (Thompson, 1992). This represents an as yet unsuccessful attempt to formally medicalise a phenomenon that is poorly understood within psycho-medicine, is commonly reported among women, and is widely understood as having a social aetiology. As is argued by Gremillion (1992), what is forgotten when self-perceptions of body size are labelled 'deluded' or 'inaccurate' is that contemporary western culture stresses extreme thinness for women. In this context, almost every female body is 'too fat' (Gremillion, 1992).

While socio-cultural explanations of eating disorders and body image dissatisfaction look to influences outside the individual, in contrast to the intra-psychic focus of psycho-medical discourse, they nevertheless offer a fairly deterministic view of women's subjectivities. Thus, women are produced as relatively passive subjects - the end products of cultural processes and victims of unrealistic ideals - where the relation between the individual and society is conceived as one-directional, rather than dynamic and interrelated. While eating problems and body image dissatisfaction are normalised within this approach, in common with pathologising discourses, women are nevertheless constructed as essentially non-agentic in the pursuit of thinness. Also, because socio-cultural factors are only narrowly conceived of

as the promotion of the thin female body ideal, other gendered aspects of experience are not considered. Furthermore, as was argued in Chapter 2, a cognitive-behavioural theorisation of eating disorders is based on a masculinised view of human functioning that reifies rationality at the expense of other aspects of experience, particularly the emotions. This makes it possible to construct body image dissatisfaction and associated eating practices as feminised problems of irrationality, with women's perceptions, thoughts and feelings again characterised as fundamentally and objectively wrong, even when their socio-cultural origins are acknowledged. The following section examines the way in which body image dissatisfaction and eating disorders are addressed in primary prevention practice, in particular, the extent to which the socio-cultural level of intervention and the gendered aspects of eating disorders are addressed.

Health Education and Health Promotion

Literature addressing the primary prevention of eating disorders largely focuses on the application of health education and health promotion theory and practice. There has been a long history of reliance by health practitioners on education strategies to increase knowledge and change behaviour in order to improve public health (Green and Raeburn, 1990). The concept of health promotion developed out of the World Health Organization during the mid-1980s, and the Ottawa Charter on Health Promotion (World Health Organization, 1986) attempted to broaden the base of health education to a more political approach by focusing on policy rather than individual behaviour, the social determinants of health problems, empowerment of individuals and communities and participatory approaches to health care (World Health Organization, 1986).

The larger proportion of the literature on the primary prevention of eating disorders focuses on the development of health education programs in school settings (Shisslak, Crago and Neal, 1990; Killen et al, 1993; Paxton, 1993). An article by Shisslak et al (1987) represents one of the earliest attempts to explore the possibilities for the primary prevention of eating disorders, and focuses on the possibilities for school-based education with adolescent girls. In common with the wider eating disorder literature, a risk factor approach based on a multidimensional model of causality is used. However, young women with eating disorders are contrasted with other young women "who master the challenges of maturation by developing a sense of identity" (Shisslak et al, 1987: 663). In line with the view promoted by the psychobiological model and psychodynamics, young women with eating disorders are seen as having failed to achieve the tasks of maturation, and preventive intervention is therefore conceptualised as

training in schools to increase body awareness and feelings of self-worth, using information provision and group discussion (Shisslak et al, 1987: 663). While modifying socio-cultural influences in the form of the pressure on women to be thin is presented as central to, and synonymous with, primary prevention, there is nevertheless a focus on changing individuals' knowledge, attitudes and behaviours in line with a cognitive-behavioural model of human behaviour (Shisslak et al, 1987).

A systematic search of the international literature revealed that nine health education programs have been undertaken and evaluated in the USA, UK, Australia, and the Netherlands similar to the theoretical one outlined above. The aims of the different programs, which are outlined in Table 1, are expressed in terms of one or more of the key cognitive-behavioural constructs of knowledge, attitudes and behaviour.

TABLE 1
AIMS OF SCHOOL-BASED HEALTH EDUCATION PROGRAMS

AIM	AUTHORS
Increasing knowledge	Shisslak, Crago and Neal (1990); Moriarty, Shore and Maxim (1990); Moreno and Thelen (1993); Carter et al (1997); Stewart (1998)
Modifying attitudes	Moriarty, Shore and Maxim (1990); Killen et al (1993); Moreno and Thelen (1993); Carter et al (1997); Stewart (1998)
Reducing unhealthy weight loss behaviors such as dieting	Rosen (1989); Killen et al (1993); Carter et al (1997); Smolak, Levine and Schermer (1998); Stewart (1998)
Reducing low body image/body dissatisfaction	Paxton (1993); Smolak, Levine and Schermer (1998)
Reducing disordered eating	Paxton (1993)

The majority of these programs were undertaken with adolescent girls in secondary schools, while one was undertaken with younger school children (aged 6-11 years) (Smolak, Levine and Schermer, 1998). The number of sessions ranged from one to eighteen, most programs involved between 80 to 200 students, and the majority were implemented with whole classes of students, rather than 'high risk' individuals only. The content of the different programs is similar, and a table outlining the different topics

included in each program is presented in Table 2. All programs used a combination of lecture/information-giving, discussion and role-play.

TABLE 2
CONTENT OF SCHOOL-BASED HEALTH EDUCATION PROGRAMS

<i>Healthy/unhealthy weight control</i> (Paxton, 1993), dieting (Smolak, Levine and Schermer, 1998; Stewart, 1998)	<i>Socio-cultural attitudes and influences</i> (Moriarty, Shore and Maxim, 1990; Moreno and Thelen, 1993; Carter et al, 1997; Stewart, 1998)
<i>Healthy eating behaviour and/or exercise</i> (Killen et al, 1993; Moreno and Thelen, 1993; Paxton, 1993; Carter et al, 1997; Smolak, Levine and Schermer, 1998)	<i>Information about eating disorders</i> Moriarty, Shore and Maxim, 1990; Shisslak, Crago and Neal, 1990; Moreno and Thelen, 1993; Moreno and Thelen, 1993; Carter et al, 1997; Stewart, 1998)
<i>Physical changes of puberty</i> (Rosen, 1989)	<i>Adverse comments about shape and weight</i> (Stewart, 1998)
<i>Developmental challenges for girls</i> (Stewart, 1998)	<i>Seeking help for eating disorders</i> (Carter et al, 1997; Stewart, 1998)
<i>Body image</i> (Rosen, 1989; Smolak, Levine and Schermer, 1998)	<i>Ways to resist peer pressure to diet</i> (Moreno, Shore and Maxim, 1990)
<i>Negative effects of unhealthy weight regulation/dieting</i> (Killen et al, 1993; Moriarty, Shore and Maxim, 1990)	<i>Ways to resist pressure to diet</i> (Carter et al, 1997)
<i>Emotional eating</i> (Paxton, 1993)	<i>Beauty ideals</i> (Paxton, 1993)
<i>Negative thinking</i> (Stewart, 1998)	<i>Skill development to resist socio-cultural pressures</i> (Killen et al, 1993)
<i>Responses to stress</i> (Stewart, 1998)	<i>Nutrition</i> (Smolak, Levine and Schermer, 1998)

A multi-dimensional approach to the aetiology of eating disorders is almost universal in reports of these programs (for example, Killen et al, 1993; Stewart, 1998; Smolak, Levine and Schermer, 1998). Most programs also draw upon a cognitive-behavioural model of individual behaviour that is characteristic of a health education approach. Moreover, a number of authors argue that they use a cognitive-behavioural approach because it is efficacious in the treatment of eating disorders (Carter et al, 1997; Stewart, 1998; Smolak, Levine and Schermer, 1998). In line with this, Carter et al (1997) teach students about the

"cognitive account" of eating disorders and their maintenance, and how to challenge negative thoughts about their bodies (Carter et al, 1997: 168), while Stewart (1998) emphasises the need to address cognitive distortions.

While there is some emphasis on the importance of the socio-cultural aspects of eating disorders in the preventive schools programs, these are largely conceived of in narrow terms as the pressure on women to be thin (Killen, 1993; Smolak, Levine and Schermer, 1998; Stewart, 1998). Furthermore, strategies to address the socio-cultural aspects of eating disorders are not developed in practice. For example, while Smolak, Levine and Schermer (1998) describe eating disorders as "primarily socio-culturally rooted", and the cognitions and behaviours associated with eating disorders as "acquired", they also argue that prevention programs in schools "could not reverse major social trends" such as sexism (Smolak, Levine and Schermer, 1998: 163). Socio-cultural factors are therefore situated outside the scope of primary prevention and, in line with the emphasis on individual factors within the multidimensional causal framework, there is a focus in practice on the individual psychological constructs of knowledge, attitudes and behaviour.

Another major dilemma with the application of a health education model to the prevention of eating disorders is that this approach has been shown to be ineffective. For example, while school-based health education programs report increases in knowledge, they do not necessarily demonstrate a concomitant decrease in risk behaviours such as dieting (Killen et al, 1993). Furthermore, many have expressed concern over reports of increases in body dissatisfaction and dieting following the implementation of health education program such as these, and this is often presented as evidence of the fact that attempts at the primary prevention of eating disorders are potentially dangerous (Carter et al, 1997; Mann et al, 1997; Paxton, 1993). For example, Carter et al (1997) report that at six months follow-up they observed an increase in dietary restraint, leading them to suggest that prevention might "do more harm than good" (Carter et al, 1997: 167). Mann et al (1997) undertook a prevention program with tertiary students in a college setting and report that, at follow-up, participants in the intervention group had slightly more symptoms of eating disorders than controls, concluding that the program may have "inadvertently normalised" eating disorders (Mann et al, 1997: 215).

On the basis of these negative results, some authors caution against being overly optimistic about the possibilities for the prevention of eating disorders (for example, Smolak, Levine and Schemer, 1998). However, what all of these health education programs have in common is an exclusive focus on educating *individuals*, with little attention to the socio-cultural context in which behaviour occurs. Only a minority of programs address the issue of the culture in the school itself (Paxton, 1993; Stewart, 1998), while none involve strategies outside the school context. When the individual is treated as distinct from their social context, behaviour is treated as if it occurs in vacuum, and the socio-cultural context of behaviour remains unaltered and unexamined. It has been widely acknowledged in the health promotion literature that the environmental context of behaviour also needs to be addressed for behaviour to change (Stokols, 1992). In addition, many of the health education programs addressing eating disorders rely on prescriptive educative methods where content is predetermined by the health educators, and didactic methods such as lectures are used. It is also widely recognised in the health promotion literature that didactic approaches are ineffective, particularly in maintaining health-related behaviour change (Taylor, 1979). Some health education programs in this area also adopt the dominant psychodynamic and psychobiological explanations of eating disorders (for example, Shisslak et al, 1987), and this leads to a focus on modifying intrapsychic constructs such as self-esteem, reproducing the valorisation of masculinized rationality and the rejection of the feminised body and emotions which are associated with these explanatory models.

A growing number of authors explicitly identify their approach to the primary prevention of eating disorders with the theory and practice of health promotion (for example, Latzer and Shatz, 1999). While a multi-dimensional approach is also universal here, there are some features that distinguish health promotion approaches from the health education programs described above, such as an emphasis on promoting health rather than the prevention of disease, and a greater emphasis on social change and participatory approaches. For example, Huon et al (1998) argue for integrated preventive practice within a broader context of health promotion. These authors, as well as others identifying with a health promotion approach (for example, Gresko and Rosenvinge, 1998), caution about the value of a risk factor approach, arguing that it is difficult to distinguish the precursors of eating disorders from their correlates once they are established (Huon et al, 1998). Instead, they suggest that dieting be the focus of intervention as the necessary, but not sufficient, condition for the onset of eating disorders (Huon et al, 1998). The need for individuals to develop skills in critically appraising the diet culture and in exercising choice over decisions

is emphasized by Huon et al (1998), rather than attempting to persuade individuals to change their attitudes and behaviours. These authors argue that the goals of this "resistance training" must be "embedded within a broader context where the preventive efforts are integrated into systemic and societal action" (Huon et al, 1998: 457). Thus, the approach to prevention advocated by Huon et al (1998) involves a focus on individual behaviour and skill development among individuals within the context of a more participatory, less prescriptive, approach that includes broader societal change. In an earlier paper, Huon (1994) reported on the evaluation of an actual prevention program she undertook with women and young girls in a university setting, where group discussion focused on ways that young women's negative food- and body-related attitudes could be changed. While there was evidence of a greater emphasis on participation and less prescription than in the more traditional health education programs reported earlier, the focus and measure of change nevertheless remained the individual psychological constructs of attitudes and behaviour (Huon, 1994). Thus, while some of the processes of intervention were distinguishable from traditional health education, the underlying theoretical assumptions and measures of change were similar, and drew on concepts from cognitive-behavioural psychology.

Neumark-Sztainer (1996) outlines an approach to a school-based program for preventing eating disturbances based on an "ecological model for health promotion" which aims to modify "both individual and environmental determinants of behaviour" (Neumark-Sztainer, 1996: 64). A multidimensional approach is again used, with socio-cultural, developmental, cognitive, behavioural, genetic, psychological, and familial factors seen as contributing to aetiology. A number of specific factors are emphasized as the focus of the program, including body dissatisfaction, cognitive factors such as knowledge and attitudes, self-esteem and body image (Neumark-Sztainer, 1996). Program content proposed by Neumark-Sztainer (1996) is not dissimilar to that of the health education programs, however, there is some attention to notions of empowerment and changing the environment through creating a health-promoting environment within the school, as well as between the school and the community. This is described as a potential catalyst for broader social changes such as the portrayal of women in the media, gender roles, acceptance of body diversity, and greater opportunities for healthy eating (Neumark-Sztainer, 1996). However, while Neumark-Sztainer (1996) gives some attention to the effects of the culture within the school and its relationship with the wider socio-cultural context, there is little attention to the development of the preventive strategies to address this. In contrast, educational interventions to address individual risk factors such as attitudes are discussed in some detail. This emphasis on the content of school-based

educational programs, and only notional attention to the need for broader strategies to address social change, is also common in other health promotion programs addressing eating disorders (for example, Rosen and Neumark-Sztainer, 1998; Gresko and Rosenvinge, 1998). Gresko and Rosenvinge (1998) subscribe to a health promotion approach to the prevention of eating disorders, arguing that prevention should focus on 'external risk factors' and include legislative and political action, as well as 'psycho-educative' programs (Gresko and Rosenvinge, 1998: 82). However, the actual program they describe is based on a health education model and focuses on the addressing self-esteem, independence and perfectionism, while Buddeberg-Fischer et al (1998) also use the term 'health promotion' to describe a cognitive-behavioural approach that is indistinguishable from the health education programs described earlier.

While health promotion approaches involve greater emphasis on the socio-cultural aspects of eating disorders and the need for social and legislative change, the individual largely remains the focus of intervention. Many of the constructs from cognitive-behavioural psychology that are the focus of health education programs are also incorporated into programs which embrace the notion of health promotion. The use of cognitive-behavioural theory further enables this focus on individuals because it is also based on a dualistic separation of the individual from the social context in which behaviour occurs. This dualistic approach allows a focus on the individual as distinct from their socio-cultural context, and as able to resist socio-cultural processes. Thus, while there is a conception of individual behaviour as the product of socio-cultural processes, the ways in which social influences and individual behaviours interrelate, and the potential implications of this for intervention, are not explored in any depth. As a consequence, the goal of intervention largely remains at the level of individual behaviour change. Somewhat ironically, the individual becomes positioned in a contradictory way within this conceptualisation as at once determined by social processes *and* as responsible for resisting them within an unchanged socio-cultural context. The means of resistance is through applying the new knowledge gained through the education program, which once again assumes the ascendancy of the rational mind over the body. Furthermore, body image dissatisfaction and eating disorders remain feminised problems related to irrational thinking styles and negative emotions, and the gendered contradictions implicated in eating disorders and practices of female body management are consequently reproduced in practice.

As noted earlier, health promotion has been widely criticized for focusing on the individual as responsible for change, rather than addressing social change (Wikler, 1978; Burrows, Nettleton and Bunton, 1995; Goltz and Bruni, 1995). Placing an emphasis on the notion that individuals can overcome massive socio-cultural pressures in the absence of social change strategies could be seen as representing a major ethical dilemma and, as was pointed out earlier, is known to be ineffective in practice. In addition, the socio-cultural aspects of eating disorders are again typically conceived of only in terms of the promotion of the thin female body ideal, and more complex questions associated with gender relations and the wider meanings of female body management practices such as those explored by post-structural feminists are not considered.

Also noted earlier, a second dilemma with this approach pertains to the fact that while health promotion claims to be empowering of individuals and groups, in practice its approach can be controlling (Grace, 1991). A number of the health promotion programs described above give some emphasis to the notion of participation but, like health education approaches, propose programs with predetermined content and didactic methods of education that position participants as passive recipients while health professionals remained in control of agendas (for example, Neumark-Sztainer, 1996; Gresko and Rosenvinge, 1998).

Feminist Approaches to the Prevention of Eating Disorders

A small number of authors advocate approaching the prevention of eating disorders from a feminist perspective. Steiner-Adair states that, through her work as a therapist with eating disordered women, it was clear that "the disorder was in the culture", and that cultural norms and values about womanhood made women "sick" (Steiner-Adair, 1994: 381). She presents the work of Carol Gilligan (1992) as an explanation of adolescent girls' experiences, where they are encouraged to risk their 'authentic selves' to fit into male-defined norms, often beginning with their bodies (Steiner-Adair, 1994). Thus, adolescence is described as a time when "femininity is on the line", with girls believing they have to risk health to be thin and attain and maintain relationships (Steiner-Adair, 1994: 381-382). Steiner-Adair argues that girls come to experience a "duplicious existence", involving the presentation of an exterior self who approximates what is expected, and a "real" self who does not fit the criteria and must be hidden. On the basis of this explanation, she describes eating disorders as "a joining of the psychological and political drama in a literal enactment, and an unconscious conflict between women's bodies and the body politic", so that eating disorders become women's attempt to escape traditional feminine roles, represented by the

rounded female body (Steiner-Adair, 1994: 382). Steiner-Adair proposes that “eating disorders dramatise the extent to which care and dependence have been doubly disparaged by their association with women and children”, because of western culture’s “unhealthy infatuation with autonomy and dependence” (Steiner-Adair, 1994: 387). Thus, women are seen as coming to deny who they are.

Steiner-Adair argues that primary prevention programs must address powerfully these cultural values, and that women need to learn competencies “to gain control of their lives” (Steiner-Adair, 1994: 387). She suggests that skills such as those taught in feminist treatment programs and attitudes like those encouraged by ‘fat acceptance’ groups are necessary, and that “relational skills and competence” and the value of “moral reasoning based on an ethic of care and connection and maternal thinking” need to be recognised (Steiner-Adair, 1994: 388).

Steiner-Adair’s (1994) approach is underpinned by a form of essentialist feminism which views characteristics such as nurturing, connection to others and “maternal thinking” as natural to women, and therefore inherently feminine. Thus, eating disorders are seen as arising because women’s and girls’ true selves are denied in male-dominated society, and the solution is to change wider attitudes so that the feminine is given greater value. This view therefore accepts gender difference as naturally occurring and is in danger of reproducing patriarchal notions of gender difference (McNay, 1992). Furthermore, the category of ‘woman’ is again reduced to her body in line with traditional discourses of femininity, existing only in opposition to the masculine, rather than as culturally produced, dynamic and changing (McNay, 1992). In reference to Delphy (1987, cited in McNay, 1992), McNay makes an argument relevant to Steiner-Adair when she suggests that the idea that the oppression of women would disappear if the feminine was more highly valued ignores more concrete mechanisms of oppression, and assumes that devaluation results in exploitation, instead of the converse. This form of essentialist feminism is, therefore, biologically reductionist and romanticising of sexual difference. Preventive efforts based on this perspective run the risk of cementing, rather than challenging, the hierarchical gender dualisms central to western culture and most health care intervention in this area.

In a more recent paper, Striegel-Moore and Steiner-Adair (1998) further articulate a feminist approach to the prevention of eating disorders. They argue that feminist approaches to prevention include the need to offer a critique of the socio-cultural values that create the cultural context for eating disorders, and that this

could involve teaching media literacy skills and opportunities to “speak out against perceived sources of the problem” (Striegel-Moore and Steiner-Adair, 1998: 6). They also argue that the systems in which girls live must be examined and these need to change in ways that support girls’ health (Striegel-Moore and Steiner-Adair, 1998). They also subscribe to a multidimensional model of the causes of eating disorders, but argue that prevention efforts to date may have failed because they neglect the social context. However, more importantly, Striegel-Moore and Steiner-Adair argue that prevention has failed because the role of factors, such as childhood physical and/or sexual abuse in female psychopathology, are ignored (Striegel-Moore and Steiner-Adair, 1998: 3). This pathologises the effects of abuse by locating them as psychological problems in individual women, and the authors leave unexplained how experiences of abuse might be associated with eating disorders.

Striegel-Moore and Steiner-Adair (1998) argue that increases in women’s knowledge and skills will lead to attitude and behaviour change. Thus, as with health education and health promotion approaches, a cognitive-behavioural model of behaviour change is uncritically employed, with its gendered assumptions about subjectivity. However, Striegel-Moore and Steiner-Adair (1998) emphasise the interpersonal aspects of interventions as important, arguing that didactic, less participatory approaches are less effective than more interactive approaches involving peer leaders. Unlike most of the other literature on the prevention of eating disorders, Striegel-Moore and Steiner-Adair (1998) also give some attention to the need for social and legislative change to reduce physical and sexual victimisation of girls, and suggest that this may be more effective than educating individuals. However, they do not elaborate on the nature of this victimisation or, for that matter, on the nature of gender inequality in general, or how change might be achieved. As such, little direction is offered for the future of preventive intervention. Furthermore, individual-society dualism leads to a dichotomous approach to individual behaviour change and social change as discrete areas of intervention, and there is little elaboration of the latter.

Piran describes a prevention program based on feminist and health promotion principles that was implemented in a ballet school, and emphasizes a participatory approach that “relies on dialogue with participants to determine the course of intervention, rather than on a predetermined professionally derived curriculum” (Piran, 1998: 173). This emphasis on participation is presented as reflective of a health promotion approach, and as an extension of a feminist understanding of issues of power associated with women and their bodies. Participation is defined as involving “the production and ownership of

knowledge", and empowerment is seen as counteracting "experiences of powerlessness, silencing or violation often associated for women with their bodies" (Piran, 1998:174-176). Encouragement is provided for students to identify situations and norms in the school environment which are experienced as oppressive, and emphasis is given to changing the way individuals relate in the school, including the role of teachers in responding to student activism on these issues (Piran, 1998). While Piran attempts to tie individual change and micro-cultural change in the school together in one interrelated process, she nevertheless emphasizes "the process of personal transformation which occurs internally when one does not presume to transform social structures 'out there', but rather aims to transform herself and her relationships with others" (Piran, 1998: 175). Thus, in the final instance, an emphasis is placed on individuals transforming their own internal functioning and interpersonal behaviour, and attempting to change social structures is presented as presumptuous (Piran, 1998). Once again, a dichotomous approach to the individual and society leads to an emphasis on the internal functioning of the individual and their relationships with other individuals as separate from the wider social realm, and Piran (1998) concludes by focusing on the individual and their immediate relationships to the exclusion of the wider social context.

While feminist approaches to prevention are distinguishable from health education and health promotion approaches in some important respects, particularly through the acknowledgement of wider gender power relations and their emphasis on participatory models of intervention, a number of dilemmas remain. These include the essentialism characterising Steiner-Adair's (1994) approach and the risk of reinforcing gendered assumptions; the dichotomous treatment of individual change and social change in Streigel-Moore and Steiner-Adair's (1998) approach and an uncritical reliance on cognitive-behavioural psychology and its gendered assumptions; and, the return to an emphasis on individual and interpersonal change to the exclusion of social change in Piran's (1998) model despite the promise of a more integrated approach.

Summary

This chapter has provided an overview of current approaches to the prevention of eating disorders, and has identified a number of important dilemmas and limitations. Firstly, approaches to early intervention reproduce psychopathological understandings, and the associated gendered contradictions, of dominant treatment interventions for eating disorders, as well as a reliance on techniques of surveillance that assume complicit, docile bodies. Secondly, despite recognising the socio-cultural aspects of eating

disorders and body image problems, current health education and health promotion programs overwhelmingly focus on individual psychological constructs, potentially reproducing the hierarchical gendered dualisms and contradictions associated with psychological knowledge. The use of cognitive-behavioural theory further enables a focus on internal psychological constructs as separate from the socio-cultural context, and leads to a separation of individual and social level interventions, with an emphasis on the former. Thus, while health promotion gives greater prominence to the role of socio-cultural context in eating disorders, in practice the approach is often indistinguishable from traditional health education. In addition, narrow conceptualizations of the socio-cultural aspects of eating disorders within both approaches leave broader questions about gender and eating disorders unexplored. Lastly, while feminist approaches bring an additional layer of understanding through an emphasis on gender power relations, essentialism, and an individual-society dualism that results in an emphasis on individual change limits, their potential in practice. Having considered and critiqued the formal account of eating disorders and the different approaches to intervention, the following chapters now turn to my field research with health care practitioners and exploration of the specific ways gendered assumptions operate within contemporary intervention. As the first step in presenting this research, the next chapter outlines the research methods utilised and the steps involved in the research process.

Chapter 4

Exploring Health Care Practitioners' Approaches to Intervention: Feminist Qualitative Methodology and Discourse Analysis

Introduction

As the previous chapters demonstrate, this thesis is concerned with examining the ways in which eating disorders, as well as women as subjects of eating disorders, are constructed in language, and with theorizing the relationship between these constructions, health care practices and wider social relations. In order to explore this relationship, a qualitative research study was conducted with health professionals working in both therapeutic and preventive settings in this area. This chapter provides an overview of the methodology utilised in this research, first outlining the principles and methods of the qualitative research paradigm, and setting this within a feminist approach to social inquiry. Against this background, I present the rationale for the field study with health care practitioners, outline the key research questions and document the research process. Because this study is concerned with the structuring effects of language, discourse analysis was chosen as the most appropriate method of data analysis. The final section of this chapter examines different approaches to discourse analysis, with particular attention to the application of post-structural theory, with its emphasis on historical perspectives and the operation of power relations within discursive practices. A critical perspective is incorporated into discussion of the research methods, so that both the strengths and limitations of the method are considered. In line with a feminist approach to social research, there is particular attention to the inter-subjective nature of the processes of social inquiry (Olesen, 1994), and I include discussion of some of the dilemmas I experienced in relation to the question of power relations between myself, as 'the researcher', and health care workers, as 'the researched'.

Qualitative Research Methods

As noted in Chapter 1, most research into eating disorders uses positivist modes of inquiry that seek to uncover the 'true' nature and causes of eating disorders and quantitatively measure them. The focus of this research study is the formal and informal theoretical knowledge through which health professionals construct eating disorders, and their relation to health care practices. Because this inquiry is concerned

with the frames of reference and meanings used by individual health care workers (Taylor and Bogden, 1998), and with explicating the construction of social reality and cultural meaning rather than with the measurement of ostensibly objective facts (Neuman, 1997), it is situated within a qualitative research paradigm. Guba and Lincoln (1994) delineate four main research paradigms, characterised by different approaches to the three interrelated items of ontology, epistemology and methodological question. The two quantitative paradigms of positivism and post-positivism are based on naïve realism, findings are held to be 'true' or probably true and methods are quantitative and include experimental and quasi-experimental manipulation, verification of hypothesis (positivism) and falsification of hypotheses (post-positivism). Guba and Lincoln (1994) identify the two qualitative paradigms of critical theory and constructivism. Critical theory is characterized by historical realism, where reality is seen as shaped by socio-cultural forces, and a transactional/subjectivist epistemology and dialogic methods, while constructivism is based on a relativist ontology that emphasizes local, specifically constructed realities, ways of knowing that are also transactional/subjectivist, and methods that are interpretative and dialectical (Guba and Lincoln, 1994). Within the qualitative paradigm, then, there is an explicit acknowledgement of values (Neuman, 1997). While quantitative researchers claim theoretical independence, objectivity and freedom from values, it is well established that theories and 'facts', and values and facts, are interdependent because facts emerge within particular theoretical frameworks with their associated values (Guba and Lincoln, 1994). Qualitative methods therefore acknowledge the situational constraints of research rather than independence of context, using small rather than large samples, thematic rather than statistical analysis and an involved rather than detached role for the researcher (Neuman, 1997), where findings emerge through an interactive process (Guba and Lincoln, 1994). Finally, the qualitative research paradigm takes the position that human behaviour, in particular, cannot be understood in the same way as 'natural phenomena' because it is necessary to take into account the meanings and motives individuals attach to their actions (Guba and Lincoln, 1994).

While the two qualitative approaches of critical theory and constructivism share many features, there are central differences. Kellehear (1993) points out that one of the central distinctions within qualitative research is between researchers who believe that social reality can be accessed through particular research techniques, and those for whom the world is socially constructed as part of the research

process. While critical theory is based on a transactional/subjectivist epistemology, its ontological position is historically realist, whereas constructivism is based on relativist ontology (Guba and Lincoln, 1994). In critical theory, reality is therefore assumed to be accessible through the research process so that findings are "value-mediated" rather than "literally created", as they are in constructivism (Guba and Lincoln, 1994: 110-111). Thus, critical social research aims to "expose" the true nature of social relations (Sarantakos, 1998: 39). This research study, set as it is within a post-structural epistemological framework that acknowledges the social construction of multiple social realities and their inter-subjective production, is consistent with a constructivist approach. However, because this thesis takes a *feminist* post-structural perspective, it is also distinguished by a concomitant understanding that gender issues involve wider social dynamics and power relations (McNay, 1992). Thus, some of the features typically associated with critical theory, such as questions about power relations, who benefits from particular interpretations and an emphasis on tension and contradiction in different versions of social reality (Sarantakos, 1998) are also relevant to, and guide, this analysis. Unlike critical theory, it is not assumed that the research process is uncovering truth but, while multiple constructions of reality are revealed through the investigation in line with a constructivist approach, links are made to their historical origins and institutional bases.

Feminist Social Research

In outlining the central features of feminist methodology, De Vault (1999) argues that the aim of feminist research has been to make visible women's lives and experiences, which have been made invisible or subjugated by traditional masculinist research. While this study focuses on health workers' knowledge, practices and experiences, rather than women's, it does so in order to make more visible a particular aspect of women's lives – the subject positions offered to them in the context of health care. There is no one approach to 'feminist research' (Stanley, 1990; De Vault, 1999; Grbich, 1999), however, a distinction can be drawn between 'feminist research', understood as any empirical study that extends feminist understandings, and 'feminist methodology' (De Vault, 1999) or 'feminist epistemology' (Stanley and Wise, 1990). The former may include standard research tools but can be distinguished from feminist methodology that emerges from feminist critique, and includes theorizing about research practice (Cook

and Fonow, 1990; De Vault, 1999) and theorizing epistemology (Stanley and Wise, 1990; De Vault, 1999).

While 'feminist research' takes many forms (Stanley, 1990; De Vault, 1999; Grbich, 1999), there are key principles that are widely associated with feminist forms of inquiry. Those that are central to the research process undertaken in this thesis include: the centring of the social constructed-ness of gender (Grbich, 1999) and reflexively attending to the significance of gender (Cook and Fonow, 1990); explicitness about the researcher's beliefs and view of reality (Grbich, 1999) and a challenging of the norm of 'objectivity' (Cook and Fonow, 1990); and, an emphasis on the transformative potential of research in challenging the oppressive effects of gender power relations (Cook and Fonow, 1990). In line with the idea of explicitness about the researcher's view of reality, I chose to present the post-structural feminist epistemological framework within which this thesis is set early in the first chapter, so that the critical literature reviews occur against this backdrop, rather than as if they are epistemologically detached from any perspective and supposedly objective. This research study can, therefore, be understood as feminist in orientation because it attempts to make visible women's lives through exploration of the ways women are positioned within health care, because it focuses on gender construction, and because it is epistemologically and ontologically explicit and includes an emancipatory agenda.

Of particular concern to feminist researchers is the issue of power relations between the researcher and the research participant (Stanley and Wise, 1990; Grbich, 1999). One of the most central principles of a feminist approach to research is to attempt a 'non-exploitative', 'egalitarian' and 'emancipatory' relationship between the researcher and the participant (Grbich, 1999). Oakley (1981), for example, argues that traditional approaches to social research interviews are based on a masculinist approach, emphasising a one-way flow of information, the objectification of the research participant, a supposedly detached and objective researcher and the impersonal nature of interaction between the researcher and the researched. These are at odds with a feminist perspective emphasising the validation of women's subjective experiences (Oakley, 1981), the equalizing of relations between researcher and researched (Grbich, 1999) and in-depth interview methods that are dialogic rather than one-directional (Sarantakos,

1998)¹. While I believe that the feminist principle of minimizing power imbalances between the researcher and the researched is important, the question of power relations between participants and myself was not straightforward in this study because this work was undertaken with health professionals, many of whom occupied high status, authoritative positions.

Because health professionals have access to the power to position themselves and others in discourses in the context of health care (Harper, 1995), my purpose partly involved a drawing out of gendered assumptions so that they could be subjected to critical analysis. In this sense, my research approach was at times conventional in that I held back my own perspectives in a relatively detached way at particular points in interviews (Oakley, 1981). However, I was aware that the health care practitioners I interviewed were nevertheless also *subjects* within my research study, and that access to power is affected by context and therefore not immutable (see Walkerdine, 1986). Adding a further layer of complexity, some of the female health care workers had previously experienced eating disorders themselves, and they discussed how this had impacted on their professional practice. Other women talked about their experiences more generally as women subject to body image prescriptions, and there was a more mutual exchange at these points because I also shared these experiences. Thus, some of the female participants effectively wore three hats during the research process, as health care practitioners, as women who had experienced eating disorders and/or body image dissatisfaction, and as research participants. Furthermore, most practitioners talked about dilemmas in practice, involving varying levels of self-disclosure. Thus, the 'status' of research participants shifted during interviews depending on the specific context and content of discussion, and this necessitated a shift in my approach from higher levels of mutuality and sharing, to a more detached interaction. Power dynamics also shifted according to the disciplinary background, professional status and gender of the interviewees. Thus, the question of power relations between health workers and myself was dynamic and changing, resulting in some dilemmas for me as a feminist researcher, which are discussed in greater detail through specific examples towards the end of this chapter.

Outline of the Research Study

As was noted earlier, eating disorders are commonly explained through the related constructs of

¹ This is not to suggest that more in-depth methods are by nature equalizing. (c.f. Tang, 2002).

'autonomy' and 'control' (Bruch, 1978; Crisp, 1980), and Chapter 2 explored the gendered nature of these ideas. The field research conducted with health workers examines in greater detail the ways gendered assumptions might also operate within actual health care intervention. This entails examination of health care workers' use of both formal *and* informal knowledge about women with eating disorders, while the eating disorder literature on the whole presents only an 'official account' (Malson, 1998). My fieldwork also provides the opportunity to examine actual interventions rather than idealised protocols, and to specifically relate these to the knowledge informing them. Because this study entails examination of formal theoretical knowledge, informal assumptions about women with eating disorders and the ways these specifically link to the operation of power dynamics within intervention, a series of in-depth interviews with health care workers was deemed most likely to produce rich and layered insights. This research method also provides the opportunity for health care practitioners to reflect on their approaches to practice in a reflexive way, including some of the key tensions and contradictions associated with intervention in this area.

Treatment Services and Prevention Programs in Australia

In order to gain insight into the diversity of discourses used by health workers, the dynamics operating between them and the potential for the development of alternative conceptualizations and practices, I included a wide variety of health care practitioners in the study (Kuzel, 1992). In Australia, health care for individuals with eating disorders occurs in a number of settings involving workers from a variety of different disciplinary backgrounds, however, treatment is primarily provided by, and controlled by, psychiatrists. While this study recruited practitioners from three Australian states to ensure a wide cross-section of practice approaches, the pattern of service delivery described here uses South Australia as an illustration because this is the state in which I am based, and because the organisation of health care systems does not differ markedly from state to state. In-patient and outpatient services in South Australia are provided by two major public hospitals, the Royal Adelaide Hospital and Flinders Medical Centre, as well as through four private hospitals. In discussions with staff in these units, I ascertained that the Weight Disorder Unit at Flinders Medical Centre sees approximately 200 patients per year, and this represents the majority of individuals diagnosed with eating disorders in this state. There are six in-patient admissions at any one time in the Weight Disorder Unit. The Department of Psychiatry at the Royal

Adelaide Hospital sees an average of three individuals per week as outpatients, with one new case every month, while there are usually one or two individuals admitted to the psychiatric unit as in-patients at any one time. Outpatient services are also provided through private psychiatric clinics for which partial reimbursement through the national health scheme is available. Approximately six psychiatrists in private practice are known to specialise in the treatment of eating disorders in South Australia, however, other private psychiatrists would also see some individuals. No figures are available on the numbers of individuals receiving private treatment. The number of psychiatric services available for individuals diagnosed with eating disorders in South Australia is probably higher than in other states because of the higher number of specialist psychiatrists, as well as two specialist private hospital programs.

Because psychiatrists are the key professional group involved in the provision of health care to individuals with eating disorders in Australia, as in other western countries, they were included in higher numbers than other disciplinary groups. Nurses commonly provide day-to-day care for inpatients as well as outpatient support (Muscari, 1998), and general practitioners increasingly provide health care services to eating disordered individuals in the community (Whitehouse et al, 1992; Turnbull et al, 1996; Britt and Del-Gobbo, 1990), so representatives of these two groups of professionals were also included.

Counselling and therapy are also provided through government funded community and women's health centres, child and adolescent mental health services and through private therapeutic practices. However, services are available on a relatively limited basis through government-funded agencies, while private therapy is only accessible to those able to pay. Feminist approaches to health care and narrative therapy are typically undertaken in women's health centres and some private therapeutic practices and, because this study examines both dominant and alternative models of intervention, practitioners from these settings were also included. Finally, community-based support groups for individuals with eating disorders exist in most states. The Eating Disorder Association of South Australia (EDASA) receives a small amount of funding (\$70,000 annually), from the Mental Health Unit of the South Australian Department of Human Services, for the provision of counselling and support to individuals and their families. Workers from this setting were included in the study because of the potentially distinctive perspective deriving from the self-help approach, where many support workers have experienced eating disorders themselves.

As was emphasized earlier, health care workers involved in preventive intervention were included in the study as part of an exploration of the potential for alternative models of practice in this area. In Australia, few health programs have addressed body image and eating disorders. The only published literature reports on the evaluation of a time-limited school-based health education program for adolescent girls addressing body dissatisfaction and disordered eating (Paxton, 1993). A review of body image-related health promotion activity in Australia in 1997 revealed three other programs. Two of these were time-limited and implemented only on a relatively small scale. The most extensive state-wide program undertaken in this area was established in 1992 with the aim of reducing body image dissatisfaction and inappropriate eating behaviour, particularly among women. In order to reveal the ways in which body image dissatisfaction and eating disorders are conceptualised and approached within health promotion, a group of health workers responsible for the design and management of this most extensive program were also included in the study.

Research Questions

A qualitative research methodology necessitates the use of an inductive, rather than deductive, research paradigm (Kellehear, 1993; Sarantakos, 1998; Taylor and Bogden, 1998). Thus, the concepts that are examined through the process of research develop and emerge within the research process, and are not firmly defined and delineated prior to undertaking the research. As is argued by Taylor and Bogden (1998), pure inductivism is not possible because research occurs within a theoretical framework, however, the goal is to ensure that the theory fits the data, and not the converse. While the concepts examined in this study were not firmly defined in advance, a series of broad research questions was developed to guide the investigative process. The research questions explored in the study are drawn from, and closely relate to, the key tensions and contradictions identified in the literature reviews of contemporary theory and practice. The three central questions that guided the investigation are presented below:

1. What subject positions are available to women within explanations of eating disorders and approaches to intervention, and in what ways are they gendered?

2. What dilemmas do health professionals face in relation to their practice, and how do they attempt to resolve them?
3. What potential do alternative practices offer for overcoming dilemmas and contradictions identified in dominant approaches?

More specifically, the study sought to explore in interviews with health workers some of the key theoretical, practical and ethical dilemmas highlighted in the critical reviews of the literature, and the ways these might influence intervention. These include:

- the operation of gendered contradictions about women and girls, particularly in relation to the constructs of autonomy and control;
- the explanations for why eating disorders are so prevalent among women and girls at this point in time;
- the power dynamics characterising intervention, in view of the potentially controlling nature of many psychiatric and preventive interventions;
- the question of how prevention might be approached in the face of limited activity in this area despite widespread acknowledgement that eating disorders involve a socio-cultural aspect.

The study therefore involved a particular emphasis on exploration of dilemmas and contradictions within health care practitioners' accounts of professional practice, and the implications for women as recipients of services and programs. Contradictions are more likely to emerge in health professionals' explanations of their practice than in official published accounts that have been polished to produce consistency. One of the chief limitations of this study, though, is that health care intervention is analysed through health care workers' talk about their practice, rather than through direct observation of practice. As such, the analysis is 'one step away' from actual practice. However, it is reasonable to assume that health care practitioners' explanations of intervention bear at least some relation to what they actually *do* in practice.

Furthermore, because of the discursive nature of this study, analysis of health practitioners' talk about their practice provides an additional layer of insight into the dilemmas experienced by practitioners, and their own understandings of these. As such, it provides greater opportunity for exploration of the impetus for, and possible directions for, change.

Interviews

The investigative method involved semi-structured, face-to-face interviews with individual health professionals. Face-to-face interviews were used because the research questions involved in-depth exploration of potentially complex constructs, as well as self-reflection, and it was important to build trust and rapport in the relationship (Taylor and Bogden, 1998). The design of the interview questions was flexible, and modified according to the particular health care setting of the worker (see Appendix 2 for interview guides), and was therefore adaptable for dealing with "multiple (and less aggregatable) realities" (Lincoln and Guba, 1985, 40). In line with this, interviews were semi-structured and systematic, so that questions were loosely formulated beforehand but allowed for modification in individual contexts and in this sense were not standardized (Denzin, 1978; Lincoln and Guba, 1985; Sarantakos, 1998; Taylor and Bogden, 1998). Thus, a naturalistic approach modelled on a conversational exchange was utilised, rather than a structured question-answer format, to encourage participants to openly discuss their approaches to the constructs being investigated (Taylor and Bogden, 1998). I also attempted to create a stimulating and collegial approach to encourage openness (Sarantakos, 1998). Open-ended questions that allow for exploration and discussion of the concepts under investigation were asked first, followed by 'probing' questions which sought clarification and more specific descriptions (Taylor and Bogden, 1998).

A number of the interview questions were drawn in a relatively straightforward manner from the underlying research questions, for example, those exploring health professionals' theoretical explanations of eating disorders and approaches to practice. In contrast, questions exploring the ways in which health care practitioners, particularly psychiatrists, approach clinical decision-making in light of the many tensions and contradictions identified in the literature were carefully worded to encourage open discussion. Practitioners were therefore asked to describe cases that may have presented dilemmas for them, rather than being asked directly about problems in practice in a way that might have created

defensiveness. Thus, maintenance of an atmosphere of openness and collegiality was important when addressing potentially difficult areas of practice. One interview was undertaken with each health care practitioner at their place of work, and ranged between one and two hours in length, and were tape-recorded and later transcribed for analysis. The tape-recorder was small and unobtrusive, and used a long-playing tape to minimize interruptions (Taylor and Bogden, 1998).

Sampling

Purposive sampling, where individuals are purposely chosen who, in the researcher's opinion, are thought to be relevant to the research topic, was used to select research participants (Lincoln and Guba, 1985; Sarantakos, 1998). Psychiatrists who were involved in the committee devising clinical practice guidelines for eating disorders under the auspices of the Australian and New Zealand College of Psychiatrists were the initial group approached to participate in interviews. This committee was chosen because its membership included senior psychiatrists who specialize in eating disorders, many having published widely in this field, therefore comprising an influential voice within contemporary psychiatry. As mentioned earlier, psychiatrists were recruited from three different states to ensure diversity in approach. Seven psychiatrists based in Sydney, Melbourne and Adelaide were approached through the guidelines committee. In addition, three additional psychiatrists were approached in Adelaide and Melbourne using snowballing sampling, whereby word of mouth of those already sampled was used to locate further appropriate individuals (Grbich, 1999). In a study of this type, the actual number in the sample size is not of primary importance, and is left to the discretion of the researcher (Sarantakos, 1998), although the nature of the specific research question is relevant (Willig, 2001). Because the number of psychiatrists specializing in eating disorders in Australia is not large, ten was deemed a sufficient number to provide an appropriate level of insight into the potentially different ways in which psychiatrists approach the issues investigated through the research questions. Snowball sampling was also used with psychiatrists to identify nurses and GPs who might be willing to participate.

Other health care workers were recruited through snowball sampling. Because these workers were mostly based in my home state of South Australia, and I have a background as a professional social worker in women's health, I was already aware that there were practitioners in women's health centres, eating

disorder support groups and private practice who used alternative feminist and narrative therapy approaches. I approached individuals who were known to me professionally or by reputation, and then used snowball sampling to identify further practitioners. One or two health care practitioners from each of these disciplines or settings were included in the sample.

The group of ten health promotion workers were drawn from among the twelve health professionals involved in the management of the largest and longest running health promotion program addressing body image and eating-related problems in Australia. The program will be referred to only as the 'body image dissatisfaction' program (BIDP) to protect the identities of participants. A sample of ten was also sufficient to provide insight into the different ways health promotion professionals approach prevention in this area.

I also attempted to ensure, as much as possible, that both genders were represented in the sample of practitioners. I was particularly eager to include female psychiatrists because of the historical domination of male psychiatrists in the explanation and treatment of eating disordered women since the nineteenth century (see Malson, 1998; Hepworth, 1999). This provided me with the opportunity to explore whether psychiatrists' approaches differed according to the gender of the practitioner. However, because most of the other health workers came from professions that have high concentrations of women (such as nursing, social work, health promotion, dietetics, psychology), overall the sample involved 21 female and 10 male practitioners.

Recruitment

Psychiatrists were initially invited to participate in the study by letter (see Appendix 3), which included an information sheet explaining the purpose of the research (see Appendix 4). Letters were followed up with a telephone call to ascertain whether individuals were willing to participate, and an appointment time for an interview was then arranged. Other health care practitioners were more easily approached by telephone, whereby the aim of the study was explained, their participation was invited and interview times arranged. All of the health practitioners who were invited to participate in the study agreed to take part. Prior to commencing interviews, a consent form explaining how the information would be used and

including an assurance of confidentiality, was provided to each participant and was signed by participants and myself (see Appendix 5). The information sheet describing the study and its aims was also provided to each participant. The study was originally commenced as a Masters thesis, and had a more specific focus on prevention. It was upgraded to a doctorate in 1999, with a broadened focus on treatment and prevention. Interviews took place over a three year period, between 1997 and 2000.

In all, thirty-one health care practitioners participated in the study, including ten psychiatrists; four social workers; four psychologists; two community support workers, counsellors, nurses, general practitioners and dieticians; and one health promotion worker, social marketer and fashion design lecturer. Those involved in managing the body image dissatisfaction program (BIDP) included all four of the psychologists, both dieticians, one of the general practitioners, and the health promotion worker, social marketer and fashion design lecturer. Twenty-two of the health care practitioners were female, and nine were male. The practitioners are referred to by pseudonym (see Appendix 6 for a list of names and respective professional backgrounds). While some practitioners indicated that they were not concerned as to whether their identities were kept anonymous or not, I decided to withhold all names to protect the identities of patients and clients referred to in case examples. Furthermore, some practitioners divulged information that might have compromised them with other colleagues had I not undertaken additional steps to ensure anonymity by also withholding the names of organizations for which they worked, and the cities and states in which they practiced.

Ethics Committee Approval

Strict university protocols were followed in seeking ethics committee approval for the research study. A formal application was made to The University of Adelaide Ethics Committee, and approval for the study was granted in 1999. Because the sample of health care workers was later widened, further approval was sought for this modification and endorsed in 2000.

Data Analysis

Data Coding, Management and Presentation

Once interviews were transcribed into Microsoft Word for Windows, they were then imported into the computer-based qualitative data analysis package, NUDIST 4. Because this research study is based on a

relatively large sample for a qualitative design, I decided it would be more practical to manage the data electronically rather than manually. Using NUDIST, I undertook an initial analysis of the data by breaking the text into themes, after first reading the transcripts through in full, and then breaking them down again into sub-themes (Kellehear, 1993). NUDIST allows the researcher to create themes 'in vivo', that is, as the text is read, and it is then a relatively straightforward process to arrange themes and sub-themes in relation to each other through the creation of an index 'tree' and 'sub-trees'. Selected extracts of interview text that best illustrate the themes and discourses under analysis are presented in the following chapters. The symbol '[.]' is used to denote text that has been removed from extracts because it is not relevant to the theme/discourse being examined and discussed.

Discourse Analysis

Discourse analysis, with its emphasis on the structuring effects of language, was used to examine texts generated through interviews with health professionals. Discourse analysis has multidisciplinary origins, developing out of a focus on text and dialogue during the 1960s within anthropology, semiotics, literary studies, linguistics, sociology, psychology and communications (van Dijk, 1990). While there is no one definitive approach to discourse analysis, Burman and Parker (1993) suggest that:

.....[d]ifferent approaches to discourse analysis share a concern with the ways language produces and constrains meaning, where meaning does not, or does not only, reside within the individual's head, and where social conditions give rise to the forms of talk available.

(Burman and Parker, 1993, 3)

Thus, discourse analysis involves exploration of the ways in which language constructs rather than simply reflects social reality, with the associated implication that "meanings are multiple and shifting, rather than unitary and fixed" (Burman and Parker, 1993, 3). Each discipline has taken a distinctive approach to the study of discourse in their 'turn to language', with some paying more attention to the structure of language than the effects of the social contexts in which language is used (van Dijk, 1990). Because this thesis examines the dialogue between health care intervention and culture, there is an emphasis on the social context in which language is used, rather than the structure of language. Furthermore, because this thesis

examines the function of psychological theories, discourse analytic approaches that have developed within critical psychology are employed. As with discourse analysis more generally, there is no one version within critical psychology, and two main approaches can be discerned, differentiated by different emphases on structure and context (van Dijk, 1990). The first approach is most closely associated with the work of Potter and Wetherell (1987). These authors draw on the concept of "interpretative repertoires", defined as "recurrently used systems of terms used for characterising and evaluating actions, events and other phenomena" (Potter and Wetherell, 1987: 149). For Potter and Wetherell (1987), one of the central aims of discourse analysis is to "reveal the interpretative procedures used... and the relationship between the construction of discourse and the particular end to which it is put" (Potter and Wetherell, 1987: 146). There is a concern with the flexible, local use of repertoires, and the way specific actions are accomplished or rhetorical devices used in, for example, the construction of facts (Potter, 1996).

The second main approach to discourse analysis used within critical psychology draws on post-structuralism, and is most closely associated with Parker (1992) and Burman and Parker (1993). Post-structuralism is defined by Burman and Parker (1993) as "an array of approaches which [are] suspicious of claims to reveal and world outside language and of claims that we can experience any aspect of ourselves as outside language" (Burman and Parker, 1993: 6). As was argued in Chapter 1, post-structuralism, and particularly the work of Foucault, brings with it a concern not only with how objects are constructed in discourse, but also the way in which subjects are constructed, and the ways in which language mirrors and reproduces power relations (Burman and Parker, 1993). Much discourse analytic research has been criticised for failing to address the broader societal or political frameworks in which interactions occur (see, for example, van Dijk, 1994). Discourse analysis informed by post-structuralism, with its emphasis on the socially constructed nature of subjectivity, its challenge to claims of truth and its attention to the role of discourse in the reproduction of power relations, helps to ensure that the social, cultural and historical dimensions of discourse are addressed (Parker, 1992; Burman, 1991; Burman and Parker, 1993).

The work of Foucault is central to the approach to discourse analysis undertaken in this thesis because

Foucault is concerned with how power operates to construct individual subjectivity (Foucault, 1982). Discourse analysis informed by the critical approach of post-structuralism, and particularly an awareness of the links between subjectivity, power and knowledge offered by Foucault, provides what Burman and Parker (1993) have described as a "social account" of subjectivity (Burman and Parker, 1993: 3). Because this thesis is concerned with the power dynamics structuring health care intervention, and with the dialogue between intervention and wider cultural processes, it is the post-structural approach of Parker (1992) and Burman and Parker (1993) that is primarily adopted here. However, there is attention where relevant to the rhetorical devices used by speakers at particular junctures to achieve specific ends (Potter, 1996).

Because discourse analysis takes a critical position in relation to language, reflexivity becomes important (Parker, 1992). Attention to meaning construction and relationships between "systems of meaning" can contribute to an understanding of the relationship between the researcher and research participants (Burman and Parker, 1993: 9). In this study, the relationship between participants and myself varied according to the extent to which meanings were shared, and this point and its implications for the research process are addressed later in this chapter under discussion of research dilemmas. Burman (1991) highlights further dilemmas associated with the concept of reflexivity, such as the risk of detaching rather than engaging researchers from political practice by shifting the focus to the account rather than what is being accounted for. On this point, Parker (1992) argues that "work in the poststructuralist tradition can ground discourse and reflection historically in a useful way" because it draws attention to the fact that discourses have a history, they categorise the social world, they are systematised and, most importantly, "they reproduce and transform the world" (Parker, 1992: 3-5). Thus, reflexivity involves the employment of available discourses (Parker, 1992), and attention to reflexivity can make links between academic and political practice, as well as monitor power relations (Burman and Parker, 1993).

While discursive forms of analysis based on post-structural ideas are widely accepted and utilised across many academic disciplines, they have also been widely criticised. For example, Rosenau points out that the discrediting of theory building within post-modernism and post-structuralism is itself a theoretical position, and the criticism of Enlightenment concepts of reason and rationality does not prevent the use

of these tools within post-modern and post-structural approaches for deconstructive purposes (Rosenau, 1992: 176, cited in Grbich, 1999). Furthermore, the focus on the marginal and the subjugated involves an allocation of internal value within an approach that has supposedly dispensed with valuing, and the inconsistencies of which modernism and structuralism are accused are therefore also present within post-modernism and post-structuralism (Grbich, 1999: 51). In relation to Foucauldian post-structural thought, in particular, McNay (1992) shows how, despite his reputation as an anti-Enlightenment thinker, Foucault does not completely reject certain Enlightenment concepts, such as autonomy, domination and self-determination, for an indiscriminate relativism. This is because Foucault retains a notion of social transformation and political resistance through his idea of ethics of the self (McNay, 1992). Furthermore, following McNay's (1992) arguments, this thesis is set within a feminist perspective, and necessarily involves normative judgements about what constitutes a legitimate challenge to the various techniques that seek to subordinate women. Thus, the approach to discourse analysis used here is informed by a feminist position that accepts Foucauldian post-structuralism as contradictory in some respects, and therefore refuses a more relativist post-modernism based on an "undifferentiated celebration of plurality" (McNay, 1992: 117).

Turning to the specific steps undertaken in the discursive analysis of health workers' interviews, I was guided by the ten criteria and associated steps for discourse analysis outlined by Parker (1992). These deal with different levels of analysis and raise questions in relation to the researcher's theoretical framework. Only those most relevant to the analytic process undertaken within this thesis are examined here. Firstly, Parker (1992) emphasises that discourses are at work in *texts*, defined as "delimited tissues of meaning reproduced in *any* form that can be given an interpretative gloss" (Parker, 1992: 5). He suggests that we can adopt, for research purposes, the post-structural maxim "[t]here is nothing outside of the text" (Derrida, 1976: 158, cited in Parker, 1992), so that the object of study becomes the text. The next step in the discourse analytic process is to ask what objects and subjects are referred to, and to describe them (Parker, 1992). This largely involved examining the way the objects of eating disorders and health care intervention were constructed, and the subjects of women with eating disorders, and involved specific attention to how subjects were placed in a relation of power (Parker, 1992).

Parker (1992) next suggests that statements in a discourse be grouped and given coherence. This is similar to Potter and Wetherell's (1987) idea of identifying 'interpretative repertoires', defined as "recurrently used systems of terms used for characterising and evaluating actions, events and other phenomena" (Potter and Wetherell, 1987: 149). It was at the point of identifying categories, or 'repertoires', that I imported my textual data into NUDIST. As was noted earlier, I called these groupings 'themes' (Kellehear, 1993) from which, on subsequent readings and re-readings of the text, discourses began to emerge. For example, I identified a large category of talk about eating disorders that drew on essentialist notions of selfhood. Terms employed by health workers that denoted this category included talk about "personality", "identity" and notions of "true" self. Only after repeated re-readings of these extracts did I come to see the gendered nature of the dualistic, humanist discourse on which these ideas were based.

Next, Parker (1992) suggests that a discourse refers to other discourses. This point deals with the issue of reflexivity, whereby "the articulation of our reflections on discourse must require the use of discourses" (Parker, 1992: 13). Thus, in deconstructing humanist discourse, I drew on a feminist post-structural discourse that is suspicious of essentialist notions of selfhood and their gendered effects. Parker (1992) also argues that "analysis is facilitated by identifying contradictions between different ways of describing something", and that we need to understand the interrelationship between different discourses (Parker, 1992: 13). This necessitates setting contrasting discourses against each other, and looking at the different objects they constitute. This point is particularly pertinent to this study, in view of its focus on contradiction and exploration of how gendered contradictions work with, and against, each other in achieving particular ends. Burman and Parker (1993) argue that an emphasis on contradiction "helps to theorise the functions they play within the social practices that give rise to them" (Parker and Burman, 1993: 9), and this point was useful in elucidating how gendered contradictions about eating disorders effectively displace and marginalise the question of gender. Parker (1992) also suggests that "discourse folds itself around and reflects on its own way of speaking" (Parker, 1992: 14). I found this point particularly useful in drawing attention to tensions in health workers' accounts. For example, health workers using pathologising discourses sometimes reflected on the negative effects of their language for women, but then moved on to reproduce the discourse by providing justification for the idea of eating disordered women as psychologically different from other women.

Parker (1992) also emphasizes the importance of referring to other texts to elaborate the discourse as it occurs. It was largely through this process of reference to other texts, such as feminist philosophy and feminist critiques of psychology, that I was able to identify emerging discourses in the text. These additional readings helped me to look below the surface of the text to the more central discourses informing the presented ideas. This leads into Parker's (1992) next criteria for discourse analysis, which emphasizes the historical location of discourse. While this thesis does not involve an historical analysis *per se*, the historical origins of discourses are identified, and this helps illustrate the contingent nature of the emergence of particular discourses at particular junctures.

Parker (1992) also emphasizes that discourses support institutions because "the employment of a discourse also often reproduces the material basis of an institution" (Parker, 1992: 17). This aspect of discourse analysis is extremely relevant to the process undertaken here, and I emphasise the ways in which certain discourses work to reproduce, or challenge, particular institutional arrangements, particularly those of psycho-medicine. I also show how discourses are employed in ways that reproduce and reinforce divisions between competing institutions, such as those between 'treatment' (psychiatry) and 'prevention' (health promotion).

Most importantly for this thesis, Parker (1992) argues that discourses reproduce power relations, and that institutions are structured around and reproduce power relations (understood as the links between power and knowledge). This criterion involves looking at which categories of person gain and lose from the employment of a particular discourse (Parker, 1992). For example, I examine how gendered assumptions about the sexuality of women with eating disorders reproduce wider gender power relations within the context of health care by making women simultaneously victims of, and responsible for, sexual abuse. Discourses also have ideological effects (Parker (1992) and, within this analysis, I most particularly explore how inherently gendered assumptions, such as those structuring theories of identity and associated psychodynamic approaches, have the effect of contributing to an ideology of gender neutrality within health care.

As a final point about the specifics of the discourse analytic process undertaken for this study, I attempt to provide a sense of how common particular discourses were within health workers' accounts as part of

establishing which might be considered dominant, and which secondary. I therefore 'borrow' from content analysis (Kellehear, 1993) the strategy of showing how widespread the use of a particularly common discourse is by indicating how many health workers utilised it. However, unlike quantitative content analysis, categories and themes were sought from within the data, rather than established beforehand (Kellehear, 1993).

Limitations of Discursive Methods

There are a number of other potential dilemmas associated with discursive methods. For example, Stenner (1993) warns of the dangers of presenting findings as if discourses are emerging by themselves from the text, when the researcher's interpretation is central to this process. Thus, one reading of a given text is not the only possible reading, and any assumption that it is negates post-structural assumptions of the multiple and shifting nature of meaning. There is also a danger of focusing on language to the exclusion of "the materiality of power" (Parker and Burman, 1993: 158). However, because this study is set within a feminist post-structural epistemology rather than within the discipline of psychology, which tends to focus on the individual (Parker and Burman, 1993), attention to the question of gender power relations is constantly addressed and exploration of the possibilities for changed practice is a central theme.

A further potential problem with discourse analysis is its tendency to remove analysis from social practice so that it becomes merely an academic pursuit (Parker and Burman, 1993). Because this study is premised on a concern with professional health care practice, though, there is an emphasis on exploring the relationship between theoretical discourses and the practice discourses which structure health care, thereby grounding the analysis in a relatively practical way. Lastly, Stenner (1993) notes the ethical problem of wielding power and control over the talk of others, and this concern about discourse analysis, in concert with feminist concerns about power dynamics within the interview process, leads into discussion of a series of specific dilemmas I encountered as a researcher in this study.

Research Dilemmas

As mentioned earlier, the question of power relations between research participants and myself was not clear-cut, and I found that they shifted according to the disciplinary background, professional status and

gender of the interviewees. For example, interviews with two of the older male senior psychiatrists ('William' and 'John') were relatively formal and shorter in duration. One of these interviews was particularly difficult. When initially invited to participate in the study, John enquired as to my background and orientation, explaining that he did not wish to be involved in an eating disorder study that used a feminist perspective because he did not agree with criticisms and perspectives emanating from other works in this paradigm. I explained that my work was indeed based on a feminist perspective, but that I was interested in exploring his conceptualizations and approach in an interview, not my own, and on this basis John agreed to participate. However, he kept the interview brief, it was difficult to achieve a sense of openness and mutual exchange and he resisted my attempts to further explore his responses. As such, this interview offered less than some of the others. In contrast to this, while other senior male psychiatrists were aware that I might have held different ideas to them about the nature of eating disorders, and alluded to this at times during interviews, it was nevertheless possible to create a relaxed and informal atmosphere. Three other senior male psychiatrists ('Philip', 'Robert' and 'Eric') were particularly frank and open about some of the dilemmas they encountered in practice, our conversations were relaxed and friendly, and power dynamics felt relatively equal.

One of the nurses ('Penny') working in a traditional psychiatric setting was curious about my theoretical approach to eating disorders. She said that throughout the interview she found my influence to be entirely "benign" but, at the same time, sensed that I held concerns about health care intervention in this area. At the end of the interview, I agreed that she could 'turn the tables' on me, and she proceeded to ask me a series of questions about my ideas in the spirit of a more mutual exchange. As is noted by Oakley (1981), participants asking researchers questions is not included in discussions of traditional interviewing procedures, however, she notes that women in her research studies commonly did so. For Penny, it was important to equalize the relationship so that she also learned something about me.

Some of the interviews with practitioners whose professional backgrounds were more similar to my own involved much more of a mutual conversation, as well as a sense of inter-subjectivity based on shared experiences (Stanley and Wise, 1990). More specifically, I shared many of the perspectives of the feminist and narrative practitioners, and this influenced the course of conversation and the levels of

openness in the interviews. In these situations, I did not stand 'outside' the discourse being employed by participants to the same extent, but more actively participated in the discussion. Sometimes this involved a lot of shared humour, particularly when some participants gave examples of what they saw as more outlandish examples of the marketing of female thinness and dieting (for example, in interviews with 'Melissa' and 'Elizabeth'). Furthermore, the fact that I shared many assumptions about eating disorders with feminist and narrative practitioners meant that the process of undertaking the research, particularly the discourse analysis, was personally transforming. This is noted later in the thesis at relevant points, but in undertaking a critique of feminist and narrative approaches to practice in which I myself had participated to some extent, my own understandings of the theoretical implications of post-structuralism for feminism, and of feminism for post-structuralism and for feminist-informed practice, were extended and developed.

One of the ongoing dilemmas I experienced as a feminist researcher in this study related to the conflict I felt in creating a friendly, mutual exchange in interviews with health care practitioners in the knowledge that their contributions would be submitted to intense scrutiny and critique through my discursive analysis. The creation of a friendly environment sometimes felt instrumental and strategic, in line with more traditional methods of social research (Oakley, 1981). However, at the same time, I was responding to the health workers as individuals, with many of whom I developed a closeness through the interview process (see Oakley, 1981, for a discussion of relationships in interviewing). As noted earlier, I believe that undertaking critical analysis of the gendered aspects of health care through interviews with practitioners is a legitimate form of distinctly feminist research. I also accept that the 'object' of scrutiny can be seen as the interview text and the discourses used (see Parker, 1992), rather than the practitioners themselves. However, I was nevertheless left with a sense of discomfort at submitting health workers' words and thoughts to intense critique. Furthermore, while I explained that I was undertaking a critical analysis of health care practice, I did not always feel that participants really understood what this would involve. For example, some of the health workers involved in BID program mentioned seeing their participation as good publicity for their program. In the earlier phases of my research, I attempted to rationalize my feelings of discomfort about the critical nature of my role through the justification of its feminist purpose. However, a feminist approach to research should incorporate attention to emotion as

part of the research experience (Stanley and Wise, 1990). On further examination, I understood my discomfort to in part emanate from my awareness that the individuals I interviewed were responding to what are often very difficult issues, usually with the best of intentions and a real commitment to providing support and help. In contrast, I sat in the university, far removed from the lives of women experiencing eating disorders, reflecting on their efforts in what felt like a critical way. I suppose this could be called an attack of the 'ivory tower' syndrome. This is not necessarily a completely resolvable dilemma, however, I do believe that it is vitally important that the findings of research in general, particularly critiques of intervention, find their way back to practitioners working in the field. As such, I am forwarding relevant parts of the data analysis to respective participants and offering them the opportunity to respond. This is not merely an attempt to assuage my own feelings of discomfort, but also to forge links between the academy and the health care field that are, I believe, of enormous importance more generally.

Lastly, while I consistently asked health workers about the broad area of eating disorders, there was a focus throughout their interviews on anorexia, reproducing the orientation of treatment services and the eating disorder literature more generally. However, I was able to usefully contrast, at relevant points, respective approaches to anorexia and bulimia.

Summary

This chapter has documented the research process undertaken for the fieldwork on which this thesis is based, situating the study within a qualitative feminist paradigm and a discursive approach to data analysis based on Foucauldian post-structuralism. Throughout, I have attempted to highlight the dilemmas and difficulties I experienced in undertaking the research, particularly those associated with the question of power relations between myself as 'the researcher', and participants as 'the researched'. Having set the scene for the study, the following chapters now turn to analysis of the interviews with health care practitioners. The first of these chapters examines the theme of 'autonomy' in eating disorders.

Chapter 5
Constructing the Self:
Identity, Autonomy and the Feminisation of Deficiency

Introduction

One of the dominant discourses to emerge from the interviews with health workers revolves around the idea that eating disorders, particularly anorexia nervosa, represent a struggle for identity. This concept was used to construct the intrapsychic realm of the eating disordered self, and to situate this self in relation to the externally located social world. The fact that eating disorders are widely understood as having at least some origin in particular historical contexts and social relationships (Gamer, Garfinkel and Olmstead, 1983) means that they provide a particularly good illustration of some of the ways in which individuals are positioned in relation to the social dimension within the mental health arena. Half of the health workers used the concept of identity in this way, representing most of the professional disciplines participating in the study.

While some of the ideas about identity used here are similar to those identified earlier in the work of Bruch (1978), health workers nevertheless use the concepts in idiosyncratic ways that have a number of specific effects in practice. In addition, this chapter explores the underlying ideas informing identity theory and their historical origins, elaborating in greater detail the ways in which these assumptions are gendered. The construct of identity has been previously identified as an important structuring concept by Hepworth (1999) in UK health workers' explanations of anorexia nervosa. However, the analysis undertaken here is distinctive for its specific focus on the ways in which the psychological theories informing accounts of identity are gendered and, later in the thesis, the implications of this for practice. Three key discursive themes emerged from health workers' constructions of identity in this study: (1) psychodynamic constructions of identity; (2) autonomy and connected-ness in identity, and (3) inauthentic identity (see Moulding, 2003).¹

¹ The themes examined in this chapter have been previously published in a paper entitled 'Constructing the self in mental health practice: identity, individualism and the feminization of deficiency', in the international journal, *Feminist Review*, 75, 57-74 (see Appendix 7).

Psychodynamic Constructions of Identity

While Bruch (1978) was the first to describe eating disorders through the psychodynamic concept of identity, the construct has specific origins in Erikson's (1980) theory of identity development. Erikson proposed that "ego identity" involves "the immediate perception of one's selfsameness and continuity in time" and a "perception of the fact that others recognize one's sameness and continuity" (Erikson, 1980: 22). Erikson (1980) also suggests that the individual gains a "sense of reality from the awareness that his [sic] individual way of mastering experience, his [sic] ego synthesis is a successful variant of a group identity", and this is understood as conferring "status and stature" on the individual (Erikson, 1980: 21-22). Thus, within Erikson's conceptualization, identity is understood as "a theory one has about oneself" (Marcia, 1987, 165), involving both a continuous sense of self, self-mastery and a recognition of this by others. While health workers were asked to explain eating disorders, many tended to focus on anorexia nervosa in particular. In line with this, Robyn, a psychiatrist providing therapy for young women diagnosed with eating disorders, emphasizes "self-control", agency and group identification in the following account of identity in the anorexic individual:

...[eating disorders are] a sort of self-definition, too, you know, a sense of identity. It's the identity of belonging to a group, or the identity of again owning one's own starving behaviour, and being in control of one's eating, and be able to make one do what one wants. Maybe [it's] a way that a young person defines her identity. So identity is another issue with this.

(Robyn, Psychiatrist)

Self-mastery is presented as the key feature of identity for the anorexic young woman, gained through mastery of "starving" practices and "control of one's eating" that are valued in the peer group. "Control" is portrayed as synonymous with agency for the individual because it signifies "owning one's own starving behaviour" and being "able to make one do what one wants", thereby projecting a sense of 'self-possession' to the outside world. Hepworth (1999) also identifies the themes of self-control and agency in UK health workers' explanations of identity in anorexia nervosa.

Also in line with psychodynamic conceptualisations of identity, health workers' emphasized the importance of 'continuity' in identity formation, and the idea that disruption in the formation of identity is implicated in

the development of eating disorders. While Patricia refers in gender-neutral terms to 'people' in the following account, as do other health workers in some of their extracts, elsewhere in these interviews it is revealed that individuals with eating disorders are universally assumed to be female. The following extract from Patricia, who is a community support worker, illustrates this notion of disrupted identity formation:

.....often there's other issues in families,.... [.]. there's histories, not in all families, but in some families. There's other histories in terms of,... just,lots of different histories and losses and,.....,and family disillusion,.... or,you know, ...break-ups, or losses, um..... Even not losses, or deaths of parents and family members, but marriage, separation.....um migrations, yeah, so legacies of changes of identity and things like that....[.]..and I suppose it's very much tied into also, um,[.].....what it means to be successful as a person in our society. Yeah, and sometimes that literal interpretation for people who are perhaps really vulnerable and are needing markers around guiding them and navigating themselves through some difficult stuff.

(Patricia, Community Worker)

In Patricia's account, "legacies of changes of identity" in the family are understood as leading to a "literal interpretation" of cultural prescriptions for individuals who are "really vulnerable". In line with psychodynamic conceptualizations, "identity confusion" is addressed by the individual through "over-identification" (Erikson, 1980: 97). Continuing with the theme of disruption in identity formation, Rebecca centres the psychodynamic idea that the parent-child relationship is of paramount importance in the early development of identity, and that disruption can lead to incomplete identity formation:

.....obviously things that happen early in a woman's life can make a difference, particularly, um, say, after losing your father earlier in life can.....would appear to be a significant risk factor. Um, you know, all sorts of...[.]..crises that interfere with a child's development of their sense of self, and their relationships with parents, and important people.

(Rebecca, Psychiatrist)

Rebecca implicitly positions eating disorders to be the outcome of trauma rather than normative in her account, where "crises" are seen to "interfere with a child's development of their sense of self". Eric also

focuses on the early parent-child relationship, suggesting that there has been “damage to the emergence of the child's sense of their own inner world”:

.....it seems very often ..[.]... quite a well meaning family to the outsiders. The fact is ultimately to damage the emergence of the child's sense of their own inner world. And what happens with the, you know, the characteristic of anorexia nervosa is that there is nothing inside. She can talk about nothing. She's, you know, the whole world is impinging upon her and she has no agency, not even a sense of control over her own thought processes. So it seems to me that the notion of control which arises, in control over her own body, and what goes into it, is in a perverse way an attempt some how or other to maintain a kind of agency which is part of the system itself [.] that has been damaged in the developmental process in that particular family environment. That seems to be, that's a characteristic situation.

(Eric, Psychiatrist)

Continuity is therefore understood to be essential to the development of a functional and complete identity in both Rebecca's and Eric's accounts. Eric's depiction of the family as “well meaning” is distinctive from Patricia's and Rebecca's emphasis on family crisis, and resonates somewhat with Bruch's (1978) notion that the families of anorexics try ‘too hard’ (particularly mothers, and Eric later goes on to clarify that he means mothers – see Chapter 9). Furthermore, Eric suggests that “damage” results in the anorexic individual lacking an identity or sense of self completely, where “there is nothing inside”. However, in this account, anorexia functions as a way for the individual to “maintain some kind of agency”, and therefore some form of ego identity, albeit a dysfunctional one. Paradoxically, the eating disorder becomes, then, an identity to deal with a lack of identity (see Malson, 1998: 147).

In common with the psychodynamic ideas of Bruch (1978) and Crisp (1980), the concept of identity is embedded in humanist discourse, with its assumption of the individual as “a unitary, essentially non-contradictory and above all rational entity” (Henriques et al, 1984: 93). Within psychodynamic identity theory, it is assumed that the healthy personality is ‘developed’ through childhood, after which the individual is a coherent self, with an identity that is continuous across time and place. The concept of ‘agency’ is also emphasized and understood to be synonymous with selfhood within humanist discourse

(Davies, 1991) and related identity theory, and this is reflected most clearly in Robyn's and Eric's accounts where the eating disorder becomes an attempt to maintain agency and, by extension, selfhood. Within this conceptualization, the individual is understood as "the agent of all social phenomena and productions" (Henriques et al, 1984: 93), and is therefore thought of as a sovereign individual, socialized by the wider collective, but at the same time standing apart from it (Davies, 1991). Thus, the humanist view of the relationship between the individual and society is dualistic. As noted earlier, the idea of the unitary, sovereign individual at the centre of humanist thought has been widely challenged by post-structural theorists, particularly Foucault, who emphasises the idea of discontinuity and contradiction as constitutive of individual subjectivity (Foucault, 1972). This challenges notions of progressive, linear development resulting in a unitary, coherent identity and, instead, views identity as a phenomenon that is contingent on social practices and, therefore, inherently unstable (McNay, 1992). The individual-society dualism structuring humanist accounts is consequently challenged in post-structural thinking because identity is understood as produced through language and discourse, rather than as residing within individuals' heads.

Autonomy and Connected-ness

In common with Bruch's (1978) theorization of anorexia nervosa, the emphasis on individual agency in humanist discourse more generally is tied to a concomitant valorisation of autonomy in the individual (Davies, 1991). Many health workers in this study problematised connected-ness and attachment in identity, implicitly idealizing the converse in the form of autonomy and separateness. For example, earlier, Eric introduced the idea that "the whole world is impinging" on the eating disordered individual because she has no identity or agency, and is therefore more subject to, and less separate from, the world around her. The idea that eating disordered individuals are more subject to forces outside themselves, and overly connected to or attached to others, was a feature of many health workers' accounts. The following from Gillian illustrates this idea:

.....people with anorexia tend to in many ways to have a much deeper level of um psychological problem,..... a sense of,..... a lack of sense of self, and a lack of sense of worth. And, um, if you've got those things acting in addition to all of these other pressures

you can,..... they're the people who are really likely to find themselves in problems with real eating disorders.

(Gillian, Psychologist)

Here, eating disordered individuals are portrayed as more subject to "all of these other pressures" because of a "lack of a sense of self". Patricia also suggests that eating disordered women are more subject to external forces, this time in the form of comments from other people:

...often I hear women's voices telling me stories which are really difficult. Um, they may have just spent six weeks in a treatment program, they go back to work, they may be receptionist at their local GP, and most of the clients coming through are going, "Oh, you've put on weight love". You know,.....it's really hard for that young woman to hold on to that fragile sense of herself, and her part of herself that she's wanting to be well, and, and, not get recruited back into self-starving. I mean it's considered quite OK for anyone to pass judgment and comment on women's bodies.

(Patricia, Community Worker)

Eating disordered women are portrayed as at risk of being "recruited back into self-starving" because they have a "fragile sense of self". While the socio-cultural dimension of eating disorders is acknowledged by Patricia through the comment that "it's considered quite OK for anyone to pass judgment and comment on women's bodies", the eating disordered individual is nevertheless constructed as suggestible and subject to others because her identity is weak. In a similar way, Melissa, having herself experienced an eating disorder, portrays such individuals as having weak, non-autonomous identities because they are controlled by others, rather than being self-determining:

.....on a personal level, eating disorder people tend to be intelligent, sensitive, perceptive people, highly creative, although their eating disorder saps that from them. And I think that makes them more vulnerable to all the other stuff that's out there, and more vulnerable to family loyalty. I think I notice family loyalty a lot with eating disorder people. That bind of trying to find themselves and be themselves which is often at the onset of sixteen,

seventeen, when they're really growing up, and yet perhaps wanting to meet their parents' needs as well, and that's a real conflict for people.

(Melissa, Counsellor)

While Melissa attempts to reframe the traits of the eating disordered individual to counter dominant deficit models, this also becomes a deficit account because pre-existing personality traits, such as "loyalty", are portrayed as disrupting the process of individuation. In common with psychodynamic identity theory, adolescence represents a critical period in identity formation in this account, where the individual must successfully tackle the "attachment and separation" developmental phase in order to gain a sense of autonomy and a complete adult identity (Bush, 1987: 210). Within this view, the individual cannot bond with others until they have fully individuated and separated themselves from their environment, including others (Erikson, 1968). In Melissa's account, eating disordered individuals fail to negotiate this separation, and remain "wanting to meet their parents needs as well". Thus, the eating disordered individual is constructed as having an immature, incomplete identity that is fundamentally *over*-connected to other people, rather than autonomous and self-contained. In the following account, Vivien also subscribes to the idea that eating disordered individuals are less separate from, and more affected by, others:

..... the issues which I think, from clinical practice, come up again and again and again is a way, especially people with anorexia, the way they seem to conceptualize relationships and living in the world, which is a bit like a seesaw. Often if they're doing better, it must be at someone else's expense. It's as if the fantasy is if things are going well for them, if they're having a good time, if they're enjoying themselves, it's as if they're pushing someone else down the other end of the seesaw. And the other way around too. That if they're having a hard time the fantasy seems to be that they're being punished, as if there's someone outside pulling strings so to speak.....[.].....And the idea that they should be able to manipulate the world, especially to feel liked. And often people that I see just haven't coped with the concept that everybody won't like them, no matter what they do, no matter how wonderful or good they might be, that everybody isn't going to like them, and that that's okay.....[.].....So I guess they're quite immature.....

(Vivien, Psychiatrist)

In this account, anorexic individuals are portrayed as fundamentally over-connected to, and affected by, others because they conceptualise relationships like a “see-saw”, and are therefore “immature” because they have failed to individuate. Further, Vivien constructs the behaviour of anorexics as “trying to manipulate.....change things” so they will feel “liked”, “accepted” and “approved of”, constructing anorexic individuals as experiencing themselves only in relation to others. This is portrayed as a deficit in the individual, and as underpinning their disorder.

Robyn also presents the eating disordered individual as particularly connected to others, emphasizing their emotional responses to their peer group:

....you find that the illness is very symptomatic of difficulties with the peer group for instance...[.]....when you see someone early on that is the thing they most want to talk about. So their peer group let them down, their boyfriend dumped them, other girls got envious, ah, you know, things like that...[.]....So that sense of [being] betrayed and let down [.] and all that sort of thing...[.]....And that's when, you know, a kid, she isn't going out as much, I mean, begins to think about her body and thinks “Oh well, this is a good time to go to the gym and I'll start starving. Bit of a self-improvement program...that'll show them”. And it does usually, ah, except often she gets locked into something she can't get out of.

(Robyn, Psychiatrist)

Girls are understood as very relational in the sense that their behaviour results from conflict with others, and is other-directed in that it has an intended audience: “that'll show them”. Thus, the supposedly improved body becomes a metaphor for an improved identity that is projected to the rest of the world. William also suggests that eating disordered individuals are seeking to communicate a new identity to the world through the metaphor of the body:

It's as though they're trying to repackage themselves by trying to change their weight and shape.

(William, Psychiatrist)

In the following extract, Sarah, who had also experienced an eating disorder in the past, introduces the idea that eating disordered individuals have weak boundaries around the self as an explanation for over-connectedness to others and the outside world more generally. The concept of weak boundaries is introduced through the idea that eating disordered individuals “lack a bit of a buffer” from the outside world:

.....these people tend to be quite perceptive, and sensitive people. And that's a great quality to have, you know, it's very useful. But this society is a very kind of competitive, hard, anxiety -ridden culture. Those people cannot then just crumble because...[.]..being [.] perceptive or considerate can be a bit too much. Sometimes you need to have a little bit of a buffer. You need to step back. These people often feel that they're somehow responsible for fixing everything..[.]..this belief that somehow you are in a position to fix other things around you.

(Sarah, Community Worker)

In common with Melissa's earlier account, Sarah also attempts to positively re-frame the traits of the eating disordered individual, however, they are nevertheless constructed as unable to cope with the demands of the modern world because they are less self-contained and too focused on the needs of others, rather than their own. Similarly, in the next extract, Melissa constructs herself and other eating disordered young women as less bounded, this time more specifically from the effects of female body appraisal:

.....personally I can remember my father saying to me, and looking back he didn't mean any harm, but I was about sixteen, seventeen, and he said to me “Oooh, you're getting a nice figure. You could go in one of those....[.]...beach girl competitions”. I was horrified. I actually felt really embarrassed and really “Oh, I don't want to because that's my dad”. I know that my sisters would not have taken that personally. I was different. I was the one that always wanted privacy in the bathroom ...[.]..... But girls are different around what they want, and I think as a parent you actually have to find out what that is and respect it, because people have a different sense of boundaries around the body. So you can touch

someone, but not touch someone else. Or you could say one thing to one person, but not to another one.....

(Melissa, Counsellor)

Melissa argues that it is the "different sense of boundaries" that individual girls have that leads some to take things "personally". Thus, girls prone to eating disorders are seen to be less bounded from the effects of female body appraisal than other girls. In this extract, boundaries are defined in two ways. Firstly, they are located around the body, in that "you can touch someone, but not touch someone else". Secondly, they are located around the self, because "you can say one thing to one person, but not to another one". For some individuals, comments penetrate weak boundaries and are internalized, while they fail to penetrate those individuals whose boundaries are more firmly delineated. The notion that the self is bounded also derives from psychodynamics, where "ego boundaries" are understood as providing "shock-absorbing delineation" from the outside world (Erikson, 1980: 42). In the individual with an incomplete ego identity, this protection is absent. As noted earlier, Hilde Bruch (1974a; 1978) centred the concept of diffuse ego-boundaries in her account of anorexia nervosa. In common with these ideas, Sarah's and Melissa's accounts construct eating disordered individuals as less bounded, less self-contained, and as therefore more vulnerable to incursions from outside.

Autonomy, Individualism and the Feminization of Incompleteness

In those accounts centring over-connected-ness, eating disordered individuals are presented as essentially non-autonomous. This is constructed as a weak and a lesser identity against its implied converse: the idealized autonomous identity. The centring of autonomy as the mark of idealized identity is embedded in a discourse of individualism which is based on the liberal belief that the individual is "a relatively autonomous, self-contained and distinctive entity, who is affected by external variables like 'socialization' and 'social context' but is in some sense separate from these 'influences'" (Kitzinger, 1992: 229). Malson (1998) identifies similar themes of idealized selfhood as autonomy within women's accounts of their experiences of anorexia nervosa, while Hepworth (1999) notes an association between identity and autonomy in UK health workers' explanations of anorexia. Malson argues that the individualism underpinning the idealization of autonomy "excludes the person who is influenced by social pressures from the idealized subject position of sovereign individual", producing this individual as 'weak' (Malson,

1998: 155). The portrayal of eating disordered individuals as overly connected to others, and responsive to social pressures, therefore constructs them as having failed to individuate and stand apart from the collective. This drives at the heart of a humanist conceptualization of selfhood because it destabilizes the notion of the sovereignty of the self, constructing eating disordered individuals as deficient in the core aspect of selfhood.

As noted in Chapter 2, an emphasis on the significance of autonomy and separateness in the development of a complete, adult identity has particular implications for the construction of women's selfhood. The observation that identity theory is based on the assumption of male identity was first made by Gilligan (1982) in her well-known work on gender and identity. Gilligan (1982) argues that the assumption of complete identity formation as characterized by autonomy and separation describes the development of male, rather than female identity. Gilligan (1982) suggests that the notion that the individual cannot bond with others until they have fully individuated and separated themselves from others and their environment is at odds with female identity because, for girls, intimacy and connected-ness are core features of identity. She argues that "male gender identity is threatened by intimacy while female gender identity is threatened by separation" (Gilligan, 1982: 8). The assumption that a healthy identity is characterized by autonomy therefore values those qualities traditionally associated with 'masculinity' while characteristics, such as connected-ness and a focus on others' needs, which are traditionally associated with 'femininity', are de-valued and rendered equivalent to incompleteness. The irony is that gender performance relies on such identification and responsiveness to others in women, and its refusal in men.

While Gilligan's (1982) critique provides a useful insight into the gendered nature of dominant assumptions about identity, it does not question the validity of the construct itself, assuming the individual to indeed have a unitary, continuous and internally located identity. Further, Gilligan (1982) asserts that because males and females undergo different stages of identity development based on differential gender role socialization, these *in reality* lead to different gender identities, where "men and women speak different languages that they assume are the same" (Gilligan, 1982: 173). Thus, in this view, 'femininity' and 'masculinity' are seen as "fixed features located exclusively in women and men" (Hollway, 1984: 228). Rather, it is argued here that respondents' use of these concepts reproduces the *idea* that connected-ness and responsiveness to others are equivalent to major deficits in the individual. Furthermore,

dominant constructions of identity are profoundly gendered in their assumptions about mental healthiness because they draw on an historical discourse of selfhood that renders qualities associated with the feminine equivalent to deficiency through the masculinization of strong identity and the feminization of weak identity.

The association of 'masculinity' with strength and independence, and 'femininity' with weakness and dependency, is by no means exclusive to psychological theories of identity. These dualistic ideas derive from long historical associations in dualist Cartesian thought between 'male', 'rationality', and 'independence', and between 'female', 'irrationality', 'emotion' and 'dependence' (Jaggar, 1989). As noted earlier, a study conducted by Broverman et al (1972) clearly demonstrates the impact of these ideas in the mental health field where socially acceptable 'feminine' characteristics, such as dependency and emotionality, were perceived by health workers as conflicting with notions of mental healthiness because they are at odds with notions of instrumentality and adulthood (Broverman et al, 1972). Conversely, 'masculine' characteristics were unproblematically understood as marks of mental health in men (Broverman et al, 1972). Thus, notions of mental health in women are inherently conflicted and contradictory because women are concurrently constructed through fundamentally contradictory discourses. While femininity discourse confers 'feminine' qualities, these are rendered deficient through psychological theories embedded in a discourse of individualism that is predicated on masculinist assumptions of idealized selfhood.

The Feminisation of Inauthentic Identity

There was one other way in which a discourse of individualism was used to construct identity in respondents' accounts, and this was employed to explain 'body image problems' rather than 'eating disorders' *per se*. However, because body image dissatisfaction was generally understood by these health workers to be a part of eating disorders, these accounts have relevance for workers' constructions of identity in eating disorders. The following accounts are structured around the notion of true and false identity:

..... we don't spend a lot of time reflecting, or working out, who we really are. We get our values or our ideas of what we should be from out there,..... externally. And I think that that sets up a lot of problems for you know, body image. And it's just such a superficial thing

really, isn't it? When you think about it. It's not really who we are, or what we're about, and yet that's what we've chosen, or especially women.....

It's interesting that women will say[.].....they'd choose to have two years off their life if they could be ten kilos skinnier..[.]....that's how much of a need there is for women to define their sense of self through how they look, and that body image. Which is quite scary, because it's, um, it's not what it's about. And it really prevents them from looking at themselves, or what they want in their lives, or, you know, who they want to be at a really deeper level. Because they're still caught in this very superficial kind ofyeah.

(Sarah, Community worker)

In Sarah's account, identity derived from outside the individual is understood to be false, while identity derived from within is real and authentic. Thus, women are distracted from the truth of themselves because "we get our values or our ideas of what we should be from out there....externally". This is framed around the idea that the truth of the self lies buried deep within the individual, and that a process of self-discovery will reveal this. Sarah also suggests that women can be architects of the self by looking at "who they want to be at a really deeper level", entailing a process of self-production in addition to one of self-discovery. The notion of self-creation reflects contemporary discourses of individualism, sometimes referred to as "new age" philosophies, which emphasize ideas of self-determination and self-actualization. It is assumed that this process needs to take place at "a deeper level" because the development of a true self occurs internally, at the heart of the individual, rather than in the superficial, external world of body image. In the next extract Paul also draws on this idea of true and false identity:

I think [body image disturbance has] risen much more in recent times when there's a tendency for people to be fairly anonymous, whereas perhaps in times gone past they'd be part of an extended community, an extended family, [and] their identity was more from being known. Um, now perhaps there is a tendency more to be known by how you look or by your money, or by your success.....

(Paul, Psychiatrist)

Thus, being “known by how you look” is a superficial, false identity in contrast to being known for your true inner self. Clare also uses a similar notion of true and false identity in body image problems:

.....there's not an acceptance of people for the size they are. There's not an acceptance of the person for who they are. It's really much more conditional on meeting certain kinds of stereotypes than that.....

(Clare, Psychologist)

In this account, “certain kinds of stereotypes” represent the world of external, false identity, while true identity involves individuals being accepted for “who they are”. Malson (1998) also identifies similar themes of true/internal and superficial/external identity in women’s explanations of their experiences of anorexia nervosa. She argues that the intersection of these metaphors with constructions of ‘feminine’ identity is problematic because dominant constructions of femininity centre physical appearance and beauty practices (Malson, 1998). The location of authentic identity within the internal depths of the individual is therefore “profoundly at odds” with the superficiality of this construction of ‘femininity’, which becomes “the other of identity” (Malson, 1998: 149). The notion of superficial identity serves, then, to feminize *inauthentic* identity, just as the privileging of autonomy feminizes *incomplete* identity.

The ‘Othering’ of Women in Discourses of Identity

The psychological theories employed by respondents to construct women with eating disorders serve to position them as “Other” to a male norm (Kitzinger and Wilkinson, 1996: 3). This is achieved by simultaneously constructing women with eating disorders through a discourse of femininity that portrays them as connected and superficial, and through supposedly non-gendered psychological theories embedded in a discourse of individualism that denigrates and negates the ‘feminine’. Psychology has been called a “masculine-invested discipline” which has applied itself to “the repudiation of all things (supposedly) feminine”, including “emotions, subjectivity, connected-ness and contextuality” (Burman, 1996b: 139). As noted earlier, this is made possible because psychology’s model of the “thinking, reasoning individual” is a model of man, defined by “male-defined criteria of normality”, and made possible by the subordinate positioning of women in gender power relations (Burman et al, 1996b: 3). Thus, “other-

ness is projected on to women...[.]...such that [women] are constructed as inferior or abnormal”
(Kitzinger and Wilkinson, 1996: 4).

Health workers' constructions of autonomous and authentic identity are also structured around a further dualism based on gendered assumptions: a Cartesian separation between mind and body, with the latter positioned as inferior and in need of control (Lloyd, 1989). In psychodynamic accounts of identity provided by health workers, the body is presented as merely a vehicle for the mind/self to establish and project an identity through the control of the body's physicality and desires. For example, Robyn suggests that control and mastery of the body by the mind/self produces an identity for young women. Thus, in psychodynamic conceptualizations, identity resides in the mental realm, and the body is merely a non-gendered appendage for the activities of this self. In health workers' accounts of true and false identity, the mind is associated with 'truth' and the body with 'falseness' and the 'superficial'. This privileging of the mind/self over the body fails to engage with the extent to which dominant conceptualizations of femininity define women as bodies, in ways men are not, through the centring of sexuality on women (MacSween, 1993). In part, this derives from historical associations between 'masculine' and mind, and 'feminine' and body (Jaggar, 1989; Lloyd, 1989). The idealization of the mind/self over the separate, feminized body in health workers' explanations of identity in eating disorders reproduces this hierarchical dualism, and fails to engage with the gendered nature of women's bodily experience.

The simultaneous positioning of women with eating disorders as feminine and deficient against an idealized notion of disembodied, masculinized autonomy is embedded in a discursive framework that places women's subjectivity in the midst of a central contradiction. As noted earlier, the idea that eating disorders themselves are understood as related to the contradictory expectations placed on women in contemporary society has been previously canvassed by post-structural feminists. In particular, MacSween (1993) argues that the body management practices associated with anorexia nervosa can be understood as "an attempt to resolve at the level of the individual body the irreconcilability of individuality and femininity" in western culture (MacSween, 1993: 252), symbolized through resistance to a traditional 'femininity' signified by the rounded female body (Bordo, 1990; MacSween, 1993). Furthermore, as noted earlier, Bryan Turner (1992) argues that contradiction is a distinguishing feature of contemporary expectations of adult women more generally, where women are expected to be 'autonomous' and

'compliant' and 'independent' *and* 'dependent'. I argue that similarly conflicted ideas about women as 'autonomous' *and* 'connected', and 'deep' *and* 'superficial' are produced through the discourses employed by health workers to delineate women with eating disorders and body image problems from other women through the construct of identity, rendering the former deficient in the masculinized ideal of selfhood.

If eating disorders are indeed reflective of contemporary women's attempts to forge subjectivities out of fundamentally irreconcilable discourses, a presumption that recovery necessitates the ascendancy of masculinized autonomy over feminized deficiency ironically reproduces the discursive double bind that has been widely implicated in structuring eating disorders themselves. Gremillion (1992) has previously shown how contemporary psycho-medical explanations of anorexia nervosa and associated treatments reproduce a host of dualisms, particularly mind-body dualism, which she argues are central in sustaining anorexic practices. In a similar way, a dualistic approach to identity as internally located selfhood structured around idealized 'masculine' and deficient 'feminine' elements reinforces the idea that the 'feminine' is indeed objectionable and must be controlled or negated. How individuals are conceptualised is "a political issue with distinct consequences for the ways in which we experience and understand our feelings and behaviours" (Malson, 1998, 156), where the "politics and the metaphysics of the "person" are closely entwined" (Hirst and Woolley, 1982: 131, cited in Malson, 1998: 156). The ways in which the 'self' is conceptualized in the context of practice therefore has political consequences for how women come to understand and experience themselves. Similarities between the discourses used by mental health workers to construct identity and selfhood in eating disorders, and those identified by Malson (1998) in her work with women on their experiences of anorexia nervosa, are indicative of the dominance of individualism and particular conceptualizations of femininity in western cultures and, more specifically, in the mental health arena. Where health workers take an uncritical stance, a correspondence between practitioners' and women's assumptions about identity and selfhood could undermine the potential for the production of new meanings in the practice context. In Chapters 8 and 9, the ways in which these ideas are taken up in health care workers' approaches to practice are explored and the implications for women examined.

Summary

This chapter has examined the gendered nature of health workers' explanations of eating disorders through the idea of identity deficiency. In particular, the chapter demonstrates how a focus on the internally located and supposedly gender-neutral construct of identity obscures the profoundly gendered nature of the discourses used to construct the subjectivities of women with eating disorders. While this chapter focused specifically on the themes of autonomy, connected-ness and authentic-ness, the construct of 'self-control' is intrinsically related to that of autonomy, and was emphasized by some health workers earlier. For example, Robyn and Eric argue that eating disorders provide individuals with a sense of self-control. The next chapter specifically examines the construct of 'control' in health workers' explanations of eating disorders, focusing again on the ways in which knowledge used to characterize eating disorders in this way is inherently gendered.

Chapter 6

Constructing the Self:

Lack of Self-Control as a Feminised Deficiency

Introduction

The idea that anorexia nervosa originates in an identity lacking in autonomy is tied to the concomitant notion that anorexia functions to provide a sense of self-control for individuals who are out of control (Bruch, 1978; Crisp, 1980). Anorexia was specifically theorised as the pursuit of self-control by many health workers in this study so that it functioned as the second dominant explanatory discourse. Control was theorised as central to eating disorders in two main ways. Firstly, the idea of sexual regression was drawn on to characterise anorexia as the pursuit of control through a retreat from adult female sexuality. However, health workers' ideas of sexuality in both anorexia and bulimia were not straightforward, and involved gendered assumptions that had implications for the way control was understood in eating disorders more generally. Secondly, health workers characterised eating disorders, primarily anorexia, as a way of controlling repressed emotion. This chapter will examine the discourses health workers utilised to characterise eating disorders in these ways, paying particular attention to the gendered nature of these conceptualisations.

Sexuality and Control

As discussed in Chapter 2, anorexic women are often described in the psycho-medical literature as regressing to a child-like state to avoid adult female sexuality through psychobiological regression (Crisp, 1980). The following extract from Paul draws directly on Crisp's theory of psychobiological regression:

If I was looking for a favourite theory it would be that of Arthur Crisp with the regression hypothesis, the notion that the child is not terribly well equipped for going through adolescence and the developmental tasks needed and sometimes later on in life finds tasks beyond their coping and then they tend to regress back to a simpler lifestyle where they weren't ultimately responsible for things and, say, become notionally an eleven year old.

(Paul, Psychiatrist)

Paul emphasises the idea of a complete retreat from the responsibilities that accompany adulthood. While Philip also employs Crisp's theory of psychobiological regression, he focuses much more specifically on the loss of female sexual characteristics:

.....and the other part of the psychiatry is that anorexia actually works. You lose weight and the normal biology of [female] weight loss is that you lose your hormonal status. [It] changes back to that of childhood. So all that chaos and disorder of adolescence just disappears... [.].....and that's one of the reasons it is a very painful disorder to have, because as you gain weight you go back through all that, all that sadness, strange identity, struggle, all that stuff comes back.

(Philip, Psychiatrist)

In this account, the loss of "hormonal status" returns the woman's body "back to that of childhood", determining whether she is adult and sexual, or child and non-sexual. Thus, as in Crisp's (1980) model, biological puberty constitutes a 'maturational crisis' associated with the "chaos and disorder" of female adolescence. However, as was pointed out earlier, it is unclear why female puberty in particular should be so problematic. Rather than focus on the cultural meanings of the female body and sexuality, "chaos and disorder" are located within young women themselves. Ironically, Philip discusses the contradictory nature of contemporary society's expectations of girls and women elsewhere in his interview, however, links are not made between the social and individual dimensions. Instead, female adolescence is assumed to be, by its very nature, tumultuous, and this is specifically tied in a biologically deterministic way to hormonal activity.

The following extracts also draw on the idea of sexual regression in anorexia nervosa, but rather than focus on puberty, they emphasise regression as a response to the experience of sexual abuse:

.....there is [.] [the important issue] of self-protection, too, for patients who have been sexually abused.....losing their sort of female secondary sexual characteristics, you know, starvation may make them feel safe from that sort of intrusion.

(Robyn, Psychiatrist)

Joanne:..... the first thing that comes to mind would be, um, sense of control. Um, I think people who have eating disorders are trying to get some control in their lives over something, um, and that might be a whole range of different things ...[....].....possibly there is a fear about something and that if they feel they can overcome that by doing what they are doing,.....or it can be a protective sort of thing for them, um, I'm not sure.

Nicole: Like as if it might relate to issues other than food and body image, is that [what you mean] when you say a fear sort of thing?

Joanne: I've heard of like a number of women who develop anorexia have done that because they don't want to be sexually attractive, or even women who have become bulimic, and that have become really overweight, um, have done it because they don't want to be sexually attractive to men. And that might have been because they were abused as a child, or they were raped or something like that. So, um, they've done that to....in a way it's a protection thing to overcome that. Now obviously that's not with everybody, but that's I suppose what I'm thinking.

(Joanne, Dietician)

.....I think we need to see that, um, say if we take something like anorexia nervosa, we're looking at an end point of a number of different possible scenarios. I do think that the idea that the young woman, and we'll say it's a young woman, has in many ways a kind of phobia of maturation and the reason for that is not always the same. I mean an obvious one is that she suddenly becomes sexually attractive, she has an unpleasant sexual experience, she doesn't want it to happen again.....

(Eric, Psychiatrist)

In the above accounts, anorexia develops as protection against sexual abuse, where the loss of secondary sexual characteristics is seen as serving a function for a woman by 'de-sexualizing' her, thereby protecting her from further abuse. Without eliding the fact that sexual abuse is likely to impact on individuals in particular ways, it is also extremely widespread in western societies (Scott, 2001). While particularly common among eating disordered women (Leonard, Steiger and Kao, 2003), sexual abuse

cannot function as an explanation of eating disorders on its own because not all eating disordered women report sexual abuse, although it is likely to be important for those who do. More particularly, the idea of sexual regression is linked to psychodynamic and psychoanalytic theory, and locates the effects of abuse deeply within the individual in a totalising and universalising way, so that it becomes psychologised as an internal sexual problem rather than a function of gender power relations. Using a post-structural feminist approach, MacSween (1993) argues that anorexia can be understood as an attempt to create a self-contained body that is impenetrable through the elimination of hunger as symbolic of all desire, including sexual desire. However, she demonstrates that anorexia involves an attempt to re-work the *discourses* of female sexuality, not the *actuality* of female sexuality (MacSween, 1993). Similarly, Malson (1998) shows that, while there is evidence that women welcome the loss of breasts and periods in anorexia, this is related to their symbolic associations with an uncontrolled and over-sexualised female body, rather than a retreat from sexuality *per se*. Health workers' deployment of the idea of sexual regression constructs eating disordered women's sexuality as personally problematic *in reality*, and as the core of their psychopathology.

An exclusive focus on breasts and other secondary sexual characteristics as indicative of female sexuality is also based on the assumption that women's sexual status is entirely determined by the observable features of the female body that distinguish it from the male. The concept of sexual regression therefore relies on one reading of the thin female body as an asexual, child-like body. While Malson's (1998) work with anorexic women demonstrates a welcoming of the loss of signifiers of female sexuality, at the same time she shows that the thin female body is sexualised in other ways. For example, women's accounts of anorexia include its sexualization as an extreme version of 'fragile' femininity (Malson, 1998). Furthermore, children's bodies, particularly girls' bodies, are commonly sexualised in western culture, for example, through pornography and the fashion industry. To suggest that such a body is protective against sexual abuse ignores the fact that it is children who are commonly abused in this way, and that many women's experiences of sexual abuse occur in childhood (Scott, 2001). Thus, the thin female body is caught up in discourses that sexualise and de-sexualise it in various ways, demonstrating its multiple, and often contradictory, meanings. The notion of sexual regression in eating disorders fails to engage with these multiple meanings and their associated power relations. Instead, the idea of regression either personalises the effects of sexual abuse so that it becomes an internalised attempt at control through

suppressing sexuality, or fails to elaborate why the transition to the adult female body in puberty might be problematic in a cultural sense. The form of the female body becomes, then, merely an external reflection of an individualised and internal psychosexual conflict.

This failure to critically engage with the contradictory meanings of female sexuality is most graphically illustrated by health workers through the oppositional depiction of sexuality in anorexia and bulimia. While health workers portray anorexic women as sexually controlled through the idea of sexual regression, the sexuality of bulimic women is constructed as flagrantly sexual and out of control. For example, in the following extract, bulimic women are described as “promiscuous”:

[I look at] whether [bulimics] are multi impulse disturbed, where sort of the eating disorder is but one manifestation of them where they might be sort of abusing alcohol, abusing drugs, being promiscuous, and the food is just another manifestation of being out of control.....

(William, Psychiatrist)

The term “promiscuous” is used almost exclusively to describe female, rather than male, sexual behaviour, and denotes immorality and licentiousness (Lees, 1986). Promiscuity is also aligned in this account with being “multi-impulse disturbed” and “out of control” more generally. In the next extract, Philip also constructs bulimic women as sexually out of control:

.....there are two or three things about bulimics. It seems funny to talk about it in that way but anyway.....one is that they are a bit more hot headed and over the top before they developed their weight disorder. So they're probably temperamental somewhat....[.].....Certainly, if you believe in a term like hysteria, which is a sort of term we abuse these days, but if you look at models, I mean, whatever the word hysteria means, they've got some of it.....[they] come in, and sort of look at me, so all that part of apparent sexuality which isn't real and that sort of stuff. Well, the bulimics have more of that kind of way of presenting themselves. I mean, they'll arrive at an interview at nine o'clock in the

morning and they'll have green eye shadow on, and lots of jewellery, and look like they're just going to a disco. They're like that. So they are different [from anorexic women].

(Philip, Psychiatrist)

Bulimic women are portrayed as hysterical in the sense that they are "over the top" in their dress and behaviour in a way which is presented as projecting sexual availability. However, the sexuality projected by the bulimic woman is only "apparent sexuality which isn't real", and is loosely tied with the idea of a past experience of sexual abuse, and with "hysteria". The idea of hysteria as involving 'play-acting' and histrionics – 'much ado about nothing' - was common in the nineteenth century (Showalter, 1985), and is clearly reproduced in the way Philip portrays the personalities and sexualities of modern day bulimic women.

The idea of opposing sexualities in anorexia and bulimia is reflective of a specific historical discourse that represents female sexuality through the dualism of the "virgin" and the "whore", that is, as passive and innocent, or active and dangerous (MacSween, 1993: 178). In the above construction, then, anorexia represents the virgin while bulimia represents the whore. The dichotomous construction of female sexuality in eating disorders is matched by a more general oppositional construction of anorexia and bulimia by psychiatrists in this study. While bulimic women are constructed as "hot headed and over the top", as having "hysteria", "abusing alcohol", "abusing drugs" and "being out of control", anorexic women are constructed as passive individuals who like to "please" (Philip). As was pointed out earlier, though, the fixing of oppositional sexualities and personalities in anorexic and bulimic women fails to acknowledge that many women actually move between these two diagnostic categories.

While health workers portray anorexic women as primarily asexual in contrast to the flagrant, uncontrolled sexuality of bulimic women, Philip nevertheless portrays sexuality in anorexia as ultimately ambiguous and contradictory. In the following extract, an anorexic young woman is initially characterised as "naïve" and innocent:

I can remember one lovely kid that I looked after who was brought up in [the country].....[.]... I think she'd been to [the city] about twice in her life, and she decided that

she would be a teacher. She arrived at the [university] and you could just imagine, it was just completely overwhelming, lost, and she developed severe anorexia and I saw her and we started to treat her as an out patient and...[.]...I was trying to explain to her how the world works and universities and then she disappeared at a point where she got depressed...[.]...she was utterly overwhelmed that we actually even thought to ring her, she was so naïve you see, [and] I said "Would you like to come back and talk to me?" and she said "Can I come this afternoon?" As it happened she could, and she arrived.....

(Philip, Psychiatrist)

In a continuation of this extract, the same young woman's appearance and behaviour at the next appointment are characterized very differently:

.....in through the door she comes, she's got her hair dyed black, and all spunky, and she's got diamonds in her nose, and a ring through her lips and, you know, and a kind of see through sort of nightie thing that she was wearing and all that sort of stuff. It turned out that she'd been sitting up all night drinking coffee and too much alcohol and she'd got into sex in a big way and she was smoking heavily...[and I said] "Well, it's not very good is it?".....

(Philip, Psychiatrist)

The once "naïve" young woman is transformed from 'ingénue' to 'tramp' in this account through the dualism of the 'virgin' and the 'whore'. The potential of the whore clearly lurks in all women, despite appearances to the contrary because, as is argued by MacSween (1993), the idea of female sexual passivity is itself based on fear of the underlying uncontrollable nature of female sexuality. Ironically, MacSween (1993) argues that the control of appetite and eating in anorexia in part represents women's attempts to control a feminine sexuality that is understood to be unacceptable, overwhelming and dangerous. Once again, a gendered dichotomy implicated in causing eating disorders in the first place is reproduced within health workers' accounts.

While health workers depict the sexuality of eating disordered women as problematic, their accounts are also implicitly underpinned by a supposedly gender-neutral assumption of 'normal', 'healthy' sexuality that is neither overly controlled nor out of control. However, Philip's depiction of the young anorexic woman's behaviour as unacceptable demonstrates how fine the line can be between sexual behaviour that is deemed acceptable for women, and that which is not. Furthermore, the fact that it is difficult to imagine a young male university student being reprimanded for drinking alcohol, smoking and sexual experimentation serves to underscore the continued operation of a gendered double standard in relation to notions of 'normal', 'healthy' sexual behaviour.

The dualistic construction of sexuality in eating disorders within health workers' accounts results in an ambiguity characteristic of many of the explanations in this study. Just as the anorexic's self-mastery and control is deemed inauthentic because it masks underlying deficiencies in autonomy and control, her apparent sexual naivety is conflicted because it masks an unbridled, uncontrollable sexuality. In these accounts, both anorexia and bulimia represent the ultimate failure of self-control, constructed in gendered terms through conflicted notions of female sexuality. Thus, health workers' accounts of sexual regression, and sexuality in eating disorders more generally, are characterised by a lack of engagement with the gendered meanings of female sexuality, resulting in a *re-inscription* of the gendered dichotomies that are implicated in causing eating disorders in the first place.

Emotion and Control

The idea that eating disorders function as a means of managing repressed emotion was the second way in which control was theorised as a central aspect of eating disorders, particularly anorexia. Health workers used a mixture of ideas from psychoanalytic and psychodynamic theory to theorise the psycho-emotional aspects of eating disorders, locating them deeply within the core of the self. For example, Rosemary uses the concept of 'depth' to construct the eating disordered individual as many-layered, where the nature of the "problem" is portrayed as "more deep-seated" than for individuals with body image problems:

I'm not an expert in this field but I guess my gut reaction is about all I can give you on this and I feel that the eating disorders are really much more deep-seated. I suppose they are

probably related to self-esteem problems and...but I think that people who have those disorders are probably, um, I think they also have other psychological problems that drive them to such extremes. I don't think.....perhaps the media has an influence with them, but I think that more in a way they have more deep-seated problems than being unhappy with the shape of your thighs.....

(Rosemary, Fashion Design Lecturer)

In contrast to the depth associated with eating disorders, "being unhappy with the shape of your thighs" is portrayed as a more superficial problem. Thus, body image is located in the realm of the superficial, external body while eating disorders implicate the core self of the individual. Rosemary also suggests that the "psychological problems" of the eating disordered individual "drive them to such extremes", suggesting that eating disorder behaviour is the product of psycho-emotional conflict, rather than conscious rationality and agency.

The idea that the individual is many-layered, and that psychological problems lie buried deep within the recesses of the self, derives from, and reproduces, the psychoanalytic concepts of the unconscious, defence mechanisms and repression. In psychoanalytic theory, the individual psyche is conceptualised as structured around a conscious and unconscious, where defence mechanisms function to repress desires unacceptable to the conscious, or "ego", into the unconscious (Neale, Davison and Haaga, 1996: 35). While these desires are repressed, they nevertheless exert an influence over behaviour of which the individual is not consciously aware (Neale, Davison and Haaga, 1996). While psychoanalytic theory places an emphasis on sexual conflict, Rosemary is not specific about the nature of the psycho-emotional conflict that is driving the individual.

Melissa also invokes this notion of repressed psycho-emotional problems, or "conflict", in her explanation of body image distortion in eating disorders:

Melissa:say if I took an example of someone who has been sexually abused, and they're not ready to deal with that and,..... so it's, ah, an easier conflict to think one is fat

and be trying to deal with that, and,...[.]..... for that person to have a clearer body image too soon may be dangerous, you know?

Nicole: So it's protecting them from other emotions is that what you [mean]?

Melissa: Other, yeah, other things that they find impossible to deal with, or that part of them knows they don't have the support yet, or they don't have the ego strength because of that...they...um, do you know what I mean? So I think eating disorders can be really protective for someone.

(Melissa, Counsellor)

Here, the individual is constructed as a self divided, where "part of them knows", that is, the unconscious self knows that the conscious self is not strong enough to face repressed psycho-emotional conflict. Body image distortion in eating disorders functions, then, to protect the individual from "things that they find impossible to deal with". Three other respondents also portray eating disorders as serving to repress psycho-emotional conflict within the individual:

Ruth:from what I've seen here they use it as a strategy against [.] anger, against rejection, um, the feeling of abandonment, um, yeah, and they u[se] [.] their issues that they have around food [as] the way that they cope with their day-to-day life. And it could be that.....the cause then leads to their eating disorder which then essentially becomes their coping strategy to deal with the.....the initial or primary issue. Does that make sense?

Nicole: And what sort of initial or primary sort of issues would you, [identify]?

Ruth:[.]..... um, abuse, um, within the family. That could be emotional abuse, sexual abuse, physical abuse. Relationship problems, um, with somebody close. It could be that there's been a breakdown in the family, you know, parents have broken up, something like that. Schooling difficulties, bullying at school.....

(Ruth, Nurse)

.....I think people, once they start losing weight, will report feeling a sense of being disciplined, feeling special, feeling high, and I think what the weight loss does is enable

them to block out whatever the underlying psychological issues were at play in the past.....

(William, Psychiatrist)

Jennifer: I can think of one woman who I'm working with whose mother died when she was just about to reach puberty..[.]...

Nicole: How would you understand for that person, the death of her mother, to have then brought her into eating related problems?

Jennifer:...[.].....I think that she would say she never actually grieved her mother. She, um,... she couldn't,.....she never cried. And she didn't have anyone to help her walk through that anger. And I think that's what kids often need because they can't necessarily help. So she went to boarding school and slipped into a food disorder from there. And she would say, you know, the eating disorder took up all of her all her time. And I think that's what eating disorders do. They come into a young woman's life often when [they are vulnerable]...And I'll talk to [them] about how they're a bit [of a] con merchant. They'll distract [from the real problem]. And that's what they did this time. She anaesthetized herself to all feelings around her mum, and around her own sense of self worth um at twelve, thirteen.....

(Jennifer, Social worker)

The eating disorder is variously constructed as: "a coping strategy against anger" (Ruth); "enabl[ing] them to block out underlying psychological issues" and "repackage themselves" through the avoidance of negative emotion (William), and; distracting the individual from "feelings" such as "anger" (Jennifer). In each of these accounts, the individual is presented as avoiding negative emotions through the eating disorder, which operates as a protective defence mechanism. For Ruth, it is negative emotions associated with past sexual abuse that are being avoided, although she doesn't explicitly suggest the idea of sexual regression. In William's account, even positive emotions associated with eating disorder practices cannot be trusted, because 'underneath' lie negative emotions "from the past". In Jennifer's account, while the eating disorder might have "anaesthetized" the individual against feelings at a conscious level, they are

nevertheless in the grip of emotion because this is seen as driving behaviour. William elaborates further the way in which eating disorder behaviour is "driven" by the avoidance of negative emotion:

William: I think what sets people apart with an eating disorder is the inability not to do it. It's the level of compulsion that's introduced. So it's the driven-ness of the behaviour, as much as the behaviour.

Nicole: OK, it's the idea of control around what they are doing and the sense of being out of control?

William: Yeah, and not being able to stop it if they wish to. It's like, ah, it's the driven-ness like, ah, there are a group of people who will take laxatives because they are constipated, and there are a group of people who have to take it because if they don't something terrible will happen. Their level of arousal will increase and they will feel absolutely distraught. And we are not talking, and I'm certainly not talking about one or two. It is sort of hundreds of laxatives a day. And so it is the intensity or the driven-ness that I think sets it apart.

(William, Psychiatrist)

Central to the suggestion that the eating disordered individual's behaviour involves "driven-ness" and "a level of compulsion", is the idea that it is the product of the avoidance of unacceptable emotion: if the individual doesn't purge "their level of arousal will increase and they will feel absolutely distraught". Repressed emotion is therefore portrayed as the driving force behind the eating disorder, which functions as a control mechanism. This is presented as setting eating disordered individuals "apart" from other individuals who are, by implication, in control of their behaviour.

Patricia also draws on psychoanalytic ideas to construct the eating disordered individual as repressing emotional conflict, but in a slightly different way:

..... I sort of probably really seem to be saying that it's an expression in people's eating behav[our of], ...emotional pain, um,.....dilemmas, conflicts, um..... past experiences. Sometimes at particular junctures in [] life when they're incredibly vulnerable. Yeah, and it's

often.....the.... often associated [with] other histories as well, and other experiences.

Legacies from families.....

(Patricia, Community Worker)

In this extract, "emotional pain" and "conflicts" can emerge from the unconscious when the individual's defences are down, "at particular junctures in [] life when they're incredibly vulnerable". Eating disordered behaviour becomes characterized, then, as an external representation of internal psycho-emotional conflict, primarily deriving from presumably negative experiences within the family, where the body of the eating disordered individual becomes a metaphor for repressed conflicts buried within the self. This is slightly different to the preceding accounts, where the eating disorder functions as a defence mechanism against repressed conflict, however, the eating disorder is nevertheless understood as driven by repressed psycho-emotional conflict, and as a way of managing and controlling emotion. Again, while Patricia draws on psychoanalytic concepts, she does not explicitly characterise repressed conflict as sexual in nature. Christina also portrays the body of the anorexic individual as a metaphor for internal psychic conflict when she suggests the eating disorder functions as "a language":

.....when you get into say the anorexia side of things, it's interesting how this body becomes a really a language to say to people "Piss off. Shut up. I don't want to do this. I can't do that." It's a language to say "I hate myself", just like cutting is. I mean, I interview a lot of my women who cut and scratch and burn and self-mutilate, and what else is [than self-abuse] taking a box of laxatives, or binging to the point that you're so much in pain, and then vomiting, which is a very, very painful experience for those who are kind of vomiters? It still hurts. They're all forms of denigration and abuse of the body, self-abuse of the body.....

(Christina, Counsellor)

This account portrays the internal world of the eating disordered individual as extremely tormented and conflicted, involving intra-psychic dynamics of self-punishment, self-hate and "pain". Mind-body dualism is clearly apparent, where 'the self' abuses 'the body' as an expression of self-hatred, and where the anorexic body becomes an expression of these repressed meanings. There is the idea here that the

anorexic individual is making a communication in response to social pressure when Christina uses "active voicing" (Potter, 1996) in: "Piss off. Shut up. I don't want to do this. I can't do that." In this account, the body is presented as symbolic of an emotionally conflicted inner self caught up in particular social expectations. However, while the individual is presented as being in relationship with the outside world, and her emotions are given a social meaning, her distress is nevertheless firmly located in the intra-psychic dimension in a dualistic way.

While these health workers borrow the concept of psycho-emotional repression from psychoanalytic theory, which rejects the humanist notion that subjectivity is unitary and fixed (Weedon, 1987), they nevertheless portray emotion as disruptive to rationality and control because it results in behaviour that is "destructive", "driven" and outside the individual's conscious control. Repressed emotion is also presented as distinguishing eating disordered individuals from other individuals, rather than as a feature of humanity in general. In this sense, then, the idealized state is to be free of psycho-emotional conflict, and in conscious, rational control of oneself. The health workers also portray psycho-emotional conflict as constantly present in the psychic structures of the eating disordered individual, and as exerting a continuous effect on behaviour. When repressed conflict is associated with past sexual abuse, its effect of repressed emotion is located within individual subjectivity itself (Weedon, 1987), its cultural meanings unexplored, producing a meta-narrative of psycho-emotional repression in the individual that is ahistorical, monolithic and totalizing, based on the assumption of universal psychic structures. This totalizing effect is reflected in these accounts more generally, where emotions are fixed within the individual, irrespective of specific social context. Thus, the way in which psychoanalytic and psychodynamic ideas are used in health workers' accounts produces an explanation that is essentially individualistic and asocial. Only Christina explicitly links the emotional conflict experienced by the eating disordered individual to its social context, however, it is nevertheless located within the psyche of the individual themselves. While some health workers link individual experiences of eating disorders to socio-cultural pressures elsewhere in their interviews, a focus on intra-psychic dynamics in these extracts fixes their effects within individuals, and underscores a dualistic approach to the relationship between the individual and society.

Gender and Emotion

While the construct of emotion is generally treated as gender-neutral within psychological theory, it is historically associated in western thought with the 'feminine', and with instability and irrationality (Jaggar, 1989; Lloyd, 1989). This equation of emotion with femininity is also one of the principal ways in which women have been disproportionately pathologised as mentally ill (Showalter, 1985). Reason and emotion are commonly counter-posed in Western thought, with reason linked to the mental, cultural, universal, public and male, and emotion with the female, irrational, physical, natural, particular and private (Jaggar, 1989; Lloyd, 1989). Thus, the emotions are counter-posed against rationality (Jaggar, 1989), and are treated with suspicion because they are conceived of as bodily and therefore as impediments to rationality (Spelman, 1989). This splitting of reason from value and emotion can be traced to the rise of modern science and objectivism (Jaggar, 1989). Modern ideas of rationality and the objectivism of science are inseparable, with the concepts emerging within the same historical period of the eighteenth century (Hollway, 1989). However, Solomon (1983) suggests the opposition of reason and emotion in Western thought is older than this:

Since the earliest of western thinking, the meaning of human existence has been sought in the calm reflections of rationality... the passions, on the other hand, have always been treated as dangerous and disruptive forces, interrupting the clarity of reasoning and leading us astray.

(Solomon, 1983:9, cited in Crawford et al, 1992:16)

The historical period of the eighteenth century, which saw the emergence of modern ideas of rationality and scientificity, also saw the concurrent development of the modern concept of 'masculinity' (Hollway, 1989). Rousseau is attributed with the first articulation of the idea of oppositional, or complementary, 'masculine' and 'feminine' psychologies, and this was related to the growing distinction between the public and private spheres, and women's increasing restriction to the latter (Hollway, 1989). Thus, the affective was essentially projected on to women as a particularly feminine characteristic, and "expunged simultaneously from scientific, rational and male thought" (Hollway, 1989:111). As noted in Chapter 1, this was further intensified in the nineteenth century with the rise of medical science and the notion that women were inherently hysterical, nervous and emotional (Showalter, 1985).

The association of women with emotionality has been made possible by the fact that women's experiences are:

.....produced by and through the positions we have been accorded within patriarchal relations. Thus, the qualities, attributes and stereotypes associated with women gain what truth they have, not through any necessary or essential 'femininity', but as a result of the historical positions women have been accorded and have correspondingly (if unwillingly) occupied. Femininity is thus a construct, the contours of which reflect the intersections of a variety of institutional power relations.

(Burman et al, 1996: 3)

Thus, as was argued earlier, psychology's standard of the rational subject is a model of *man*, which is made possible by this subordinate positioning of women in gender power relations (Burman et al, 1996:3). The construction of emotion as primarily feminine and irrational is a feature, then, of the rise of scientificity and related notions of 'masculinity', and of the ways in which psychological theory has incorporated these ideas into "male-defined criteria of normality" (Burman et al, 1996: 3). Thus, health workers once again drew on supposedly non-gendered psychological theories to construct women with eating disorders that rely on masculinized notions of rationality that specifically equate emotionality with dysfunction and psychopathology.

When drawing on these psychological discourses, health workers tended to refer to the subjects of their explanations as "people", rather than women. This is despite the fact that eating disorders were universally understood to be primarily *women's* problems, and nearly all of the case examples provided by workers assumed the subject to be female. Subscription to the ideology of the non-gendered subject in health workers' accounts inevitably fails to engage with the specific social and gendered aspects of body image and eating disorders, and their relationship to emotion. Thus, while psychoanalytic and psychodynamic accounts of emotionality in eating disorders are profoundly gendered, their claim to gender neutrality actually serves to obscure the contextual and gendered nature of these experiences (Crawford et al, 1992). The fact that eating disordered individuals were overwhelmingly assumed by

health workers to be female invariably affects the ways in which they are constructed as subjects because discourse is always gendered (Weedon, 1987), and women, in particular, can “never appear as non-gendered subjects” (Black and Coward, 1981: 83, cited in MacSween, 1993: 2). Women with eating disorders are therefore constructed by health workers through recourse to a traditional discourse of femininity where there is a “differential assignment” of emotion to women based on historical associations between emotionality and femaleness (Jaggar, 1989:142). At the same time, there is a convergence between this discourse of femininity as equivalent to emotionality, and masculinised psychological theories that pathologise emotion and the ‘feminine’ (Burman, 1996a). In this way, then, the idea of repressed emotional conflict in eating disorders re-inscribes conflicted notions of emotion as peculiarly feminine *and* as equivalent to psychopathology.

The location of emotional conflict deeply within the individual is one of the central effects of individualistic and asocial explanations based on supposedly non-gendered psychological theory. In contrast to this, post-structural feminist theorists argue that emotion is constituted in the “inter-subjective” dynamics between individuals (Crawford et al, 1992: 9), and is “the domain of the repressed that betrays the structure of regulation” (Burman et al, 1996: 13). Within this approach, subjectivity is seen as the site of conflicting and competing subject positions, where conflict arises from “the attempt to take up a single, unified position in competing or incoherent discourses” (Weedon, 1987:150). Weedon (1987) argues that these subject positions constitute desire in particular ways, implying particular forms of repression, and while attempts to “reconcile the irreconcilable” are understood as potentially leading to emotional conflict, this is located in the “symbolic order” rather than the psychic structures of the individual (Weedon, 1987:151). Furthermore, “because women are likely to incorporate greater multiplicity than men because of what woman means in a relation of otherness to humankind” (Hollway, 1989:129), women are more likely to be called on to reconcile the irreconcilable. Women are also likely to appear to be more emotional than men because we are not only permitted, but *required*, to express emotion (Jaggar, 1989). The presence and expression of emotion “demonstrates the [woman’s] commitment to the cultural values exemplified in particular situations and episodes” (Crawford et al, 1992:37), thus, emotion can be understood as serving both a social and moral function (Jaggar, 1989; Crawford et al, 1992), as well as signifying repressed meaning.

In her study of women's experiences of anorexia nervosa, Malson (1998) also identifies the theme of emotion in women's accounts. She argues that women's explanations simultaneously signify, in addition to a host of other multiple and contradictory subjectivities, "a stereotypical association between femininity and emotionality" (Malson, 1998: 117). Malson (1998) argues that there is a resistance to this particular construction of femininity through an "expunging of feelings" made possible by a focus on the details of anorexic body practices, such as purging (Malson, 1998: 169). Malson (1998) also shows that women's accounts demonstrate an association between the thin, non-menstruating anorexic body, and escape from this version of femininity. This is similar to other post-structural feminist readings of anorexia nervosa, such as those of Bordo (1990) and MacSween (1993). Thus, rather than reinscribe emotion within women as a peculiarly feminine characteristic and use male-defined criteria to pathologise it, emotion in eating disorders is approached and examined in terms of its cultural associations and gendered meanings.

Summary

This chapter demonstrates the centrality of the concept of control in health workers' theorisations of eating disorders. In particular, the chapter explores the gendered assumptions underpinning ideas of sexuality and control, and emotion and control, in eating disorders. The supposedly gender-neutral discourses used by health workers to pathologise the feminine serve both to obscure the gendered meanings of sexuality and emotion in eating disorders, as well as re-inscribe gendered contradictions and hierarchical dualisms that have been implicated by post-structural feminists in causing eating disorders in the first place. Following on with this theme of the displacement of gender within health workers' accounts, the next chapter examines the way in which multidimensional explanations of the causes of eating disorders continue to make gender invisible in health workers' accounts.

Chapter 7

Multidimensional Models of Causation: Reductionism and the Displacement of Gender

Introduction

Almost four-fifths of the health workers involved in this study drew on multidimensional models to explain the causes of eating disorders. As was pointed out in Chapter Two, a central criticism of multidimensional models, despite their claims to address a diversity of causes, is their tendency to focus on “those factors ‘closest’ to the ‘outcome’ under investigation”, that is, the individual (Krieger, 1994: 891). This tendency is apparent in health workers’ accounts of the causes of eating disorders through an adherence, firstly, to biomedical discourse with its inherent biological reductionism and, secondly, to a humanist discourse of the essential self, which is intrinsically psychologically reductionist. This chapter will investigate the ways in which health workers’ accounts demonstrate reductionist tendencies, and how this results in a displacement of gender within causal theorisations through a focus on *why particular* women develop eating disorders, rather than *why women in particular* develop them. The chapter also examines causal explanations that do not conform to the multidimensional model, more specifically, the small number of accounts that draw on the idea of innate gender difference as an explanation for the gender asymmetry characterising eating disorders. Finally, the chapter examines the subtle nature of engendering that characterises contemporary explanations of eating disorders.

Because the interview extracts demonstrating health workers’ use of multifactorial explanations were interspersed with talk on other related topics, these texts have been submitted to a heavier editing process than those in other chapters so that a sense of the overall explanation used by health workers can be gained. Despite this, some of the extracts are nonetheless longer than those in other chapters. Where the purpose of analysis is to show that many health workers used a particular idea or term, I present small examples and summarise them together, rather than whole extracts from each participant.

Biomedical Discourse and Biological Reductionism

The following accounts demonstrate the use of multifactorial explanatory frameworks structured around biological determinism. Biomedical discourse was used to anchor multicausal explanations within the

biological body of the eating disordered individual in two ways. Firstly, there was recourse to the idea that personality is determined by genetic traits and, secondly, to the notion that the body of the eating disordered individual responds differently to food restriction. Once again, despite the fact that health practitioners were asked about the causes of eating disorders, many focused on anorexia nervosa in particular. While John suggests that the causes of anorexia are "unknown", he nevertheless argues that it is the product of a "social determinant" working on "a genetic factor" determining psychological vulnerability:

.....anorexia nervosa's aetiology is unknown. [It] is undoubtedly a genetic factor, or seems to be undoubtedly a genetic factor.....the relationship with obsessional compulsive disorder, and a vulnerability. So that while there's a social determinant, it's working on a vulnerable person.

(John, Psychiatrist)

For Steven, also, there is a "genetic psychological proneness" to social pressure:

Nicole: On aetiology, how would you see the aetiology of, um, disordered eating?

Steven: Multi-factorial. (Laughs) From anything from child- (laughs) birth issues, early childhood, all the way through to dieting which clearly is a significant factor in terms of creating issues with food and body image... [.]...from my experience but also from what's been written up in terms of some research that dieting increases the risk of disordered eating and eating disorders, due to psychological proneness to different issues... [.]...that society, er, has, ah, due to appearance and peer pressure and,

Nicole: When you say psychological proneness, do you mean [.] individual vulnerability?

Steven: Correct, yep. Just genetics. So genetic susceptibility.

(Steven, General practitioner)

In the following extract from Helen, she argues that there is a "biological factor" which renders the individual "vulnerable" to other causal factors such as culture:

.....in general I would see the aetiology of eating disorders as being multifactorial, as being related to [...] a complex interplay of...[...]...any individual, cultural factors,...[...]...developmental factors [that] happen to people in their formative years as they are growing up in their childhood and their adolescent years. And biological factors which may be predisposing, or may render them vulnerable.....

(Helen, Psychiatrist)

Joanne suggests that some individuals are probably genetically "more susceptible than others" to a "triggering event":

.....I don't know whether anyone's found a genetic cause, but I think there are probably some people who are more prone to something triggering, some event...[...]...because otherwise it means like everybody who watches television and sees all the models and all that sort of thing.....not everybody develops the eating disorder. Or not everybody ends up feeling really dissatisfied with their bodies. So I think there must be.....I think it's more psychological..[...]...there are probably people that are more susceptible than others.

(Joanne, Dietician)

Christina describes some individuals in western culture as "sitting ducks because of their physiology":

.....only one in one hundred [individuals] will do anorexia nervosa, which suggests there is a physiological difference...[...].....some people are just sitting ducks because of their physiology, their genetics, their chemistry. And combine that with messing up their eating patterns [and] you get what I would call dietary accidents, people who will go on a diet because you've got a culture that says basically...[...].....we're groomed to be the right kind of human being for a modernized, westernised culture.....

(Christina, Counsellor)

In Steven's, Joanne's and Christina's accounts, socio-cultural factors are narrowly conceived of as the pressure on women to be thin, while elsewhere in John's and Helen's interviews, social factors were also largely presented in this way. Individual experience of social forces is consequently assumed to be essentially homogenous in nature, and this corresponds with the assumption that fixed, pre-social biological differences between individuals explain the development of eating disorders in a uniformly 'exposed' population. Indeed, this point is overtly made when Joanne suggests that "everybody who watches television and sees all the models" would have eating disorders if exposure to these influences were the determining factor, while Christina argues that, because anorexia nervosa is rare, this "suggests there is a physiological difference". Thus, social factors interact in a one-directional fashion to trigger genes in predisposed individuals. In the following two accounts, William and Robert go a step further and dismiss socio-cultural factors as having much explanatory power at all on the basis of the rarity of anorexia nervosa, and the uniform exposure of women to thin body ideals. Firstly, William emphasises biological and family factors, but rules out socio-cultural context because of the small numbers of "people" who develop anorexia nervosa:

Firstly, I think [anorexia nervosa is] clearly multi-determined. I personally think there is a biologically determined predisposition in some way... [.]... I think you inherit is a tendency either to be too sensitive or a tendency to be depressed.... [.]... but I think that an eating disorder will only occur... [.]... [if there is] a milieu in which that can occur, and that is usually in a family setting where again I think weight and food is often given a value [.] it is not entitled to..... [.]..... if you look at the number of Dolly magazines and the amount of emphasis on weight or shape and the like, there is a relatively small number of people actually develop anorexia nervosa... [.]... it's more a dissatisfaction with themselves, and I think they might latch on to some sort of image that's put forward.....

(William, Psychiatrist)

Robert also argues that socio-cultural context cannot explain anorexia because "general mechanisms cannot explain a rare condition":

.....to understand anorexia nervosa we [...] cannot posit general mechanisms.
Axiomatically, a mechanism which affects the population at large cannot account for a rare condition.... [...]....I think it is eminently possible that in fifty years time we'll laugh ourselves sick because someone will discover that anorexia nervosa, for instance, is a problem to do with set point adjustment in the hypothalamus and that the behavioural phenomena are completely secondary... [...]....and we'll think "God where did all this clap trap come from about body image and society and fashion models?" and we'll say "why didn't we recognise that this is a rare condition?"... [...]....if I may put it bluntly, when I hear politicians standing up and saying "I'm going to get the fashion industry for creating anorexia nervosa", I say to myself "This is just such bullshit". I can't bear the.....extent to.....I mean, you know, how many people read fashion magazines and don't develop anorexia nervosa?... [...]....I mean that is just so, that is so inherently implausible.... [...]....I mean, it is a very severe [condition]..... people die of this all the time, you know. People don't die of reading Vogue.

(Robert, Psychiatrist)

Socio-cultural factors are almost incidental to the development of anorexia nervosa in these two accounts. Robert became very animated during this part of the interview, claiming that it is simply "implausible" to suggest that the fashion industry causes anorexia nervosa because "people don't die of reading Vogue". Thus, the key to causation *must* rest with individual biology because of the rarity of anorexia which only genetic variability can explain, as opposed to the supposedly uniform nature of environmental exposure and the inherently trivial nature of "fashion". As was noted earlier, health workers were actually asked about the causes of 'eating disorders', not 'anorexia nervosa', and their answers fail to explain the other diagnosable disorders of bulimia nervosa and 'eating disorder not otherwise specified' (EDNOS), which are not considered rare, even within mainstream psychiatry (c.f. Abraham and Llewellyn-Jones, 1992).

The presumption that anorexia nervosa is rare and therefore biologically caused is based on the belief that psychiatric epidemiology is actually measuring a real, distinctive and pre-existing psychiatric entity,

rather than participating in the social construction of illness. Estimates of the prevalence of anorexia nervosa in the population, as well as other eating disorders, actually varies widely depending on the restrictiveness of the operational definition used (Wade et al, 1996). In addition, the creation of the separate category of EDNOS in acknowledgement of the pervasiveness of body concerns and eating-related problems among women (Wade et al, 1996), rather than widening the diagnostic criteria for the formal conditions, actually ensures that eating disorders remain relatively rare. This is in keeping with a psychiatric discourse that concerns itself with the abnormal and the individual, rather than the common and the social. As is pointed out by Gremillion (1992), "by psychiatric definition, mental disorder does not articulate with human relations or cultural conflict", and mental illness must therefore be the manifestation of biological, behavioural or psychological dysfunction in the individual (Gremillion, 1992: 59). In contrast to this, however, one of the psychiatrists, John, defines bulimia as "a socially caused illness", distinguishing the causes of bulimia nervosa from those of anorexia nervosa, having previously argued that the latter is "undoubtedly" caused by "a genetic factor":

Bulimia nervosa, I think, is entirely a socially caused illness. And I think if you look at aetiology....[.]....I think there's very good evidence that it's been socially induced. That it's really come out of a dilemma where the pressure on a woman to be thin, and also a lot of pressure to eat high-energy food, leads to a dilemma, and the resolution of the dilemma is to eat foods and then vomit them or get rid of them in that way. And then that became identified as an illness after a [.] paper in 1979, and once it became identified as an illness, it spread throughout the western world. It's got a very different history to anorexia nervosa.

(John, Psychiatrist)

It is interesting that John suggests bulimia nervosa "spread throughout the western world" after it was "identified as an illness". He means that new cases developed after the original 'discovery', but his comment unintentionally hints at the role of psychiatry in the social construction of the so-called illnesses it claims to uncover. It also suggests that anorexics and bulimics are distinctly different groups when women commonly move between the two diagnoses (Vaz, Guisedo and Penas-Lledo, 2003).

Biological reductionist multicausal explanations of eating disorders rest on an understanding of the material body as fixed and pre-social, carrying within it the potential for psychopathology in the form of either genetic personality traits or predisposing digestive tendencies. Thus, within this view, the individual is either reduced to the physical body, or the mind/self is merely an effect of genes. Some of the health workers who drew on this conceptualisation, including William, Christina and Joanne, also used psychodynamic theory earlier to explain the psychological aspects of eating disorders in the individual. Psychodynamics places an emphasis on the early parent-child relationship in the development of the self, while biomedical discourse emphasises genetic personality tendencies. Only William tied these together by suggesting that an eating disorder will only occur if there is "a biological predisposition" and a particular "family setting". On the whole, though, because the health workers tended to address biological and psychological aspects of causation separately, the relationship between genes and the development of the mind/self was not elaborated. As a consequence, these accounts participate in a reproduction of Cartesian mind/body dualism where mind and body are separate but, at the same time, mutually dependent on each other (see Gremillion, 1992).

While biomedical discourse is wedded to the notion of scientific proof for its claims, 'evidence' for the existence of genetic or other biological causes of eating disorders is highly contested within the psycho-medical literature. As was pointed out in Chapter 2, genetic studies are unable to distinguish between 'family environment' and 'genetic family history', while many of the physiological processes observed in eating disorder patients have been shown to be corollaries of starvation or other life events, rather than causal. Newer DNA sampling is in its infancy, and findings which suggest a genetic cause for anorexia based on this research also need to be treated with caution. In the absence of 'definitive' scientific evidence, the biological reductionist view of eating disorders draws somewhat contradictorily on a biomedical discourse that is situated within an epidemiological *theory* of multi-causality, rather than 'hard' evidence. Historically, this model derives from attempts to explain the spread of infectious pathogenic disease in biologically vulnerable 'host' organisms (Krieger, 1994). Its application to understandings of mental health problems potentially limits possibilities for theorizing in a more dynamic way the relation between individuals and the social world.

Humanist Discourse and Psychological Reductionism

In the following accounts, health workers provide multidimensional explanations of eating disorders structured around a psychological discourse of the essential self. This is achieved by anchoring explanations within the self of the individual through notions such 'self-esteem', 'personal influences', 'vulnerability' and 'personality traits'. Where health workers did not specify a biological source for these, the extracts have been included here because the emphasis in these accounts is on a disembodied essential self, rather than the biological body. Firstly, while Vivien identifies socio-cultural influences, such as "our culture's preoccupation with appearance", it is vulnerability in the individual that determines who will develop and eating disorder:

..... I think there's a whole lot of other things that contribute [to eating disorders]. I most certainly think our culture's preoccupation with appearance, particularly for women, and over-valuing of certain appearances and de-valuing of others is very important, and focus on weight. And then the back up media hype that justifies that by saying that it's connected with health, which is often a load of rubbish....[.].....but I think that those things, that's like in the atmosphere making [.] someone who is already vulnerable,.....whereas another kid that doesn't get too fussed by that, moves in and moves out of it, but these kids get wrapped up in it.....

(Vivien, Psychiatrist)

Paul identifies "personality style", "family" and the marketing of "body image" as causal, but ultimately emphasises Crisp's (1980) "regression hypothesis" and the idea of poor individual coping skills:

I think there are multiple causes. There are predisposing factors and which are probably related to personality style, perfectionism in particular, going on to obsessionality, and then there would be developmental causes of growing up in a family where perfection is held highly and there is a fear of failure. And then there might be precipitating causes which could include perhaps body image as shown in magazines, encouragement to diet to feel better, that sort of thing. But in terms of the real aetiology, I guess we don't know. If I was

looking for a favourite theory it would be that of Arthur Crisp with the regression hypothesis, the notion that the child is not terribly well equipped for going through adolescence.....

(Paul, Psychiatrist)

For Clare, eating disordered individuals are "more vulnerable in their self-esteem" and therefore more vulnerable to "the sorts of influences that are out there":

.....there is the suggestion that some people may be more vulnerable in their self-esteem. This is a suggestion I don't think is proven yet, but it's a reasonable hypothesis and that therefore they're more vulnerable to the sorts of influences that are out there.....there's also the suggestion that girls who are somewhat obsessional, self demanding, perfectionistic, may be more at risk. They're certainly totally over-represented in the people I see with eating disorders.....

(Clare, Psychologist)

While Matthew gives some emphasis to "sick community attitudes", "very low self-esteem" distinguishes women with eating disorders from other women:

.....I don't actually like pathologising [eating disorders] because a lot of the problem is aetiology [that] comes from fairly sick community attitudes around body image and eating behaviours.....[.].....[but] those who develop extreme eating disorders tend to have a complex range of other risk factors. They're not just women [.] (laughs) who worry about their bodies. There are other factors that contribute to the development of eating disorders.....very low self-esteem.

(Matthew, Psychologist)

Melissa identifies "socio-cultural, political, family and personal" causes, but it is individual 'vulnerability' in the form of sensitivity and perceptiveness that determines whether an eating disorder develops:

.....we often talk about the main levels of [causes as] socio-cultural, family, personal, and political...[.].... So that the socio-cultural stuff we've got the heavy focus on women's appearance in itself, and now much more pressure than ever to be thin and to be the right shape...[.]..... Politically I think we've got an economy that needs women to feel bad about themselves in order to spend money....[.]..... I don't like to sort of make a prototype of a family but some of the common issues are families that can't communicate very well, they don't deal very well with conflict... Often there's been a crisis in the family, a loss or a trauma, ah, abuse is common with eating disorders, although it doesn't have to be there, particularly sexual abuse..... on a personal level eating disorder people tend to be intelligent, sensitive, perceptive people um highly creative, although their eating disorder saps that from them, and I think that makes them more vulnerable to all the other stuff that's out there

(Melissa, Counsellor)

Julie identifies a number of social causes, however, she goes on to argue that eating disorders, particularly anorexia, are more "mental health issues" that are in "a little world of their own":

..... there is a lot of reward from, socially for losing weight, even amongst people who aren't really overweight. But also I think this is where the health field comes in, the public health arena has a role to play because it has created the notion of good and bad food. And so the idea is if you avoid 'bad' food, um you will lose weight and you know you're morally better. I mean it's all linked to this idea of being beautiful and healthy and pure.....[but].... I think eating disorders is much more to do with is really very much a mental health issue. Maybe not so much bulimia. Bulimia I think can become [.] a habitual thing which is much closer to disordered eating, and in fact is much more easily cured. But anorexia seems to be kind of in a little world of its own.

(Julie, Health promotion worker)

While Julie places disordered eating in a social context more generally, anorexia is particularly sectioned off. The fact that the world of "anorexia" is "little" and "of its own" denotes the subjective, separate, internal world of the anorexic, rather than the shared, objective, external, verifiable world inhabited by other individuals (Sarantakos, 1998).

Philip argues that "extreme" biological adaptation to starvation, as well as a compliant personality, predisposes anorexic girls to have difficulty coping with contemporary changes in women's role:

..... I think the reasons [for eating disorders] are that, firstly, you would have to have, or imagine, some kind of special biology. Not necessarily biological defect, or deep defect, but at least at some extreme of certain adaptive patterns. And one of those, for example, would be that these girls when they start to diet lose their periods much more quickly than ordinary girls do. So they've probably got the biology of starvation all tied down and exaggerated.....[.].....the kids who are predisposed to anorexia probably found that whole change [in women's role in the 1960s] more difficult than anybody else because they're not good at asserting themselves, and they actually like everybody to be happy and pleasant and so on, and they like to please. And so thinness became another way of pleasing people....[.]....then you come to the psychiatry of it..[.]....the total net store of psychiatric disorder probably does not change very much. So probably the proportion of these people in another era when anorexia wasn't around would have got something else like [obsessive-compulsive disorder] say.....

(Philip, Psychiatrist)

While Philip identifies biological, psychological and socio-cultural factors as relevant, in the final instance it is individual psychological factors that determine psychiatric illness such as eating disorders and obsessive-compulsive disorder. Thus, anorexic girls were destined to develop psychological problems, and it is only the specific nature of mental disorder which is said to be determined by socio-cultural context.

Sarah identifies cultural, family and individual factors as implicated in causing eating disorders:

I'd say a lot of disordered eating would come probably more from the media, and cultural values that are put on women to look slim and so there's that,...[.]... But eating disorders is I think is a little bit more in terms of the very low self esteem, these girls, and probably men too are a lot more perfectionistic um quite um wanting to control things....[.]... And that's a hugely powerful thing which obviously shows how disempowered women do feel in society that they have to turn back within themselves to try and [reclaim], and in such a negative way too....[but] the thing with [.] eating disorders is that one girl will go through a family that perhaps is quite dysfunctional. Another girl could have the exact same family and she wouldn't develop an eating disorder. So I guess some individuals are more susceptible, er, to going into some sort of addictive behaviour...[.]... These people tend to be quite perceptive, and sensitive, people.

(Sarah, Community Worker)

While the idea that women feel generally "disempowered" in society is based on a feminist understanding not dissimilar to that of Orbach (1986) and Lawrence (1984), Sarah goes on to argue that individual susceptibility determines which girl will develop an eating disorder in a particular family environment, producing a psychologically reductionist account. Patricia also alludes to feminist ideas when she suggests that eating disorders are tied to "what it means to be raised a woman in our culture", but goes on to argue that it is "people who are perhaps really vulnerable" who are at risk from these pressures:

..... I guess there is a lot of disquiet anyway around eating, body image and.....and, you know, this is the embodiment of a lot of this stuff. I mean there is a lot of,....that,..... it's a tradition of western culture. It's very tied into femininity, it's very tied into what it means to be raised a woman in our culture, so it's kind of the edge of that can trip some people a little bit more than others...[.]... And I suppose it's very much tied into also discourses and emotions in our personhood, and what it means to be a good person, what it means to be successful as a person in our society. Yeah, and sometimes that literal interpretation for

people who are perhaps really vulnerable and are needing markers around guiding them and navigating themselves through some difficult stuff.

(Patricia, Community worker)

The idea that the individual is the 'embodiment' of the cultural draws on feminist post-structural ideas that challenge humanist assumptions of a core unitary self (for example, Grosz, 1994). There is a key tension in this account, though, because while a post-structural understanding of the relationship between individuals and their social world is deployed early in the extract, a psychodynamic construct of identity confusion is used later to explain how "vulnerable" individuals take on the social prescriptions within discourses in an extreme way. This account therefore draws on post-structural theory and the concept of discourse to explain the social, but on psychodynamic theory and the assumption of a pre-discursive, unitary, and separate self who has a dualistic relationship to the external world, to explain the individual. This is completely at odds with a post-structural understanding of the individual as fundamentally embedded in multiple discourses involving shifting subjectivities.

In each of these accounts, a psycho-emotional or personality characteristic in the individual is positioned as the key to the development of eating disorders. In Chapter 5 I demonstrated that most of these health workers also subscribed to a psychodynamic conceptualisation of identity, and the idea that eating disordered individuals are less bounded from external influences than others. Identity theory therefore functions as an important adjunct in these explanations in terms of positioning the individual in relation to the social, and grounding cause in the intrapsychic rather than the external dimension. While Philip's and Paul's multidimensional explanations are set within a psychobiological theory of regression, again, personality deficiencies lead to inability to cope with social pressures. In the final instance, then, cause rests with the individual in all of these accounts, while a socio-cultural discourse, through reference to "media", "fashion" and "sick community attitudes", is also drawn upon to explain how eating disorders are triggered in vulnerable individuals in a not dissimilar way to Bruch's theorisation (1978).

Eric is even more cautious about the influence of wider socio-cultural factors, and focuses exclusively on the individual and family:

What I'm anxious to do is to not reply in a way which would be to a journalist because [...] you can obviously make up common sense explanations, you know, "it's the culture and people are told about their bodies and what's a good body and what's a bad body and what's admired and what's not admired". Well, that might be so but I would like to see kind of cross cultural studies, and there are cross cultural studies out there where in some cultures a big body is valued and whether in those cultures there is a difference in eating disorders or not.

(Eric, Psychiatrist)

Eric is unwilling to attribute a socio-cultural causal component in the absence of evidence. However, evidence is never offered to support his theorisations about individual and familial causes. Furthermore, a dualistic approach to the individual and society allows for a separation of the individual and the family from "society", which operates only in a remote and less well understood way. Biologically and psychologically reductionist accounts provided by other health workers also locate the social dimension at a distance from the individual as a uniform and remote influence. For example, Steven, Helen and William ordered causal factors hierarchically, starting with the body/self, then family/peers and, lastly, social factors. These accounts underscore a dualistic understanding of the individual's relationship to society, delineated by the boundaries of the physical body in biological accounts, and an essential self "coincident with the biological human body" (Kitzinger, 1992: 229) in psychological accounts. In the following multicausal explanation, while Adam grounds his explanation in the intrapsychic in a similar way to the other psychologically reductionist accounts, he uses metaphor in an illustrative way to symbolize the position of the individual in relation to external causative factors:

Gee whizz. It's like, you know, just superficial things [that cause eating disorders]. For instance, factors that contribute to eating disorders affect, ah, self-esteem sort of stuff, and the eating becomes an issue. Um, but there's obviously influences, like parents... [...] others generally, which might be siblings, [...] boyfriends, girlfriends, [...] other friends... [...] the media, advertising, fashion, education, the whole lot... [...] I can actually go on forever

about the things that contribute or influence...[.].....you have to sort of work out what's the outside layers of the onion and what are the inside layers....[.].....the cause ultimately is how you feel about yourself, because there's a million mitigating factors in there that you could just.....I mean you could go on forever.....Virtually every instance in your life could contribute to it if you're so disposed.

(Adam, Market Researcher)

Adam moves from “personal” factors such as “self-esteem”, to families and peers, to “environmental things” in a hierarchical way, ordering the causative factors and locating the social at a distance from the individual. The causal schema is not constructed in linear terms, though, as in other examples, but through the metaphor of an “onion”. Because the personal, in the form of “self-esteem”, is given so much prominence in Adam’s accounts here and elsewhere, the onion inevitably situates the intrapsychic at its centre, where the “inside layers” have greater explanatory power than the “outside layers”. In addition to the placement of the social at a distance from the individual, causes external to the individual are portrayed as so multifarious as to be virtually meaningless because “there a million mitigating factors” and “virtually every instance in your life could contribute”. However, the causative framework is grounded in the individual and self-esteem because, in the final instance, you will only develop an eating disorder “if you’re so disposed”. By presenting causes external to the individual as infinite, it becomes unnecessary, indeed impossible to explain them and the individual remains the only tangible, knowable entity. Thus, while the external environment plays a role, ultimately the emergence of an eating disorder is only traceable to pre-existing characteristics in the individual because the social is infinitely diverse. In contrast to other reductionist accounts where the social is dismissed on the basis that it exerts a *homogenous* influence, here it is dismissed because its *heterogeneity* defies theorisation.

While Ruth also places social factors at a distance from the individual, she provides a slightly different explanation, focusing on the role of the family and relationship breakdown:

Ruth:.....a lot of the problems that some of our clients have experienced that could, I'm not saying that they definitely have, but could be the reason why the eating disorder has developed.....abuse within the family, that could be emotional abuse, sexual abuse,

physical abuse. Relationship problems with somebody close, it could be that there's been a breakdown in the family, you know, parents have broken up, something like that, schooling difficulties, bullying at school....[.].....there's also the belief, and I guess it is quite true, that pressure from society for women, and men I guess, to look a certain way and, you know, and be thin.

Nicole: You see that as playing a role in some way?

Ruth: Oh, not to the extent that I think it's perceived to be...[.]...there's usually lots of other problems within their lives as well that are compounding that.

(Ruth, Nurse)

In contrast to psychological reductionist accounts that essentialise the individual, this account places an emphasis on relationships rather than intrapsychic factors, however, the way in which these might contribute to the development of an eating disorder is not specified. At the same time, socio-cultural factors are portrayed as only having a limited impact on the development of eating disorders. While the family rather than the individual is emphasised here, this participates in a further “western socio-cultural dichotomy” identified in Chapter 2, because “the family is viewed as a system unto itself”, where the realms of “public” and “private” are separated (Gremillion, 1992: 65). In this account, as well as in other extracts that emphasise family factors, family relationships and social factors are treated entirely separately from each other, and the former are focused on the individual through their location as “close” while, again, the ‘social’ is located at a distance as less important.

Limitations of Multidimensional Explanatory Frameworks

The tendency of multidimensional models to focus on the individual is clearly demonstrated in the reductionist tendencies of the above accounts. Another limitation is the way in which causative variables are simply grouped and categorized in some explanations, with little attempt to explain the dynamics of causation. In these extracts, then, no one set of causative factors is elevated over another, and each is presented in isolation. Because these extracts do little more than list categories of causative variables, I do not present them in full and, instead, describe only the main categories. For example, Rebecca identifies “biological factors”, “temperamental features”, experiences in the family and “social factors” as relevant, but does not elevate any one cause over another. Stacy identifies “sex”, “society” and personality

as causal factors, but does not theorise any relationship between the variables or prioritise one over another. Robyn's explanation is particularly wide ranging, and covers "genetic" personality factors, family background, peer group problems and the marketing of thinness, again, without theorising or prioritising. Similarly, Georgia identifies "physical" and "psychological" causes, and also draws on feminist ideas about the way in which women's bodies have been historically controlled and manipulated for fashion, without relating the different categories of explanation to each other. Lastly, Jennifer identifies individual personality characteristics, such as being "sensitive", family or friends, and "society's prescription", emphasising that the different categories vary in significance from individual to individual.

Gremillion (1992) also notes that the multidimensional approach to eating disorders deals with the different causative 'factors' or 'variables' as "separate and isolated" (Gremillion, 1992: 65). This results in explanations that are seemingly detailed, yet offer little theorization of causation, offering fragmented accounts with limited explanatory power. Krieger (1994) argues that the tendency to 'factorise' rather than 'theorise' cause derives from the fact that epidemiological models of disease have been developed for the identification of specific, measurable variables to enhance epidemiological research, rather than to elaborate an explanation of the origins of health problems. In common with Adam's earlier account, many health workers entirely removed the need to theorize the way in which risk factors might lead to the development of eating disorders by suggesting that the combination of factors is "varied", "complex", "different" or "unique" for each individual (Rebecca, Ruth, Steven, Jennifer, Helen and William). As in Adam's earlier extract, to interrelate the different components is rendered impossible in accounts that emphasise unique combinations. This removes the need to theorize the interrelationship between the different risk factors, because they are infinitely diverse and therefore beyond theorization. However, because the combination of risk factors is different for each person, the individual remains the pivotal explanatory factor in the causative framework.

A further limitation of multidimensional frameworks lies in their depleted notion of the 'social'. While the multicausal accounts provided by health workers usually identify the promotion of the thin female body as

the pivotal social/environmental factor implicated in causation, the social and cultural are reduced to variables that nonetheless focus on the individual. Thus, within multidimensional models:

....the 'social' and the 'cultural' have been operationalised and thereby reduced from the status of an interpretive perspective to that of a factor or variable.....As such, the 'social' and the 'cultural' are relocated from the level of social interaction to the level of the individual.

(Barrett, 1987: 78, cited in Gremillion, 1992: 65)

Thus, cause "returns to the individual", who is located at the centre of the causative framework (Gremillion, 1992: 65). The focus therefore remains on the individual as the material object upon which 'social factors' operate in a one directional fashion, precluding an interpretive approach to social interaction. In this sense, then, multicausal explanations are also 'socially reductionist' because they reduce the social from an interpretive perspective to a 'risk factor' relevant only in so far as it triggers pathology in certain individuals. More particularly, the operationalisation of the social in this way renders gender invisible because it is only relevant in so far as the social factor of the marketing of thinness acts in a relatively specific manner on women and girls. Thus, gender is reduced to the risk factor of 'sex'. In common with psychological theories of identity and control, multidimensional models of causation actually assume a pre-social, 'gender-neutral' individual (with different risk factors according to 'sex'), and therefore cannot account for the specifically gendered nature of subjectivity and how this might relate to health. Indeed, because of the narrow, operationalised approach to the social, this aspect of causation in eating disorders is trivialised, for example, through the comment that "people don't die of reading Vogue". Where socio-cultural context is envisioned in a more complex way, for example, in Patricia's, Philip's and Robyn's accounts, there is no attempt to link the individual and social dimensions because they remain essentially separate, with the former granted the major share of explanatory power. The ultimate effect of health workers' reliance on reductionist multidimensional explanations therefore focuses attention on the question of why *particular* women develop eating disorders, rather than why women *in particular* develop them.

As a last point on the limitations of multidimensional frameworks, while most workers adhere to this model, a small number of health workers nevertheless retain the idea of cause as a single factor. Thus, while professing multi-causality, Paul, Robert and John all state that the aetiology of anorexia is unknown. In Hepworth's (1999) study with health workers, the idea that the causes of anorexia are unknown was common. While less common in this study, the idea that cause is multi-determined operated as shorthand for 'unknown aetiology' in these three health workers' accounts.

The Question of "Why Women?"

When I asked the health workers presenting multidimensional explanations further probing questions about why women are over-represented among those diagnosed with eating disorders, many argued that this was because of the heavier emphasis on thinness for women (Patricia, Sarah, Joanne, Steven, Stacey, Julie, Adam). Others mentioned the more general objectification of women's bodies (John), the cultural emphasis on women's appearance more generally (Rebecca and Paul), the sexualization of women in marketing (Vivien) and women's role as preparers of food (Julie and Jennifer). While Penny (a nurse) did not provide a multi-causal explanation, but described eating disorders as individual problems of "maladaptive coping", she nevertheless argued they were more common among women and girls because of the cultural pressure to be thin. At the same time, some health workers argued that while eating disorders are more common in women, they predicted that they are likely to increase for men with perceived increases in the marketing of men's body image (Sarah, Steven, Stacy, Adam, Jennifer). Thus, individual factors faded in favour of social factors when health workers were called on to explain women's over-representation among those with eating disorders at the *population* level, while at the individual level there was a focus on delineating eating disordered women from other women.

Robyn put a feminist argument for why eating disorders are more common in women, suggesting that women are generally in less powerful positions in gender power relations. She argues further that male-dominated society is essentially misogynistic, and that this pervades advertising where women are exhorted to objectify themselves:

.....women are in this more passive position...[.]....you still might say [that] activity is the preserve of males and women are still, you know.....a lot of girls still have that very

traditional view, they're waiting around for somebody to call them or choose them or....and they even, you know, at high levels of performance [...] it's usually a man who's head [...] and women are sort of callowing... [...]....you know, you have to be concerned about this. I really do think about... [...]....the sort of hatred of women, and hatred of a woman being normally functional and displaying her own agency... [...]....and it's really quite pervasive and it goes through all advertising, media, all this really pervades all of that. Ah, very dehumanising, I suppose you'd say, yeah, quite objectifying, and I mean exactly how girls are then encouraged to treat their bodies as objects to be modified in some way, to be acceptable.

(Robyn, Psychiatrist)

While Robyn's account offers a quite strong feminist argument about women's oppression, because elsewhere it is situated within a wider multi-causal framework and draws on identity theory as its main theoretical perspective, the backdrop of gender power relations is set against a foreground of identity problems, vulnerable personality characteristics and peer group difficulties. Thus, feminist ideas are used to understand the broader social sphere, while psychological theory is used to theorize the individual in a not dissimilar way to the early feminist theories of eating disorders outlined in Chapter 2. Reliance on individual-society dualism minimises theorization of how these macro and micro 'factors' intertwine to produce eating disorders, and the individual level of explanation ultimately dominates. This point pertains to many of the other health workers' accounts, too. Thus, while most health workers posit a socio-cultural explanation for why eating disorders are more common in women, this is set within a multidimensional framework that emphasises individual explanations through biological and psychological discourses, so that the question of which women develop eating disorders remains paramount. In the final instance, gender remains largely invisible.

A smaller number of health workers drew on notions of essential gender differences as an explanation for why eating disorders are more common in women. There were three main ways in which a discourse of gender difference was employed. Firstly, Rosemary, Philip and Eric propose an innate 'feminine' psychology; secondly, John argues that physical differences between male and female bodies explain why eating disorders are more common in women; and, thirdly, Philip, Helen and Gillian explain the higher prevalence of eating disorders in women through ideas from evolutionist discourse. In positing the idea of

an innate feminine psychology, Rosemary argues that women are “more concerned with what other people think” and that this is “the very nature of women”:

I think it's the basic nature of women....[.].....I think men can shrug off what you or I think about them. I think men can just say “Oh well, tough, that's me, here I am”, whereas I think women are more concerned with what other people think and take things like that to heart and I really think that that's at the heart, the very nature of women....[.]...I think it's what makes them caring people and sensitive people...[.]...I think it also in a way backfires because they're so attuned to what other people are thinking about them that perhaps they give too much credibility to what others think about them...[.]...I think that it is that vulnerability that makes women...[.].....more malleable from an outside point of view.....

(Rosemary, Fashion design lecturer)

While Rosemary presents what she sees to be inherently ‘feminine’ characteristics such as ‘sensitivity to others’ as positive, the idea of natural sex differences normalises eating disorders as inherently feminine problems bound up with women’s “nature”. Thus, those qualities that were used in Chapter 5 to distinguish eating disordered women from other women as overly connected to others and as lacking identity, are used here to characterise women *in general*. This is not dissimilar to the way nineteenth century discourses of femininity pathologised young women precisely because of their sex (see Malson, 1998; Hepworth, 1999). Rosemary’s account also suggests, by extension, that women who are not eating disordered are less ‘feminine’, caring and sensitive. Eric also postulates a specific ‘feminine’ psychology as implicated in eating disorders through the idea that women are “harder wired” for shame:

Shame in women seems to be harder wired, if you like, than in men....[.]....but it seems to me that notion of being ashamed of one’s body, women might be more susceptible to it in a way which is part of the genetic endowment....[.]....I mean the behaviour of women in general who are much more concerned about appearance apparently than men....[.]...However, the other thing is that if you take this scenario of the young woman who, she'd only been a jolly little girl and everybody thought she was a jolly little girl and suddenly she's quite beautiful and suddenly she is a sexual trophy and suddenly the world

is in a way horrible and out of her control and, you know, she wants to back out of it. Well, a way of backing out of it is to not be a sexual object, and I mean that seems to me to also make the thing obviously a female syndrome.

(Eric, Psychiatrist)

Here, "being ashamed of one's body" is taken to be part of women's "genetic endowment", making them prone to eating disorders. Eric goes on to argue that becoming a "sex object" is experienced as unpleasant and anorexia offers a way out. This view would also suggest that anorexia is more common in 'beautiful' and sexually precocious young women. Furthermore, the fact that women experience sexual objectification as "horrible" arises from their feminine psychology, rather than the social relationships in which they find themselves. Femininity is, therefore, an *innately* conflicted, psychopathological state and eating disorders a natural consequence, while the social world and predatory orientation of men towards 'attractive' women remains unproblematic and natural. In contrast, Philip focuses on the idea that women have a distinctive feminine psychology because they demonstrate higher levels of sociability, and that problems such as eating disorders arise from women's attempts to be "like the blokes":

.....ten years ago a successful woman behaved like the blokes do...[.]....I mean it doesn't come naturally to many women. I mean you sit down with a group of your girlfriends, I mean the whole lot of you talk at once and everybody follows five conversations, don't they?...[.]....and I think that's written into the psychobiology. I don't think it's taught. I mean if you go back, [in] all societies young women do that. Well I think....[.]....there are many women now who are saying "well, you know, I want to be me, I don't actually want to have to behave like these blokes"...[.]....the next step would be finding a way of experiencing this new society in a way which fits women as distinct from feeling that somehow they've got to be more masculine and I would have thought that might be the way in which all this silly stuff [eating disorders] might disappear.

(Philip, Psychiatrist)

Thus, eating disorders are seen to arise from women's rejection of their natural, feminine selves and their attempts to be like men, and Philip argues that eating disorders "disappear" if women simply accepted

their true femininity. In contrast to the other extracts that pathologise the feminine, here, salvation contradictorily lies *within* the feminine. In other sections of Philip's account, certain types of feminism are implicitly blamed for leading women into behaving "like the blokes" in the first place.

While the above accounts posit the idea of a feminine psychology arising from biological differences as central in eating disorders, John argues that women are more prone to eating disorders because the female body is "overweight" in adolescence:

I think there is a purely biological issue, which always surprises people... [...]...that when a girl goes through puberty she starts producing oestrogens which metabolise in fat tissue, and she stops growing so that the average girl of eighteen eats less than she did when she was twelve. When a boy goes through puberty he produces testosterone and his growth increases and he grows longer than the girl does and he also puts on muscle bulk.... [...]...For young men it is mainly muscle tissue so that men very rarely have a problem with weight in their teenage years... [...]...women usually have a weight problem in those years and I think that's, of course, [...] the years where they are making contacts with peers.....

(John, Psychiatrist)

John characterises adolescent women as typically having a "weight problem" by problematising female body "fat" in comparison to the "muscle" of the male body. It is simply taken as given that adolescent female bodies are therefore "overweight" and "fat" in an objective sense. This account therefore participates in the idea that the female body is less efficient, and an obstacle to 'fitness' and 'health' (see Gremillion, 2001). The marking of the female body as inferior through comparison with the male is one of the central ways in which gender inequality has been historically legitimated (McNay, 1992). Within this conceptualisation, then, eating disorders are again naturalised as inherently feminine disorders arising out of a specific form of biological inferiority. Particularly concerning here is the fact that the cultural obsession with female 'fatness' is directly implicated in the origins of eating disorders themselves (see Bordo, 1990; 1993).

The next three extracts employ ideas from evolutionist discourse to naturalise sex differences as an explanation for why eating disorders are more common in women. Firstly, Philip argues that body "signalling" is much more of a "female business":

I think the meaning of sexuality in women is more complicated than men. I think that has an impact. I think probably as a species there is an array of signalling that goes on between men and women which has to do with bodies and their shapes and so on, and I think that it's a much more female business than a male business...[.]...like if you went back twenty thousand years you'd see the same thing [.] or a hundred thousand or a million years...

(Philip, Psychiatrist)

Within evolutionist discourse, specific human behaviours, such as women's concerns about their bodies and their attractiveness, become naturalised as part of 'natural law', and as therefore having utility for the human species as a whole (Venn, 1984). In line with this, Helen argues that "men choose women because of their looks", and that, in the past, this was tied to associations between appearance and fertility. The fact that eating disorders commonly result in at least temporary infertility, and even death, seems to undermine the argument that they are functional in any sense for human evolution and survival of the species. However, Gillian provides a more sophisticated argument for how natural drives have become dysfunctional in the contemporary context:

I think women are often are much more [.] biologically programmed to compete on the level of appearance. Men are more likely to compete on issues of function, [.] say sporting ability, what you can do, not what you look like. Or how much how successful you can be as a provider...[.]...and I think if you're looking from a biological point of view, then really you're competing on different levels. [For men] it's what you can do that becomes more important, not how decorative you are or whether you can have um babies...[.]...and so I think women have always been judged on their appearance, and that's still the case. And then we've got a marketing of all the problems of appearance, and again this gets back to the fact that

we're very easy to exploit in the area of appearance, and so women are exploited in the area of appearance and men are exploited in other areas like what sort of car you get....

(Gillian, Psychologist)

The fact that women are "biologically programmed to compete on the level of appearance" therefore only becomes problematic when marketers exploit women's natural vulnerability in this regard. Nevertheless, eating disorders again become peculiarly feminine problems within this conceptualisation. Furthermore, the socio-biological perspective has other effects, because it also naturalises the idea of sex differences in general so that both men's and women's behaviour becomes biologically determined and unchangeable (Hollway, 1984). Such views have been used to discredit feminist arguments for the social basis of women's oppression, and to naturalise the idea that male sexual aggression is also a natural drive that ensures the survival of the species (Hollway, 1984).

As noted above, an emphasis on the idea of natural sex differences as an explanation for why eating disorders are more common in women echoes the discourses of the nineteenth century which feminise eating disorders in more overt ways through the idea of women's inherently unstable nature. It is significant to note, though, that only a small number of contemporary health workers drew on these ideas (many of them older male psychiatrists). Instead, contemporary explanations tend to use more *covert* means to pathologise the feminine through the employment of 'gender neutral' psychological theories that are inherently gendered. This shift from the more overt and direct legacy of pathologisation of eating disordered women and girls precisely *because* they are female (Malson, 1998), to more covert methods under cover of an ideology of gender-neutrality, reflects the rise in modern individualism over this period, and the participation of disciplines such as psychology in the creation of the contemporary subject (see Henriques et al, 1984). As was argued earlier, this subject masquerades as 'gender-neutral', but is in fact a model of man, not woman (Burman et al, 1996: 3).

A further illustration of the covert nature of engendering in contemporary discourses of eating disorders can be found through an examination of the way health workers characterise eating disorders in males. Hepworth (1999) undertakes a more in-depth analysis of health workers' explanations of anorexia in males, demonstrating that the diagnosis of males results in a discursive dilemma because of the historical

links between anorexia and femininity. Hepworth (1999) also shows how male anorexia is painted in more dramatic terms as more severe, how males are more likely to be given another diagnosis, or are likely to be under-diagnosed. I briefly examine health workers' constructions of eating disorders in males with the explicit purpose of exploring where they diverge from, as well as converge with, portrayals of eating disorders in women.

Similarly to some of the health workers in Hepworth's (1999) study, eating disorders in males are depicted as more severe and dramatic by some of the health workers in this study. For example, Eric describes one young man's anorexia as "awful" and a "terrible case", while William describes a male patient as having "self-loathing" – a much stronger term than is used for women and girls. Penny describes a young man's previous experiences of bullying as "very painful and powerful", while Jennifer describes another's as "brutal", underscoring their seriousness and, therefore, their status as valid causes. Also in common with some of the health workers in Hepworth's (1999) study, Paul emphasises the idea of "co-morbidities" in males, such as "schizoid personality", which are presented as pre-dating the development of an eating disorder and, therefore, as primary diagnoses. A small number of health workers (for example, Rebecca, Eric, Vivien, Clare), mention the idea also explored in the eating disorder literature that eating disorders in males are tied to confusion over sexual orientation (for example, Russell and Keel, 2002).

William and Julie present eating disorders in males as arising from participation in sports that require particular body sizes and shapes, such as jockeying, while Rebecca and Christina present cases where eating disorders in males developed out of an original attempt to lose weight in order to prevent health problems for which there was a family history. These conceptualisations lend an air of rationality and agency to male eating disorders that is absent from their depiction in females. Philip talks about one young male pianist's experience of anorexia as a "deep mystery". He describes how the young man was allowed to bring his piano into the eating disorder unit and how, as the treating psychiatrist, he "didn't understand why [the patient] had anorexia when he arrived and [...] had no idea why when he left". This young man's case is therefore depicted through the ideas of 'mystery', 'special-ness' and 'individuality'. Other case histories of males with eating disorders also involve notions of special-ness and individuality, and some male patients are even valorised. For example, Christina describes an anorexic boy she treated as "a brilliant young man" and "an extra-ordinary artist", while Penny describes a male patient as "brave"

for talking about emotions and as "particularly intelligent". Within these accounts, male patients are granted a level of individuality and respect that seems to be absent in cases histories describing female patients, which are usually presented as specific illustrations of more universal, axiomatic experiences. Indeed, Eric refuses to generalise about male eating disorders at all because "each one seemed to be different".

What is of particular interest in health workers' talk about eating disorders in males, and is distinctive from Hepworth's (1999) findings, is the relatively widespread adherence to the idea of gender *sameness*. Thus, despite the variations outlined above, almost half of the health workers suggest that the aetiology and presentation of eating disorders in males is 'the same' as, or 'similar' to, that for females. However, at the same time, men and boys are rarely brought into dominant explanatory theories of identity deficiency and control – these are reserved almost exclusively for women and girls, or are described in the language of gender-neutrality where, in the course of conversation, it is revealed that the subjects are assumed to be female. Thus, despite the widespread idea of sameness, eating disorders are explained differently in males and females, and it is primarily through the employment of supposedly gender-neutral psychological theories that gendered ideas about women are applied. The adherence to a discourse of gender neutrality in explanations of eating disorders in males therefore serves to further obscure the operation of gender in health workers' accounts.

Summary

This chapter has explored the dominant multidimensional model of the causes of eating disorders in health workers' accounts. While this model professes to incorporate individual, family and socio-cultural factors into an explanation of causation, an inherent reductionism, reinforced through the use of biological and psychological theories, serves to reproduce a focus on the individual as the key causal factor. Further, a tendency to 'factorise' rather than 'theorise' cause reduces the 'social' to a variable rather than an interpretative perspective, and the individual remains at the centre of causative variables. This has the effect of reducing gender to the risk factor of 'sex', and renders the social construction of gender largely invisible so that the focus remains on why certain women develop eating disorders rather than why eating disorders are more common in women. The chapter also shows that while a small number of health workers subscribe to notions of innate gender difference to explain the gender asymmetry of eating

disorders, contemporary explanations on the whole break with the nineteenth century tradition that overtly pathologised women and girls because they were female. Instead, psychological discourses which are imbricated in an ideology of gender-neutrality undertake the work of re-inscribing gender contradictions. Finally, while eating disorders are explained differently in males and females, the adherence to an idea of gender sameness works to further obscure gender in explanatory accounts. The following two chapters now turn to an analysis of the ways in which gendered contradictions operate within psychiatric intervention.

Chapter 8

Constructing Psychiatric Practice: The Body as the Object of Intervention

Introduction

This chapter examines health practitioners' constructions of psychiatric practices that focus primarily on the body as the object of intervention. In particular, this chapter examines the way in which a contradictory approach to patient autonomy and control emerges within health workers' constructions of psychiatric interventions targeting the body. Practitioners described two types of intervention that aimed to bring about weight gain in the anorexic individual: naso-gastric feeding and bed rest programs, while pharmacological therapy was presented as a form of therapeutic intervention that seeks to control some of the symptoms associated with both anorexia and bulimia. While these interventions formed part of a multidimensional treatment approach in each of the practitioner's accounts, health workers did not explicitly relate intervention to causal theories about the origins of eating disorders. This chapter will therefore include an examination of other factors that led health workers to include them within a multidimensional treatment approach. The chapter will also explore central contradictions that emerge between theoretical and practice discourses, and within particular practice approaches themselves, as well as power relations between practitioners and eating disordered women.

Re-feeding the Body: Variations in Practice and the Issue of Consent

The treatment of severely underweight anorexic patients typically involves some form of re-feeding, typically nasogastric feeding (NGF) (Larocca and Goodner, 1986). NGF involves the insertion of a tube into the stomach of the individual via the nose and the introduction of a nutritional formula or, alternatively, individuals might be fed glucose directly into the bloodstream (Gilchrist et al, 1985). Psychiatrists' constructions of re-feeding intervention involve a focus on distinguishing their practices from those in other units or from practices in the past, as well as an emphasis on the importance of patient's rights and of gaining patient consent. For example, William alludes to practice differences when he states that "naso-gastric tubes" are "rarely" used in his unit, but he "suspects" the practice is "relatively common" in "some centres". Philip emphasises that NGF is an uncommon treatment in this same unit, tying its infrequent use to the idea that it is "a pretty big invasion of the person's [...] autonomy". The idea that NGF is ethically problematic in this sense is carried over by Philip into discussion of changed practices that emphasise

consent, reductions in the incidence of involuntary admission, and improved skills in the assessment of patients' physical status. Philip places a heavy emphasis on the idea of changed practice, going on to argue that the new approach of "slow resuscitation" now means that fewer patients die. As was pointed out in Chapter 2, in the past, rapid weight gain had been the central goal of therapy. The contested nature of NGF was also mentioned in Robyn's interview, who says she avoids NGF and, like William, she similarly positions the practices in her unit as less invasive than those of another unit in the same state who "readily naso-gastric feed". Robyn indicates that her own practice has changed over time, and also alludes to ethical dilemmas involved in "bed rest" and "nasogastric feeding", saying that patients feel "we're contravening their rights". However, Robyn positions the 'client' as 'choosing' their level of intervention through deciding into which hospital they will be admitted. This reinforces the image of voluntary admission. As was noted in Chapter 2, the practice of NGF has been controversial over the years both within and outside psychiatry. An emphasis on the use of other forms of re-feeding in William's, Philip's and Robyn's accounts is therefore set against a backdrop of concern over the use of NGF more generally, and the main purpose of these accounts is to establish distance from earlier, more controversial practices, and to demonstrate an awareness of patient 'rights'.

In contrast to the approaches described by William, Philip and Robyn, John states that to "feed a patient forcefully" using NGF is "quite common" in his unit. He argues that this is because he sees "the most severe cases in the state", however, the unit William and Philip are based in is similarly placed in another state and yet involuntary feeding is a rare event. John also indicates, though, that force-feeding is a problematic form of intervention that "doesn't solve the issue either":

.....if one forces it one can sometimes feed a patient forcefully, but that doesn't mean you've really done much to treat her illness and one can't always even do that. I mean I've had patients who have pulled out tubes and made themselves untreatable, and I've got one at the moment who has now agreed to be treated, but that's after she's developed a lung abscess and she's very much threatened, and it was only then that she was able to break the sort of circle of self punishment she had for herself.

(John, Psychiatrist)

This extract provides some insight into the tensions involved in the use of force-feeding. However, a patient's refusal to accept treatment is presented as part of her psychopathology, rather than in terms of the patient's rights to autonomy, thereby implicitly justifying force.

Like William, Philip and Robyn, Paul, who is based in a unit in a third state, describes an approach to naso-gastric feeding that emphasises patient consent and choice:

Paul: The ones that are really afraid of eating and drinking, have kind of dropped weight quite acutely in the last little while, we would probably be starting by telling them that they've just got to drink otherwise they'll die and offer them the chance to have a nasal gastric tube to be put in at their option and taken out when they've had enough of it just to relieve them of the agony of making a decision of eating and drinking for a few days.

Nicole: But you emphasise the consent aspects around that?

Paul: I emphasise that it's something that will take away some of the anxiety about [eating] and that they can have it out when they feel they can eat and drink by themselves. Um probably sixty or seventy percent of them would accept that as an idea if they're really too afraid to eat and drink.

(Paul, Psychiatrist)

Paul's more compassionate description of patients as "really afraid of eating and drinking" contrasts, to some extent, with John's portrayal of treatment refusal as a form of psychopathological self-punishment. Next, Paul goes on to explain his approach when patients continue to refuse the insertion of a naso-gastric tube:

Paul: [If patients don't accept the idea of a naso-gastric tube] then it really gets a lot harder. You try and get them to accept some [...] medication.

Nicole: What's that?

Paul: Oh Valium, that sort of thing.

Nicole: Oh okay, relaxant, sort of medication.

Paul: Yes, something to relax them um and you do a bit of talking. If they get too sick and I mean you've got to watch them closely in that, but once they start to get too dehydrated

for instance then they're a medical condition and they go to a general hospital probably as a compulsory admission if need be.

(Paul, Psychiatrist)

The role of the psychiatrist is presented as one of gentle persuasion, where force is situated as a last resort, and as being out of the practitioner's hands once the physical deterioration requires transfer to emergency care. The fact that anorexia nervosa can be life threatening and continues to be associated with a high mortality rate (Steinhausen, 2002) cannot be ignored or downplayed. Clearly, when individuals are severely malnourished and physically compromised, practitioners feel compelled to find ways of providing re-nourishment. However, while these accounts involve portrayals of intervention in situations where lives may be in danger, they are nevertheless characterised by marked differences in the approach to re-feeding. This reflects actual variations in practice patterns between units in different states, as well as a shift in practices over-time documented in Chapter 2 (see, for example, Touyz, Beumont and Dunn, 1987). Because NGF has been controversial more generally (Vandereycken and Meerman, 1984: 92), changes in practices, and the concern of psychiatrists in this study to emphasise new approaches and patient consent, is perhaps in part a response to criticisms of NGF and its possible harmful effects. However, the extent to which consent is emphasised in practice, and naso-gastric feeding avoided, appears to depend on to which treatment centre an individual is admitted. Such a marked variation in practice, and the possibility that there is a continued adherence to more invasive procedures in some centres when others have found alternative methods for addressing severe malnourishment, reflects a continuing ethical dilemma in this area.

The contemporary emphasis on consent and voluntary treatment in psychiatrists' constructions of re-feeding represents a positive shift in terms of recognition of patient rights and the potentially harmful effects of force-feeding. However, notions of choice and voluntarism in this context are often no more than theoretical, because the extent to which subjects of pathologising discourses and practices can be understood to exercise free and informed choice about treatment must be placed within the context of unequal power relations operating within the therapeutic context. Furthermore, many patients are not in a position to exercise choice over their treatment because most Australian cities have only one publicly funded eating disorder treatment unit.

Subduing the Body: 'Altering' Interventions in the Treatment of Eating Disorders

Therapeutic interventions described by all but one of the clinical psychiatrists included the use of antidepressant medication, usually selective serotonin uptake inhibitors (SSRI) such as Prozac, as an adjunct to psychotherapy. Antidepressants were presented as useful to control "bingeing" and "vomiting" in bulimia nervosa, and "depression" in anorexia nervosa. Helen, Philip, Paul and John relate their use of antidepressants in bulimia to evidence in the literature, although John and William acknowledge that the mechanisms through which antidepressants act to decrease bingeing and purging remains unclear. Vivien, William and John also argue that antidepressants reduce "arousal" in eating disorders, making the individual more "calm". For Vivien and William, antidepressants calm the individual so that so that psychotherapy can proceed, while John emphasises their role in breaking the "vicious circle" of bulimic bingeing and purging behaviours. Thus, the use of antidepressants was not generally tied to the idea that medication addresses causal factors, such as chemical imbalances in the individual, but to the control of symptoms.

There was some diversity in explanations for the use of antidepressants in anorexia nervosa. For example, Helen describes herself as "cautious" about using antidepressants in anorexic patients, because of the "dangers around people who are very malnourished", and because depression in anorexia is "secondary to the eating disorder" and patients "improve as the eating disorder improves". Rebecca states that she would prescribe antidepressants "if the person was feeling totally hopeless about everything, suicidal [and] withdrawn". However, she argues that "often antidepressants aren't necessary once they start to recover a bit". William, on the other hand, places greater emphasis on the use of antidepressants in the treatment of anorexia and bulimia, justifying his approach with the idea that the new generation of SSRI medications involve fewer side effects than the older tricyclic medications. As noted in Chapter 2, there is an increased tendency to prescribe antidepressants in the treatment of eating disorders and, in particular, the SSRI antidepressants such as Prozac are increasingly recommended as part of the treatment protocol for bulimia nervosa (Crow and Mitchell, 1994; Stokes and Holtz, 1997; Bacaltchuk et al, 2000). However, as was also pointed out earlier, one study found high rates of patients dropping out of treatment when antidepressants were included as part of treatment for bulimia nervosa (Bacaltchuk et al, 2000). The side effect of weight gain may be problematic to patients and Penny, one of the nurses involved in this study, described a case where an anorexic patient became traumatised by the weight gain associated with taking antidepressants.

Increased prescribing of antidepressants in the treatment of eating disorders occurs against the backdrop of a more general upsurge in the prescription of SSRI antidepressants, particularly for women (Gardiner, 1995) in western countries such as Australia. The ubiquity of 'depression' as a late twentieth century and early twenty first century diagnosis is perhaps reflected in William's question about "whether in fact anorexia is some sort of depressive equivalent". Indeed, the idea that anorexia and depression share aspects of aetiology through a common genetic vulnerability is becoming increasingly common in the psycho-medical literature (for example, Wade et al, 2000). In line with this, William suggests that "you may well find in that group there is a family history of recurrent depression", alluding to the possibility that individuals with anorexia nervosa are biologically vulnerable to depression, which he earlier linked to the idea of a 'vulnerable personality'. In this case, then, antidepressant treatment might be conceived of as addressing a causal biological vulnerability in the individual, however, biomedical treatment does not seek to 'cure', but to 'replace' or supplement, the detrimental effect of faulty genes. Thus, the therapy is compensatory, not restorative.

While not wishing to negate reports from some eating disordered women that antidepressants provide relief in the short-term, an emphasis on external methods of bodily control emphasises the idea that the individual is, indeed, outside her own rational control. Thus, the bulimic individual finds that she needs drugs to control her impulses to binge and purge, while the anorexic may find herself labelled with a second psychiatric illness to which she is 'biologically' vulnerable. This potentially reinforces the experience of bulimic women as fundamentally out of control of themselves and their bodies (Brook, Le Couteur and Hepworth, 1998), and is at odds with the self-controlled bodily ordering of the anorexic woman (Gremillion, 1992). As is argued by Gremillion (1992), the biological model locates the problem as "deeply internal" to the individual, justifying "altering" methods of treatment such as antidepressant medication (Gremillion, 1992: 60). It is also problematic in the sense that the anorexic individual continues to carry this potential within, because no amount of medication will cure a genetic personality defect.

While electro-convulsive shock therapy (ECT) is not widely associated with contemporary treatment of anorexia nervosa, it is sometimes recommended for anorexic individuals whose condition is labelled "intractable" and who have not responded to other forms of treatment (Ferguson, 1993: 195). Paul states that he uses ECT on an infrequent basis in his unit and, similarly to constructions of NGF, he emphasises

the idea of patient consent is emphasised. However, once again the idea of voluntary treatment is circumscribed by the power relations operating in the treatment context, particularly if patients are led to believe their problem is 'intractable'. Like NGF, historically, ECT has been surrounded by controversy (Breggin, 1979). In its earlier incarnation, patients were often compulsorily treated, undergoing the procedure in a conscious state, with many reporting a terrifying and extremely painful experience (Ussher, 1991; Breggin, 1979). Even after it became standard practice to anaesthetise patients before administering electric shocks, many continued to report extreme terror, usually associated with the "mental dysfunction" produced by the treatment (Breggin, 1979: 166). While Paul presents the procedure as having positive outcomes and no negative side effects, it has been well established that memory loss and other forms of permanent cognitive dysfunction are associated with ECT (Prudic, Olfson and Sakheim, 2001; Ganeson, 1986, cited in Ussher, 1991; Breggin, 1979). The use of ECT therefore remains controversial and ethically problematic within psychiatry.

Because the pathways through which ECT is theorised to operate are not well understood (Ussher, 1991; Ferguson, 1993), it operates only as symptomatic relief and is not part of an effort to address particular causal mechanisms. Like pharmacological treatment, though, ECT nevertheless confirms for the individual that she is indeed outside her own control and requires dramatic, altering forms of intervention. Because ECT is more likely to be prescribed for female than male psychiatric patients (Breggin, 1979; Showalter, 1985), it is also likely that gendered assumptions to some extent guide its use. Breggin (1979) argues that practitioners may find it easier to submit women to the mentally disabling effects of ECT because dependence and helplessness are "far more acceptable in women than in men" (Breggin, 1979: 189). It is not possible to speculate on the specific reasons for the use of ECT in the above cases, however, it remains an uncommon treatment for anorexia nervosa, and apparently one of last resort.

Surveillance and Disciplinary Control in Psychiatric Practice

Inpatient bed rest programs are commonly used to bring about weight gain in the treatment of anorexia nervosa (Touyz, Beumont and Dunn, 1987). These programs typically involve the confinement of anorexic patients to bed or to their rooms, a controlled diet, regular weighing and the use of positive and negative reinforcement based on the behaviourist theory of operant conditioning (Bemis, 1978). Positive reinforcement for weight gain within this approach might include increased physical activity, visiting privileges and social contact (Halmi, Powers and Cunningham, 1975), while negative reinforcement has

historically involved the restriction of toilet facilities (for example, use of bedpans instead of the toilet) and isolation (Dally, 1969). While behaviourist programs obviously address themselves to the mind as well as the body in that they attempt to condition individuals to eat 'normally', they are included here under an examination of interventions targeting the body because weight gain, in and of itself, is the central therapeutic goal.

Bed rest programs for the treatment of anorexia nervosa have been widely criticised for their controlling and punitive approaches (Bemis, 1978; Bruch, 1974b; Gremillion, 1992). None of the psychiatrists involved in this study explicitly described the use of behaviourist techniques of reward and punishment. For example, John states that he uses a "cognitive-behaviourist approach", and when explicitly asked if his unit used a system of rewards and punishments, William was evasive. Ruth, a nurse responsible for the day-to-day supervision of patients on the bed rest program in William's unit, described a "behavioural stroke [...] cognitive approach", but did not mention positive or negative reinforcements. The written contract associated with this program confirms that a behaviourist approach based on positive and negative reinforcement is in use. For example, "toilet privileges" and "showers" operate as a form of reinforcement, where patients must initially use a bedpan and are only "allowed" a certain number of showers per week, later progressing to freer access to the bathroom depending on their level of "compliance" with food consumption and weight gain. Thus, while there is an avoidance of behaviourist language in health workers' explanations, behaviourist techniques remain in place.

In outlining the bed rest program that operates in his unit, William first describes a stepped approach to weight gain that is indicative of a less rigid approach than had been used in the past:

....what we would be more inclined to do now, would be again to grade [the treatment].....[.].....it depends on the individual, again, it's flexible within what appears to be a relatively rigid framework.....[.].....we would be more inclined to do four weeks and see how somebody was, the aim to see if they could begin to manage or if somebody has come in at 32 or 33 kilos and they need to be weighing 50 kilos that it's a bit like looking at Mt Everest, it's just too high to climb. So we would say "OK, we'll get you for four weeks and that will give us 3 or 4 kilos so you'll feel physically more robust", give them a period of 24 to 36 hours, put them back on for another four weeks and by that

stage they may be physically well enough to leave hospital to see how they go as an out-patient and then if they can't, if they have to bring them back in, more likely at that stage for a longer term admission.

(William, Psychiatrist)

While the idea of the program as "flexible within what appears to be a relatively rigid framework" is a contradiction in terms, William's account alludes to changed practice when he says "what we would be more inclined to do *now*", setting current treatment approaches against the backdrop of a less "flexible" approach in the past. As is noted in Chapter 2, there is evidence of a more general relaxation in the approach to bed rest during the 1980s (Touyz, Beumont and Dunn, 1987: 151). Bemis (1978) also mentions that earlier programs were criticized for causing rapid weight gain, and William's account instead emphasises a more gradual process. However, weight gain is nevertheless an integral focus of treatment in William's account, and must occur in concert with psychotherapeutic treatment:

I adhere to a sort of set of principles about helping people with eating disorders, that you need to be in a healthy weight range, that you need to begin to identify whatever individual issues are, or either personal issues, or family issues are, and you need to find a solution to those rather than resorting to weight and food.

(William, Psychiatrist)

Thus, the restoration of weight is necessary before therapeutic work on resolving "individual issues" or "family issues" can proceed. In line with a psychodynamic conceptualisation, eating disorders function as a defence against other repressed conflicts in William's earlier explanation, and the simultaneous restoration of body weight is therefore conceptualised as removing defence mechanisms so that a "solution" can be found to repressed psycho-emotional conflict. In the following extract, William describes in more detail the stages that lead to a bed rest program for patients in his unit:

William: We've got stages from the acute resuscitation, then into sort of for a two week assessment...[.]...often that two weeks is very educational where they begin to see how much they can eat without putting on weight, or how much they need to eat to put on weight. If it's clear that they are unable to manage or they are too physically unwell, we

look at a more supervised environment, which is basically what we call a bed program where they are actually put to bed.

Nicole: And you stay in bed, that's the idea of it?

William: And you are fed.

(William, Psychiatrist)

Bed rest is presented as the consequence of a 'failed' attempt at self-management. In response to further questioning about the nature of this stage of the program and whether it involves behaviourist strategies, rather than directly answer the question, William somewhat evasively emphasises the knowledge and expertise of the staff:

We would be promoting ourselves now saying "We provide you with a resource. We've got an understanding of what the condition is, this is what you need to do to get better", that we acknowledge their fears. I think what we are attempting to do is really demystify the condition, you know, you arrive on a ward where there are already a half a dozen people with the same condition. There is nothing particularly special about it. And I think they begin to see very quickly that this is a desperate attempt to solve a variety of other problems. That we're shifting from the start the emphasis of weight and food onto what those issues are.

(William, Psychiatrist)

The idea of the unit as a "resource" shifts responsibility for recovery on to patients in terms of whether they choose to utilise staff expertise or not. The professionals working in the unit are therefore positioned as authorities with expert knowledge about the true nature of anorexia nervosa and its treatment, while patients are located in the less powerful position as fearful and in need of education. The role of the hospital is to "demystify" the condition for patients, so that they see that "there is nothing particularly special about it". The notion that there is nothing special about anorexia nervosa is implicitly contrasted here against two common ideas. Firstly, anorexia nervosa is often portrayed as a romantic, enigmatic or mysterious condition (Bruch, 1978; Sohlberg and Strober, 1994) and, secondly, it is commonly believed that anorexics have 'narcissistic' personalities and seek to gain attention through self-starvation (Steiger et al, 1995; 1997). Against these assumptions, the ward is portrayed as a place that denies this desire for

special-ness and attention and which, instead, reveals to the anorexic the fact that she is really "desperate" and needy. The tone of this account is essentially parental and disciplinary, with the hospital staff providing a corrective to the anorexic's mistaken beliefs and misguided behaviour. The parental tone of the above account is continued in the next extract, where William specifically characterizes the role of the nursing staff in disciplinary terms:

The nursing staff are very familiar with the difficulties that these patients have and are really very patient, but at the same time consistent and firm, about what needs to be done.

(William, Psychiatrist)

The terms "patient", "consistent" and "firm" are commonly associated with the care and discipline of young children, and they essentially locate patients in the less powerful position within a parent-child dynamic.

As is indicated above, despite direct questioning about the approach used in bed rest weight gain programs, little detail was provided by psychiatrists working in units known to use this approach. Ruth, a nurse with responsibility for the day-to-day supervision of the bed rest program in William's unit, was able to provide a more detailed account of this program, structuring her account around the interrelated themes of surveillance and control:

.....in regards to their eating and the behaviours associated, that's done through observation, um, checking their menus when they fill in their menus, talking to them about food and their, you know, beliefs surrounding food.....Um, when they're on the bed there's a much greater degree of control, um, they have a contract that they have to sign and there's very specific.....um.....rules, I guess, for want of a better word, that they have to follow. They're not able to complete the menus, their menus, their meals get organized by the dietician. They are able to choose three dislikes that shouldn't ever appear on the tray, and they have to eat everything that's presented to them and drink everything that's presented to them. Um, they get weighed twice a week. So it's very much that

behavioural, stroke, I guess, cognitive approach because the ongoing sort of therapeutic relationship, one-to-one interviews, counselling still continues.

(Ruth, Nurse)

The themes of surveillance and control are clearly evident in this extract. Indeed, the program is used precisely because it offers “a much greater degree of control” of patients through techniques of surveillance, such as “observation”, “checking their menus” and being “weighed every week”. Hepworth (1999) also notes an emphasis on surveillance in UK nurses’ portrayals of inpatient treatment programs for anorexia nervosa. Eric works in a different unit in another state where a bed rest program exists, and while he is not directly involved in the program, and expresses serious misgivings about this approach elsewhere in his interview, the following extract nevertheless captures the emphasis on surveillance and containment central to bed rest programs, as well as the paternalism inherent in the description of patients as “children”:

.....the children are put into cubicles. The cubicles might have glass doors so everybody can see exactly what they are doing, you know, they have no autonomy....

(Eric, Psychiatrist)

The patient’s loss of privacy and control over their environment is presented as equivalent to a total loss of “autonomy”. In the following extract from Ruth, the language of surveillance and control is taken a step further:

Ruth: (sigh) They're confined to their room and they're.....they're put on bed rest as such. I mean they do get up and um.....I guess wander around their rooms slightly but that is kept to a, a minimum as much as possible.

Nicole: What's the idea behind then the, you know, staying in the room... [...]... the rationale?

Ruth: They're observable and their, their activity is decreased...

Nicole: Weight... [...]... related?

Ruth: It's amazing how much energy you can burn, lying on a bed, moving a leg (laughs).

Nicole: Oh, right. Yep. And the food consumption as well then, that, that's observable as well, that's the other.....

Ruth: Yeah, I, I mean it's limited what can be observed. I mean we've got four side rooms and unless we actually sit in there with them, you know, you can you can see,....you can visibly see the first two beds, you can't visibly see this the third and fourth. Um, so a lot of it I, I guess is put, there is still a degree of responsibility on the individual that they comply and they, you know, eat their meals and come in we take their meals in on their trays. Um and if everything's gone everything's gone,....I mean if they don't gain weight then you know, part of the guidelines is that we will do a room search.

(Ruth, Nurse)

Similarly to William, there is an emphasis on the notion of patient responsibility for self-monitoring through the idea that because all beds cannot be seen, "there is still a degree of responsibility on the individual that they comply". The idea that patients are responsible for their behaviour because they cannot be constantly observed is augmented, though, by the fact that if they fail to gain weight their room will be searched. The prospect of surveillance is, in the final instance, the mechanism through which compliance is achieved. The idea of patient responsibility for treatment is also noted by Gremillion (1992) as a characteristic feature of behaviourist treatment approaches for anorexia. In line with the idea of patient responsibility, Ruth mentions that patients on the bed rest program "have a contract that they have to sign and there's very specific [...] rules". Hepworth (1999) also notes the use of a contract to gain patient consent in UK inpatient treatment programs. The mechanism of the contract had a more complex corollary in my study, though. The concept of the contract is drawn from the commercial world of business, and is premised on the idea of rational decision-making based on mutual self-interest between equal parties (Sullivan, 1997). The mechanism of the contract, with its inherent assumptions of patient choice and voluntarism, therefore has the specific function of shifting responsibility for participation in treatment on to patients. However, while Ruth places an emphasis on the idea of patient 'choice', there is also an emphasis on the contradictory notion of 'compliance':

I guess our philosophy is that, um, we want to provide a safe secure environment that is seen as nurturing, that the client feels comfortable in and complies with, um, and that they want to improve their well-being and their health, so they're motivated to make some

changes. Um, so, essentially all our patients are admitted on a voluntary basis, so they choose to come in and they sign a contract and agree to abide by that contract.....

(Ruth, Nurse)

The program is described as "safe", "secure" and "nurturing", and individuals are referred to as "clients" rather than "patients", underscoring the idea of choice and voluntary participation. However, while the voluntary nature of involvement is emphasised, the language of control also features because it is also important that the individual "complies" with the program. "Compliance" is constructed as being related to patients' motivation to improve their health, and therefore as a function of choice, but 'compliance' denotes obedience to authority rather than autonomous, self-motivated behaviour. The ward is therefore constructed as a place reminiscent of the stereotypical nuclear family home, with the patient in the role of the child who is nurtured by their parents, but is also expected to obey them. Furthermore, the notion of the contract is based on the idea of obligation, as well as choice, because clients are described as having agreed to "abide" by it. The idea of being obliged to comply goes further than that of patient responsibility, and is based on the expectation that patients are likely to become 'non-compliant' after commencing the program. It therefore represents an effort to control patient behaviour at a later point. This account is distinguished by the rhetoric of 'good' health care, where clients take responsibility and intervention is 'non-authoritarian', however, this is at odds with the enforced nature of the contract. Next, Ruth discusses how anorexic women experience the inpatient program, again through the contradictory notions of 'choice' and 'compliance':

Some find that they do really well, and cope really well with it, and comply. Others don't, dislike it, don't comply (laughs). Um, but even with that a lot of them are too fearful to actually get up and leave, whereas others will, you know, will just normally will only last for a couple of days and that's, "I don't want to do this, it's too hard" and we'll discharge them, so its is variable, yeah, yeah....[.]... We'll have others that will be compliant and stick to the guidelines and continue through. We'll have others that won't stick to the guidelines, will what we call cheat, or be non-compliant, but don't want to get up off the bed...because it is seen, because they...they feel safe, you know?

(Ruth, Nurse)

Anorexic women are somewhat tragically positioned in this account because while they may be guilty of 'cheating', they are effectively trapped because they are "too fearful to actually get up and leave". This undermines the notion of choice integral to the concept of the contract, particularly in view of the fact that this program represents the only publicly funded treatment program for eating disorders in this particular state. The notion of the patient contract, with its assumptions of rationality, choice and obligation, also sits in a contradictory relation to Ruth's construction of eating disordered women as irrational and cognitively dysfunctional at low weight:

.....I guess their weight often impacts. I mean if they're able to gain some weight so their, so their cognitive ability improves.....as much as I guess it can then be said that they're more in tune with what's been happening to them and why its been happening it, it would also probably make it easier for them to start challenging, you know, their, their behaviours and...[.]...their thoughts that are in their head...[.]...Catch 22, really, isn't it? I mean when they're, they're thinner their, their cognitive ability is impaired and it's, you know, they can almost block out a lot of the issues that have been happening to them, but then because their cognitive ability isn't as intact, it makes it difficult, more difficult, to, to make challenges and gain weight.....

(Ruth, Nurse)

The "catch 22" of anorexia revolves around the idea that anorexics are less rational when they are most underweight, and most rational when they are less in need of gaining weight. The health worker is charged, then, with producing rationality in an individual who is essentially irrational at that point in time. Thus, the idea of rationality that underpins the notion of the contract is completely contradicted by the irrationality of cognitive dysfunction. The following extract from Ruth further elaborates the assumptions about the subjectivity of eating disordered women that underpin this contradictory positioning:

.....they want to get better, they hate it, but on the other hand....they've got a constant tug of war going on in their heads. You know, they've got that one part of them that wants to do really well, you know, wants to get over this, doesn't, doesn't want, you know, they don't want to have anorexia, they don't want to have bulimia, it's taking over their whole lives, its awful for them. And yet they've got that other part of them, the anorexia part of

them, or the bulimic part of them that, you know, is struggling against the rational side of them, you know, and they.....they it's constantly being pulled one way or the other.....

(Ruth, Nurse)

Through the analogy of a "tug of war", Ruth constructs the anorexic individual as a self-divided, where the 'rational' part "wants to do really well", while the 'irrational' part is "struggling against the rational side of them". Thus, anorexic women are described as inherently conflicted within themselves, with contradictory selves at odds with each other. Next, Ruth describes her approach to the divided self in practice, infantilising patients as "girls":

.....[the idea of a tug of war is] probably an analogy that I use when I do talk to the girls...[.]....that....that they have to try and take control of the rational part.....part of them and make that the strongest part of them so that they can pull that rope over and pull that other side you know off balance, and challenge it and overcome it. But I, I, I'm sure that that must be what it's like. And they all.....they can all sit there and, and, and say "yeah that's right, I have got that, that one part of me and that other part of me and...", yeah, so it does make it difficult because as, I guess, therapists and nurses you're forever trying to grasp onto that rational part of them to help them to try and challenge the part of them that they don't want to be anymore. So that's why it's probably difficult, and they are, you know, it is hard, it's hard work, very draining.

(Ruth, Nurse)

The health worker's task involves forging an alliance with the rational, or 'true', self against the irrational. This positions the patient at the epicentre of a battle, pulled in opposite directions within herself, as well as by the health worker. William also constructs his role as one of attempting to rationalise with patients through the idea of persuading them that "there is a problem":

Basically the stumbling block for most of the people that I would see with anorexia nervosa is once they've actually developed some insight, they acknowledge there is a problem. Sometimes people initially are very much a reluctant attender. If you can

persuade them there is a problem, the next stumbling block is that they would like to get better, but they don't want to put any weight on.

(William, Psychiatrist)

This account constructs the therapeutic relationship as inherently conflicted from its inception, again centring the idea of treatment as a corrective by shifting anorexics from their mistaken beliefs.

While participants in this study did not link behaviourist bed rest intervention to a specific causal explanation of the development of anorexia nervosa, justifications for using a controlling approach to treatment were offered by two practitioners. Firstly, despite his reservations about the approach, Eric justifies bed rest intervention through the notion that anorexic women expect structure and a controlling environment:

Basically the understanding of it is this. If you take the person with anorexia nervosa, they've left an environment, which is highly controlled. They come into a hospital and their expectation is because of the past that there will be structure, that they will be controlled and if they don't have that they feel uneasy, that this isn't a proper place....[.].....the way in which I try to put forward our model is this. That those people have those expectations and we cannot treat the disorder without entering into the patient's world, in other words do we.....have to provide that structure and we initially are providing that structure around diets and what you expect it to do and this is the thing that is going to happen.

(Eric, Psychiatrist)

This shifts responsibility for the highly controlled environment of the hospital onto patients. Similarly, William argues that patients experience a "sense of relief" on bed rest programs because "someone has taken responsibility away":

.... often there is a sense of relief when the patient feels that someone has taken responsibility away, that somebody else has actually taken control for a while.

(William, Psychiatrist)

William depicts the passive surrender of control to others as positive and as a step towards recovery. To suggest that treatment necessitates deference to an external authority, and the relinquishment of autonomy and control, seems to reinforce those very qualities that were earlier pathologised in anorexic individuals. However, the idea that anorexics secretly *want* to surrender themselves to external sources of control enables William to step around this dilemma.

The Paradox of Autonomy and Control in Behaviourist Intervention

While health workers did not specifically tie the use of behaviourist bed rest intervention to a causal explanation, behaviourist approaches nevertheless involve a specific, implicit theory of causation: behaviour is seen as the product of environmental stimuli, and the anorexic must therefore be passively conditioned to learn new behaviours through the controlled environment of the hospital ward (Gremillion, 1992). As was noted in Chapter 2, this is a very mechanistic model of human behaviour, where the mind is conceived of as little more than "a privatised, internal 'processing centre'" (Gremillion, 1992: 62). In this conceptualisation, the mind is really no more than 'brain', because this very rudimentary conceptualisation of human functioning leaves no room for the idea that individuals might have the capacity for reflection, effectively producing the individual as a body/object to be manipulated in line with treatment goals.

While practitioners did not provide explicit behaviourist explanations of the causes of anorexia nervosa, bed rest intervention was implicitly linked, through the notions of autonomy and control, to the dominant causal explanations that posit anorexia nervosa as an attempt to overcome identity deficiencies and to achieve control over repressed psycho-emotional conflict. To passively surrender inauthentic autonomy and control to hospital staff through the bed rest program becomes, then, the first step in addressing psychological deficits and learning authentic autonomy and rational self-control. The nature of anorexia therefore becomes the justification for forms of intervention that are controlling and punitive, explicitly demonstrated through the construction of anorexic women as *really* desiring to surrender their inauthentic means of control to authoritative health professionals.

While the surrender of control is re-framed through assumptions of freedom and choice as an act of autonomous rational self-control, this sits uncomfortably within a treatment approach that is essentially controlling and disciplinary. One is moved to ask the question: if patients are truly voluntary, why is a

contract and surveillance necessary? The emphasis on rational, voluntary choice also represents a major slippage between theory and practice because these same practitioners also constructed the anorexic as *lacking* autonomy and rational self-control, particularly at low weights when a bed rest program is most likely to be recommended. Thus, the anorexic individual is called upon to make a free and rational choice using capacities she is theorised not to possess. She is also called upon to *actively* collude in *passively* surrendering control to external sources through the assumptions of individual choice and responsibility. Gremillion (1992) similarly notes duplicity in behaviourist approaches in terms of the anorexic having to "learn passively new behaviours", but being simultaneously asked to "participate in the controlling" of her behaviour through self-monitoring (Gremillion, 1992: 63). A contradictory positioning of the anorexic individual as simultaneously autonomous *and* externally controlled, active *and* passive, underpins health workers' constructions of bed rest intervention in this study too, so that an intricate discursive web is woven through the conflicted concepts of 'choice' and 'compliance', rendering the anorexic ultimately responsible for the controlling nature of the treatment she receives. This shifts the burden of blame to the anorexic woman should treatment fail, and behaviourist bed rest programs are historically associated with poor outcomes (Bemis, 1978; Bruch, 1974b). This paradoxical emphasis on individual autonomy and control in the context of an essentially disciplinary intervention is manipulative, based on the conviction that weight gain must feature as an integral short-term outcome of treatment. However, such an assertive approach to the 'removal' of defence mechanisms sits in a problematic relation to other psychotherapeutic goals associated with multidimensional intervention, and this is examined further in the next chapter. The contradictory approach to autonomy and control that distinguishes the bed rest approach also reproduces *in practice* the gendered approach to autonomy and control that characterises the discourses used by health workers to explain eating disorders. Thus, women are both explained through contradictory ideas about autonomy and control, and treated in contradictory ways as both autonomous and rational when they enter treatment contracts, and inherently irrational and out of control through surveillance and punitive treatment techniques.

In a Foucauldian sense, the emphasis on surveillance and self-monitoring in practitioners' constructions of behaviourist treatment regimes typifies modern disciplinary power at work. Foucault (1977a) argued that modern individuality is produced through techniques of observation and examination, such as those characterising medicine and other modern social institutions, where the individual is positioned in a "field of surveillance" (Foucault, 1977a: 189). In examining the emergence of 'the examination' at the end of the

eighteenth century, Foucault (1977a) argues that this form of power operates as “a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish.” (Foucault, 1977a: 184). The techniques of surveillance that characterise bed rest interventions, and the normalizing techniques of controlled diets and weighing, can be understood in this way. The emphasis on self-surveillance integral to these programs is exemplified in Foucault’s description of the ‘Panopticon’ – a prison designed by Bentham in the nineteenth century – in which prisoners can be observed from a central tower so that there is always the possibility of surveillance, but inmates never know when they are being observed (Foucault, 1977a). Because of the ever-present possibility of surveillance, the Panopticon produces disciplined individuals who self-monitor (Foucault, 1977a). The possibility of surveillance in health workers’ constructions of bed rest interventions is also ever-present through, for example, the techniques of weighing and room searches. However, ironically, the disciplinary practices of bed rest interventions mirror and reproduce the self-surveillance and attention to food and weight that characterise anorexic practices themselves (Gremillion, 1992; Malson, 1998).

The analogy of the Panopticon clearly demonstrates the power dynamics at play in bed rest interventions, where patients effectively become ‘the watched’. The positioning of patients as equal partners in this arrangement through the mechanism of the contract, and assumptions of freedom and choice, completely fails to come to grips with the intrinsically *unequal* power dynamics that characterise a therapeutic relationship based on this form of disciplinary power. While it may be argued that patients are not prisoners and that most can leave the hospital at any time, again, the notion of freedom in this context is not necessarily any more than theoretical, most tellingly captured by Ruth’s portrayal of anorexic women as “too fearful” to leave. If some indeed feel trapped in this way (an effect not improbable when individuals are persuaded to become the subjects of pathologising and objectifying discourses and practices), then notions of choice and responsibility become unconvincing rationalisations for essentially manipulative practice. This is not to say, though, that resistance to these forms of disciplinary power is not possible. Indeed, the emphasis on ‘cheating’ in Ruth’s account hints at its possibility. It is probable that the controlling, disciplinary nature of the bed rest approach inadvertently strengthens some individuals’ determination to continue their weight loss practices. On this point, a number of the psychiatrists involved in this study somewhat controversially raise the possibility of ‘resistance’ as a reaction to controlling forms of psychiatric intervention, and this is considered further in Chapter 9.

Summary

Health workers' accounts clearly indicate some modification in approach to inpatient psychiatric treatment for anorexia nervosa over the past two to three decades, particularly in terms of an avoidance of involuntary detention and force-feeding, as well as a relaxation in the setting of goals weights in some bed rest programs. While health practitioners' accounts are also characterised by an emphasis on notions of choice, voluntary participation and patient responsibility, controlling disciplinary approaches nevertheless remain a central feature of constructions of bed rest intervention in particular, exemplified through the contradictory emphasis on 'choice' and 'compliance'. Through these ideas, health workers weave an elaborate discursive web around the broader concepts of autonomy and control, shifting responsibility for the disciplinary nature of bed rest intervention to patients, and rendering invisible the power relations that structure the therapeutic context. This re-inscribes the gendered contradictions earlier identified in health workers' explanations of eating disorders, reproducing in practice a contradictory approach to women as simultaneously autonomous and non-autonomous, in control and out of control that is implicated in causing eating disorders in the first place. The following chapter continues an examination of the paradox of autonomy and control in psychiatric practice, focusing specifically on psychiatrists' constructions of psychotherapy. The ways in which interventions targeting the mind conflict with those targeting the body is examined, as well as the contradictory nature of approaches to autonomy and control within psychotherapeutic intervention itself.

Chapter 9

Constructing Psychiatric Practice: The Mind as the Object of Intervention

Introduction

All nine of the clinical psychiatrists involved in the study describe some form of psychotherapy within a multidimensional approach to treatment. This usually involves descriptions of cognitive-behavioural, psychoanalytic or psychodynamic approaches. Cognitive-behavioural therapy is seen as useful in addressing 'dysfunctional' thoughts and attitudes said to be implicated in eating disorders, particularly bulimia nervosa. In contrast, psychoanalytic and psychodynamic therapy is associated with treatment for the more internally located identity problems and psycho-emotional conflicts said to characterise anorexia nervosa. The concepts of autonomy and control are also pivotal in health workers' constructions of psychotherapeutic intervention for eating disorders, and this chapter explores contradictions in the ways in which women are positioned within therapeutic processes in relation to these constructs. The chapter also addresses tensions between the goals of psychotherapeutic intervention and those associated with interventions targeting the body.

Cognitive-Behavioural Therapy and the Correction of Misconception

Six of the psychiatrists describe cognitive behavioural therapy (CBT) as part of their psychotherapeutic approach. As was noted in Chapter 2, CBT involves a focus on the "thoughts, beliefs and values" that maintain eating disorder practices, with a particular focus on concerns about size and shape (Fairburn, Marcus and Wilson, 1993: 365). Some of the psychiatrists using CBT particularly emphasise its use in addressing these concerns (Helen and Robyn), while Helen and John state that they specifically use the CBT approach outlined by Christopher Fairburn and colleagues, which focuses on 'restructuring' the thoughts, beliefs and values seen as maintaining eating disorder behaviour. Participants did not provide specific details about their approaches to CBT, and it was generally presented as an adjunct to other forms of psychotherapy, rather than as a central technique.

In common with explanations of behaviourist bed rest programs, none of those health workers advocating CBT suggested that attitudes and beliefs play a causal role in eating disorders. As in behaviourism, the theory of causation in CBT is implicit and is based on the assumption that individuals have learned to think

and behave in particular ways. As was noted in Chapter 2, CBT is based on a very rationalistic approach that eschews exploration of the meaning of eating disorder practices, because the practitioner already knows what they are. This is because CBT is based on an objectivist ontology that posits 'reality' to be 'out there', stable, perceived uniformly by all, and defined in one way only (Sarantakos, 1998). Thus, eating disordered individuals' perceptions, thoughts and feelings become fundamentally *wrong* within this formulation and, in common with behaviourist bed rest intervention, the practitioner is in possession of 'truth', and patients' attitudes and perceptions must be corrected before they can become rational, functional individuals.

The emphasis on rational, objective thinking also reproduces a reification of masculinized rationality over the feminised body and emotions (Jaggar, 1989). As was also argued in Chapter 2, this reification is characterised by a subtle undermining of the individual's subjectivity so that others are positioned as more rational and as having a firmer grip on reality. Aspects of the approach share other disciplinary features with constructions of bed rest intervention. For example, the therapist is entreated to be "firm and authoritative" (Fairburn, Marcus and Wilson, 1993: 368-369). While CBT privileges expert knowledge over patient and, like behaviourist treatment programs, seeks to control behaviour in a very specific direction, it places a greater emphasis on the individual learning to self-monitor, rather than practitioner-controlled systems of reward and punishment. While CBT is therefore an example, *par excellence*, of disciplinary power at work, it can offer individuals techniques for managing specific aspects of eating disorders, such as bingeing and purging, which some individuals have reported to be useful (Fairburn et al., 1995; Hsu et al, 2001). However, because CBT does not seek to explore the meanings of food and the body with the individual, its goal is to produce self-disciplining rather than reflective subjects.

Psychotherapy and the Development of Autonomy and Self-Control

Most of the psychiatrists included psychotherapy, involving aspects of psychoanalytic and psychodynamic approaches, as part of their treatment approach. While a number of psychiatrists emphasised intervention with the family as a further aspect of treatment, the family was largely positioned in a support role to individual psychotherapy, rather than the object of therapeutic intervention in and of itself.

Psychotherapeutic approaches included an emphasis on the ideas of 'reflection' and 'insight', and on the development of a positive therapeutic relationship. As mentioned, reflective, insight-oriented psychotherapy was more often included in the treatment of anorexia nervosa, which is seen to be a more

pathological condition than bulimia nervosa, and as implicating the core self of the individual. For example, Helen says that she uses “reflective psychotherapy” to address “more deep-seated problems”, placing an emphasis on “relationship issues”:

Quite a few people need more [...] reflective psychotherapy. They've maybe more deep seated problems that may benefit from a psychodynamic approach or a reflective approach in addition to cognitive behaviour technique and....relationship issues are always often very important, and to some degree addressing those and addressing interpersonal issues [!] usually incorporate as well.

(Helen, Psychiatrist)

The idea of “reflective psychotherapy” centres on the need to explore the “deep” levels of the psyche where psycho-emotional conflicts are said to reside. At the same time, Helen emphasises addressing “relationship issues” and the “interpersonal”, in line with a psychodynamic concern with the psyche in relationship, which usually involves focus on the parent-child relationship. Paul also emphasises the development of insight as part of his therapeutic approach:

....it's probably more in initially a supportive psychotherapeutic approach and then perhaps as they get more engaged in it you move into a more insight orientated approach.

(Paul, Psychiatrist)

The notion of ‘insight’ in psychotherapy also focuses on the idea of the individual coming to understand the causes of her eating disorder. For example, William emphasises the importance of trying “to tease out whatever the contributing factors were”; Robyn argues for the importance of “allowing the young person to talk about what we think the triggers and precipitants were”; while Rebecca uses an approach where “they really can work on issues that may have contributed towards the illness”. All these psychiatrists included in their explanatory accounts the idea of identity or psycho-emotional deficiencies in the individual herself as central to the development of an eating disorder.

William's emphasis on the development of insight situates behaviourist bed rest intervention within the context of a wider psychotherapeutic approach that aims to reveal the "inner world" that the eating disordered individual is "trying to switch off" through eating disorder behaviours:

.....[I use] sort of psychological strategies.....trying to break that sort of pattern of behaviour where you are again trying to get in touch with your inner world, about what we will try to do with your bingeing, what you are trying to actually switch off [through the eating disorder].....

(William, Psychiatrist)

Psychotherapeutic intervention is conceptualised as attempting to "break" behaviour patterns that function as defence mechanisms in order to reveal the psycho-emotional conflict that is theorized as underpinning the disorder. Thus, the 'truth' of the individual will be revealed and the individual will no longer be able to repress psycho-emotional conflict through inappropriate mechanisms of control because insight into this "inner world" works to uncover and resolve conflict. A relatively aggressive assault on defence mechanisms through disciplinary forms of behaviourist treatment sits somewhat uncomfortably, though, alongside a psychoanalytic concern with self-actualisation, and the more gradual dawning of insight through the development of a long-term therapeutic relationship.

In the following extract from Philip, there is an emphasis on the development of individual "autonomy" through psychotherapeutic intervention:

.....the [...] thing which you want to cause to flourish is their autonomy. These kids are poor at asserting their own selves.....

(Philip, Psychiatrist)

The goal of psychotherapeutic intervention is to bring about an increase in individual autonomy, because anorexic individuals are understood to be unassertive and passive, and Philip earlier presented this as central to their disorder. Eric's approach to psychotherapy also emphasises the development of autonomous identity, as well as a psychodynamic concern with the development of a positive therapeutic

relationship. Eric considers that the individual needs to develop "a sense of self", criticising psychiatry's illness-focus when "what has gone wrong is the person":

.....it seems to me one of the problems about psychiatry is there is a big hole in the middle of it. That we talk about kind of illnesses all the time, but not about the person to whom they happen. And it seems that what has gone wrong is the person, you know, and so it's now manifested as an eating disorder. So I have a model and the idea is that the cure is going to come through the individual discovering a sense of self ...[.]...but it's based on the idea that the condition is a disorder of the self....

(Eric, Psychiatrist)

This is a very humanistic approach to the individual, eschewing an illness model and centring "the person" and the development of autonomous selfhood. This is consistent with Eric's earlier construction of anorexia as an identity problem related to a lack of autonomy and sense of self. Eric goes on to explain his approach to psychotherapy:

.....we try and begin, and this is an ideal situation, another parallel for the treatment which is to do with the development, you know, the developmental stream and this might be a senior nurse, it might be a psychologist who begins to try to make a relationship with the individual and initially that's not, that's barely possible. The person is totally wooden and not interested, cannot connect with anybody, there's nothing going on inside them, no imaginings, nothing, you know, barely even emotionally alive. As the thing goes on in the ideal circumstance this interpersonal developmental theme becomes more and more important.....

(Eric, Psychiatrist)

The therapeutic approach portrayed here is intrinsically psychodynamic, emphasising the development of a relationship with the health care worker as integral to the therapeutic process. At first, this is expected to be difficult because the individual has "nothing going on inside them". Eric drew on this idea earlier when he described the eating disordered individual as a 'non-self', while here they are characterised as "barely

even emotionally alive". However, over time "this interpersonal developmental thing becomes more and more important". In the following extract, Eric explains what this entailed in one particular case:

.....a principle problem seems to be that the maternal figure is one which.....with whom there is a conflict, but also a dependence, and the child is kind of trapped in this situation and um it seems to me in the way I've worked anyway, but the child needs to find another female figure to identify with...[.].... I chose the chief nurse, you know, choosing a kind of idealisable female figure, and this is what happened. The therapy more and more became the..... working with, you know, who she was, her inner life, you know, her world and the other thing [the anorexia] vanished. The outcome was that the patient made a complete recovery and she changed the course of her life and she became a star nurse.

(Eric, Psychiatrist)

The above extract provides an insight into the way this psychiatrist conceptualises the function of therapy as analogous to 're-mothering'. As noted in Chapter 2, within psychodynamic identity theory, anorexia nervosa is understood to arise in the context of an overly controlling mother who stunts the individual's development so they cannot become an autonomous, independent individual with a functional identity (Bruch, 1978). In line with this, therapy involves re-mothering through the involvement of "another female figure to identify with" and "idealise". Through the mechanism of this healthy, non-controlling relationship, the individual develops an authentic, autonomous adult identity. However, the construction of the ideal identity in this extract is gendered because it is assumed that the chief nurse provides a suitable figure to idealise. Thus, becoming "a star nurse" is an appropriate and successful thing for a young woman to do. The idea of psychotherapeutic intervention as 're-mothering' draws once again on a parental dynamic in the treatment of anorexia nervosa, however, while this involves disciplinary techniques of control in bed rest intervention, and to a lesser extent in CBT through the correction of misconception, Eric's account presents psychotherapeutic intervention as nurturing and developmental.

Both in accounts of bed rest and psychodynamic intervention the usually female nurses play a pivotal role in the day-to-day therapeutic process. In bed rest programs, it is they who monitor, discipline and control patients, ironically reproducing the model of the overly controlling mother who is implicated in identity theory as causing anorexia nervosa in the first place (see Bruch, 1978). In Eric's construction of

psychotherapy, the mother is 'ideal' and nurtures the individual's developmental needs. In both cases, the father is notably absent from the picture, just as he was in health workers' earlier explanations of eating disorders and in psycho-medical explanations of eating disorders more generally (Horsfall, 1991, cited in Hepworth, 1999). While the usually female nurses have day-to-day responsibility for implementing and monitoring treatment, overall management and control actually rests with the usually male senior psychiatrists. As fathers are rendered largely invisible in psycho-medical explanations of the eating disordered family, so is the power and control exercised by the usually male psychiatrist. The role of the psychiatrist is further elaborated in the following analysis of constructions of the therapeutic relationship, with particular attention to the implications for gender power relations in the therapeutic setting.

Father/Psychiatrists and Daughter/Patients

As noted above, while a parental dynamic is present within psychodynamic therapy in the form of 're-mothering', the overtly controlling and disciplinary overtones associated with bed rest are absent and autonomy is given prominence. However, a disciplinary parental dynamic is present in accounts of psychotherapy through constructions of the psychotherapeutic relationship as analogous to a paternalistic father and daughter relationship. This representation was exclusive to older male psychiatrists in their explanations of therapy with young anorexic patients. The following extract from Philip is an example of the paternalism characterising the construction of the therapeutic relationship through the notion of the father/psychiatrist and daughter/patient:

.....it's not transference, but [patients] will treat you, I mean, it's probably just my age, I suppose, it's like a parent, I mean they'll say things like "That wasn't very good, was it?" And I say "No, no, it's awful really, and I wouldn't say that again if I was you." So there's a lot of humour involved as well, you know.....

(Philip, Psychiatrist)

While the interchange between Philip and a fictional patient is portrayed as involving "a lot of humour", young women are nevertheless located in the less powerful position of seeking judgement and guidance from an older, male authority figure. Philip is also anxious to point out that "it's not transference", as if this

implies something inappropriate, but a 'healthy' therapeutic relationship. John also positions himself in a "paternal role", tied to the fact that he is "dealing with adolescent girls and young women":

.....I'm dealing with adolescent girls and young women, so I play the sort of paternal role. I have over the last ten or fifteen years and spend a lot of my time not talking about the anorexia, talking about other things.

(John, Psychiatrist)

John emphasises a father-daughter style of relationship in which his role is constructed as 'father-confessor' to the young women. The following extract from Philip further demonstrate paternalism in the therapeutic relationship:

I had a lovely patient and [she] had two funny things about her. One, she got terrible anorexia, and she also had ulcerative colitis. It was really an ordeal... [.]...... and we got her into treatment, and it was very complicated, but basically she got better. But she became,.....the family couldn't cope with her being home. They fought all the time. It sounds unfeeling, but it was a very complex issue. So we all decided that she would have to go to boarding school.....

(Philip, Psychiatrist)

In the above account, the psychiatrist joins with the family as the rational (paternal) voice of reason in making decisions about the young woman's life, while the young woman is presented as completely uninvolved in the process. Indeed, Philip implies that she is unwilling to go to boarding school when he explains: "It sounds unfeeling, but it was a complex issue". While Paul does not explicitly draw on the analogy of the father-daughter relationship, the following account evokes a similar parental dynamic:

....you get the impression after a while that they get better as much for the relationship as anything.....and, um, they become keen to please you.....

(Paul, Psychiatrist)

The portrayal of anorexic women as "keen to please" the psychiatrist positions them in a child-like and dependent relation to the psychiatrist as deferential to an external, more powerful authority. This echoes the image of eating disordered women projected earlier by a number of other health workers as other-focused 'pleasers', rather than self-directed with a healthy level of self-interest. However, while this desire to please was defined as a deficiency in autonomy that is implicated in the *causation* of eating disorders in these earlier accounts, Paul portrays the desire to please as a positive quality implicated in *recovery*. Again, the notion of autonomy in the treatment of anorexia nervosa is conflicted and contradictory.

Paternalistic constructions of the therapeutic relationship were also explicitly tied to gendered assumptions about female sexuality and eating disorders. In the following extract, Philip constructs the therapeutic relationship in paternalistic terms through the portrayal of young anorexic women as "vulnerable" and prone to being "sexually victimized", again infantilising them as "kids":

.....these are very vulnerable kids and they do get sexually victimized, and it's not a big thing, but I mean you do wonder how much you [should] try and protect them. They have to learn in the real world how life works but, and it's not sexual abuse, I don't mean like sexual abuse in childhood, I mean like at work somebody makes some kind of suggestion and they might blush, but they don't say I don't want to talk about that or learn to deal with that....[.].....so the perpetrator takes that as some kind of signal and then suddenly you find one of them on the phone to you saying all these awful things are happening and they don't know what to do and we usually see them and talk to them about that and how to handle it and we rehearse things that they can say or they can cope with and by and large it works alright.

(Philip, Psychiatrist)

In this account of sexual vulnerability, young anorexic women are located in the relatively naïve and powerless position of being in need of protection as both victims *and* inciters of sexual harassment. As in constructions of sexuality in eating disorders in explanatory discourses examined in Chapter 6, this is structured around a dualistic conceptualisation of female sexuality as simultaneously passive and provocative (MacSween, 1993). The construction of women in this way in depictions of sexual abuse has the effect of shifting responsibility for abuse away from perpetrators and onto women (Griffin, 1971; Lees,

1986). At the same time, Philip plays down the nature of victimization, stressing "it's not sexual abuse...like sexual abuse in childhood", delimiting 'real' sexual abuse as something that occurs only to children. Instead, 'sexual victimization' is characterized as "not a big thing", dismissing the young women's experiences despite the fact that they are described as distressed, and characterizing the women as simply unable to "handle" "how the real world works". This constructs sexual victimization as natural, and as something young women simply have to come to grips with: another discursive device that shifts responsibility onto women (Kelly, 1996). At the same time, Philip positions himself as informed about "the real world", and locates himself in a protective, fatherly role in terms of teaching young women its ways. However, the unequal power relations inherent in the analogy of the patriarchal father/daughter relationship, structured around a dualistic notion of female sexuality as both passive and provocative, ironically reproduces the discourses and gender power relations implicated in sexual abuse itself (see MacSween, 1993; Griffin, 1971), as well as in eating disorders. One other older male psychiatrist, John, presented a very similar account, portraying anorexic women as vulnerable to sexual abuse, including from their male psychiatrists:

I've come across quite a few patients who've been sexually harassed or abused in some way or other, and I think that's more common in anorexia nervosa than in most other conditions, for two reasons. I think one is that a patient regresses and they become very vulnerable looking...[.].....and I think they also get very dependant...[.]...so I've seen several of my patients who've been sexually abused and I've seen several who have been dealt with inappropriately by previous psychiatrists..... I wouldn't say abused, but dealt with inappropriately.....[.].....It's not that I think they are provocative as such. I don't think they are. I think they are very vulnerable. And I think it's that which provokes predatory action on some people's part.

(John, Psychiatrist)

John draws on the psychobiological notion of 'regression', which was also used earlier by a number of other health workers to explain the meaning of the thin female body in anorexia nervosa. Thus, John suggests that a "vulnerable", child-like appearance and "dependant" behaviour lead to anorexic women being "dealt with inappropriately" by some male psychiatrists, and provoke "predatory action" in some other men. While anorexic women are presented as not intentionally seeking this, the focus is

nevertheless on their ability to provoke abusive behaviour in men through their appearance and behaviour: an idea that has commonly been used to explain rape and other forms of sexual abuse (Carrington, 1997; MacSween, 1993). This illustrates the contradictory positioning of the anorexic body as simultaneously non-sexual through the idea of regression, and sexual through its supposed vulnerability. While inadvertently hinting at the multiple, and often contradictory, meanings of the thin female body (see Malson, 1998), it represents an internal contradiction within the terms of John's account, based as it is on a psychodynamic conceptualisation of regression that assumes only one reading of the anorexic body. In common with Philip's earlier account, this dualistic notion of female sexuality places the anorexic woman in the contradictory position of being simultaneously an innocent victim of, *and* responsible to some extent for, sexual abuse. It also naturalises predatory behaviour in men, in that it becomes 'natural' to exploit vulnerability, rather than 'abusive'. Thus, also in common with Philip, John suggests that anorexic women are not what he would call "abused", playing down the nature of these experiences and ignoring the unequal gender power dynamics involved, particularly in the context of the doctor-patient relationship. While the precise nature of these incidents is not specified, they hint at serious professional misconduct in the form of sexual relations between doctors and patients. The gender power dynamics in this context are further exacerbated by the fact that the woman occupies the much less powerful position of psychiatric patient, while the male psychiatrist occupies the far more powerful position by virtue of his status as a medical authority. When asked how he deals with these issues in practice, John characterizes himself as a "grandfather figure":

Nicole: So how does this [vulnerability of anorexic patients] influence your practice with them then? How do you sort of get around, deal with, address these sorts of problems?

John: Well, I suppose, sadly, as I've got older it's.....I've adopted a much more paternalistic role...[.]...I think most of my patients see me [.] very much as a grandfather figure. So it's never been an issue for me. But it is an issue for some of [the other male psychiatrists].....

(John, Psychiatrist)

John places himself outside the gender power dynamics characterizing the therapeutic relationship for younger male psychiatrists through the analogy of the (grand)father-(grand)daughter relationship.

However, again, the unequal gender power relations implicated in sexual abuse are again reproduced in

the therapeutic setting through a paternalistic relationship based on unequal power dynamics and gendered assumptions about female sexuality. While John aligns himself with the position of father/protector, rather than abuser, this nevertheless locates women in the less powerful position as targets of men's actions, whether they be predatory or protective.

In Chapter 6, I examined two extracts from Philip depicting a young anorexic woman's transformation from 'ingénue' to 'tramp'. The latter part of the second extract is re-examined here to demonstrate the way in which gendered assumptions about female sexuality are linked to paternalistic approaches to therapeutic intervention. After portraying the young woman as having "got into sex in a big way", Philip describes his approach to dealing with her behaviour:

"Well, it's not very good is it?" I said, and she burst into tears and sobbed her little heart out...[.].....anyway she went home and, God knows, you'd wait thirty years for somebody [to do this]. She went home, stopped doing all this stuff, started going to university on time and had meals and by the time she had put in about two weeks of her admission to hospital she was a normal weight, not depressed and kind of fine.....[.].....but I mean sometimes it's almost like that, you know, it's almost like just putting up some sign posts and sort of explaining it and let's sort of do it.

(Philip, Psychiatrist)

As was noted in Chapter 6, this young woman's transformation from innocent to tramp demonstrates the idea of the inherently uncontrollable nature of female sexuality (MacSween, 1993). Because all women carry the potential of the whore, the various forms of social control and prohibition historically regulating female sexuality are thereby justified (MacSween, 1993). In line with this, the gentle but firm father-psychiatrist attempts to control the young woman's sexuality by reprimanding her: "Well, it's not very good, is it?" The account of recovery is almost a parody of de Beauvoir's narrative of 'the dutiful daughter': the young woman is suitably contrite - "she burst into tears and sobbed her little heart out"; she returns home to her parents; and later takes up a more acceptable, ordered university life. In the next extract from

Philip, the psychiatrist's paternalistic approach to a young anorexic patient is once again initially structured around the notion of sexual naivety:

...she came down to see me one day and she was all flushed, coming in the door, and this,.....a nice bloke just appeared, and I said, "There's one." And her neck is all red and she said, "I've met a bloke" and I said, "That's nice and how old is he?", she said, "Thirty two" and she was eighteen so I said "What's he do?". She said "He's really nice and he's going to take me out on Saturday night." And then she said, "Do you think it's alright if I hold his hand?" and I thought, "My God, this bloke has probably had at least four or five important long term relationships and she wants to hold his hand!" So I had to take her all through that, you know, what you can and can't do, and how you handle it, and all that stuff. So that's the kind of protectiveness.....

(Philip, Psychiatrist)

In the first part of this extract, the questions posed to the young woman about her boyfriend are stereotypical of the father quizzing his daughter about the suitability of a prospective husband: "How old is he? "What's he do?" Philip's role is presented as one of guiding the inexperienced young woman about acceptable standards of sexual behaviour in terms of "what you can and can't do, and how you handle it". This once again locates the woman in the dualistic position of being simultaneously naïve *and* responsible for male sexual behaviour, this time in terms of placing limits around advances from a more sexually experienced man. Again, it is difficult to imagine similar advice being given to a young man. Having presented the young woman as naïve and innocent, Philip then presents "the other side" of this young woman's behaviour:

On the other side of the coin, she wasn't without her own sense of power because, after about a year..[she weighed about] nine stone two. So about a year after that I said to her "Well, look, I'm [moving] and [.] and you're pretty well, you don't have to see me too often." She said she would see me twice more, but I was thinking about maybe ten times or something. And I said, "Okay", and she came back next time and she was nine stone four and had her periods back, so it was just like that. So [anorexics] have, you know, it's very interesting, this whole ethical issue of control and power and use of relationships and so,

no, they're not without dubiousness in a funny way. I mean she knew that was her ticket to the relationship and help continuing and.....but she had a very mature way of giving up.

(Philip, Psychiatrist)

The young woman is presented as having power and control in the psychiatric relationship because she decided when to end it, having kept her weight at "nine stone two", which was just below the threshold set by the psychiatrist for wellness, so she could retain his involvement. Only when he was about to leave the country did she choose to increase her weight to the level where she started menstruating again and was deemed recovered. While exercising this power is portrayed as "a mature way" to end the relationship, it is also presented as "dubiousness" through its juxtaposition as "the other side of the coin" against supposed sexual naivety and innocence. Thus, anorexics are not as naïve and innocent as they seem. This draws on the gendered historical notion that women are 'not what they appear', especially in relation to their sexuality, which is seemingly passive but in reality powerful and dangerous. In this account, the young woman is positioned as simultaneously powerless and powerful, and this is presented as ambiguous. It echoes, to some extent, the classic portrayal of anorexic women as "manipulative" (Crisp and Bhat, 1982: 178; Schlemmer and Barnett, 1977: 35). Again, eating disordered women are constructed through inherently contradictory discourses.

The depiction of the young woman's tactical handling of the end of the therapeutic relationship as "dubiousness" ignores the power relations operating in the psychiatric context, and the fact that it is the psychiatrist's rules that patients are largely required to conform to. The setting of goal weights in the treatment of anorexia is a psychiatric convention, and not something over which patients generally have any direct control. To remain just under such a weight might function as one of the few ways of maintaining ongoing psychiatric support. The representation of anorexic women as 'dubious' therefore does not recognise that they are operating within the psychiatrist's domain, and that more direct means of control over treatment are generally denied them.

In contrast to the father-daughter analogy drawn on by some older male psychiatrists, female psychiatrists tended to construct a more reciprocal therapeutic relationship based on notions of "rapport" and "alliance" (Vivien), and the development of "a satisfying, trustworthy adult relationship" (Rebecca). These ideas

contrast sharply with the paternalism characterising the construction of the therapeutic relationship by some older male psychiatrists.

The Paradox of Autonomy and Control Re-visited

The above accounts of psychotherapy emphasise the development of authentic autonomy through re-identification, and the resolution of control through insight into psycho-emotional conflict. In contrast, constructions of the therapeutic relationship by older male psychiatrists position women as children, more specifically as girls within a father-daughter dynamic. The construction of the therapeutic relationship through the notion of the father/psychiatrist-daughter/patient resonates with the psychoanalytic concept of 'transference'. Freud (1973) argued that patients transfer their feelings onto the therapist, so that "a wish can emerge between a young girl and an old man to be received as a favourite daughter" (Freud, 1973: 495). This is understood by Freud to be an integral and positive characteristic of psychotherapy because it "clothes the doctor in authority", allowing the patient to access and resolve repressed conflicts (Freud, 1973: 498). Within Freud's (1973) conceptualisation, the impetus for transference emerges entirely from the patient, and is part of her psychopathology. In line with this, Philip and John portray the invitation to become father figures as emanating from the young women themselves in their efforts to seek advice and support. However, constructions of the father/psychiatrist-daughter/patient dynamic in the above accounts are also distinguished by paternalism and by efforts to control young women's behaviour, particularly their sexuality. Thus, the supposed pursuit of autonomy becomes augmented by overtly controlling practices that have a peculiarly gendered flavour. In a similar way to constructions of bed rest intervention, controlling psychotherapeutic practices result in a conflicted, and even duplicitous, approach to individual autonomy and control in the therapeutic setting. On the one hand, masculinised notions of autonomy and control are idealised as the goal of psychotherapeutic treatment and, on the other, gendered assumptions about female sexuality underpin attempts to control women through psychotherapy. In a slightly different way to constructions of bed rest programs, the discursive 'double-bind' of femininity that also structured health workers' explanations of eating disorders is once again reproduced in practice.

The positioning of anorexic women as children in a paternalistic therapeutic relationship also resonates with certain aspects of their positioning in practitioners' explanatory accounts of eating disorders. Most particularly, anorexic women were infantilised through the concepts of "sexual regression". Philip brings these ideas directly into the therapeutic setting by questioning the status of anorexic women as legal

adults in the context of treatment, explicitly positioning them as children both psychologically and biologically:

.....[a dilemma] is the extent to which you regard the anorexic as an autonomous adult if [they're] over eighteen when in fact they're often functioning mentally at a much younger age than that. [So] the extent to which you [work] with their families [is] tricky. By and large it's solvable because you work with the family at one stage and as she comes out of it and in a sense becomes biologically a young woman again, I mean, then she needs her own treatment in her own right. So that would be a common [dilemma].

(Philip, Psychiatrist)

As was argued in Chapter 6, the idea of psychobiological regression functions to infantilise young women in a biologically deterministic way. Here, this is taken a step further to justify paternalistic treatment approaches. Philip also mentions that most of the patients in this unit are not detained under the Mental Health Act and are, in fact, legal adults. Thus, the infantilisation of the anorexic based on the idea that she is not a biological woman is used here as a justification for overriding autonomy, yet anorexic women are simultaneously portrayed by Philip as sexual and powerful, undermining the idea of their child-like status.

The construction of the therapeutic relationship through a disciplinary parental dynamic has a number of implications for gender power relations in the therapeutic setting. As noted earlier, the hospital setting is constructed in a way reminiscent of the patriarchal nuclear family. It is not being suggested here that the gender power relations of the hospital directly reflect those of the family, nor vice versa. Within a Foucauldian analysis, power relations are understood to be "diffuse, heterogenous and changeable rather than reducible to one ultimate determining source" (McNay, 1992: 59). However, there is a dynamic relationship between social structures and the individual through the idea of the "rule of double conditioning" (McNay, 1992: 59). The following quote demonstrates the way in which Foucault understood this relation:

One must conceive of the double conditioning of a strategy by the specificity of possible tactics, and of tactics by the strategic envelop that makes them work. Thus the father in the family is not the 'representative' of the sovereign or the state; and the latter are not

projections of the father on a different scale. The family does not duplicate society, just as society does not imitate the family.

(Foucault, 1978: 100)

McNay (1992) argues that, in Foucault's conceptualisation, the power relations historically characterising the sovereign or the state are not simply duplicated in the position of the father in the family. This is because "each type of authority is determined by its own specific set of social forces and power relations" (McNay, 1992: 60). However, they are not discontinuous:

It is possible to perceive how the authority of the father in the family eventually feeds into more global patriarchal systems which devalue women without reducing the former to a reflection of the latter. The family is both a relatively autonomous unit which has its own logic and specific history; at the same time, it has been 'invested and annexed' by more 'global mechanisms of domination'.

(McNay, 1992: 60)

The similarities between the gender power relations characterising practitioners' constructions of intervention in the hospital setting are therefore similar to those characterising the traditional patriarchal nuclear family. This is ironic in the sense that eating disorders were commonly understood to arise in the context of unhealthy dynamics within the nuclear family, although it might be argued that treatment regimens seek to 'correct' these dynamics through a 'healthy' model of familial interaction. Thus, the more authoritative father/psychiatrist takes over from the 'absent fathers', while suitably firm but nurturing nurses replace the 'controlling mothers'. Nevertheless, the contradictory positioning of daughter/patients within practices that both idealise autonomy *and* seek to control them is a dramatic illustration *in practice* of the discursive double-bind of femininity outlined in the earlier analysis of explanatory discourses. A contradictory approach to autonomy and control in practice also extends across the different types of psychiatric intervention. Thus, while I have demonstrated that psychotherapy is controlling in certain respects, it does offer the *promise* of developing autonomy and self-control, while bed rest programs are intrinsically controlling and punitive.

While the goal of psychotherapy is to increase individual autonomy and rational self-control, this is not to say that psychotherapy is not disciplinary itself in a Foucauldian sense. In *The History of Sexuality*, Foucault (1978) argues that the body has been increasingly subjected to surveillance and invested with neurosis since the nineteenth century, instilling in the individual a compulsion to confess (McNay, 1992). Psychoanalysis is seen to represent one of the chief modes through which this occurs. The urge to confess is not perceived by the individual to be coerced, and is seen as liberating and as leading to self-knowledge (McNay, 1992). However, as McNay argues, this leads to "a more efficient regulation and normalization" through the production of "self-policing subjects" (McNay, 1992: 87). Thus, "the confessing subject is both the instrument and effect of domination" (McNay, 1992: 87). While I acknowledge the disciplinary nature of traditional psychotherapeutic practice in this sense, a distinction can nevertheless be drawn between the more overtly controlling practices of bed rest intervention and the father/psychiatrist-daughter/patient dynamic, and the those of psychotherapeutic interventions that seek to encourage reflection and the development of autonomy, albeit it within the limitations of the practitioner's theoretical orientation. The concluding chapter of this thesis involves further analysis of the possibilities for the development of individual autonomy and critical reflection within the therapeutic context.

A multifaceted treatment approach that constructs relatively separate and distinct interventions for the body and mind is consistent with a multidimensional model of the causes of eating disorders. Those interventions targeting the mind were explicitly tied to the dominant causal explanation of eating disorders as manifestations of psycho-emotional conflict and inadequate identity, and reproduced the gendered contradictions inherent in these discourses in relation to autonomy and control. In contrast, interventions targeting the body were not, on the whole, explicitly tied to specific causal explanations, however, interventions essentially functioned in concert with the psychotherapeutic emphasis on the removal of defence mechanisms. The conflicted nature of the relation between more overtly controlling forms of intervention targeting the body, and those seeking autonomy and the resolution of conflict through reflection and insight, is indicative of the way mind-body dualism continues to structure approaches to intervention in this area.

When I questioned psychiatrists about dilemmas encountered in practice, it became clear that many were aware of the oppositional, even antithetical, nature of aspects of psychiatric intervention with eating disorders, although they demonstrated no awareness of the peculiarly gendered flavour of these

dilemmas. Of particular interest is the finding that some practitioners hold psychiatry itself partly responsible for producing 'relapse', 'chronicity' and 'resistance to treatment' in anorexia nervosa, blaming paternalistic approaches to intervention, particularly bed rest intervention, and the tendency of some practitioners to behave reactively to, and become overly controlling of, anorexic patients. This represents a radical criticism of the more disciplinary treatment regimes, and implicates psychiatry in the creation of some of the most central characteristics of anorexia that have long been held to be an integral feature of the condition itself within psychiatric discourse (c.f. Crisp, 1970; Herzog et al, 1999; Strober, Freeman and Morrell, 1997; Vitousek, Watson and Wilson, 1998; Fairburn, Shafran and Cooper, 1998). Some psychiatrists also indicated that they have changed their practices in the light of these criticisms, demonstrating some willingness to modify approaches within the discipline itself. However, the assumption of the psychiatrist as expert, and of patient as relatively passive recipient of a largely predetermined approach to care, remained largely undisturbed, even by those advocating modified approaches to intervention.

Wider social factors, which were included in most of the multidimensional explanations of eating disorders provided by these practitioners, were almost entirely absent from constructions of therapeutic intervention. Only Robyn constructed treatment intervention as potentially extending beyond the individual and their family to take in the individual's wider social context through the notion of addressing "peer group problems". While this at least positions the individual *in relationship* in a world external to her immediate family and the treatment setting, in common with constructions of the family in psychiatric intervention, the impact of peer groups is addressed only in terms of individual therapeutic intervention and its consequences for the *intra-psyche* functioning of the individual. While a number of the female psychiatrists drew on feminist interpretations of the social and cultural factors implicated in eating disorders as part of their multidimensional explanations, these were not carried over into intervention. This is explained in part by the reliance on supposedly gender neutral discourses that mask gender, and by the inherent reductionism of multidimensional models where the individual is conceived of as essentially separate from the wider social context and is placed at the furthest point from it.

Summary

This chapter examined psychiatrists' approaches to psychotherapy, and I demonstrated that a contradictory approach to autonomy and control are again reproduced in the context of practice. More

specifically, within psychotherapeutic intervention, an idealisation of the pursuit of masculinized autonomy and control is offset by de-powering eating disordered women within a paternalistic father/psychiatrist-daughter/patient dynamic that has a peculiarly gendered flavour. Furthermore, health practitioners' portrayals of psychotherapeutic intervention construct the hospital environment as reminiscent of the patriarchal family home, ironically reproducing the dynamics theorised within psychodynamics as giving rise to eating disorders themselves. More specifically, a dualistic conceptualisation of female sexuality as dangerous and in need of control is used to legitimise a paternalistic approach to treatment. While psychotherapeutic intervention is shown to be inherently conflicted, these contradictions extend across the two main forms of psychiatric intervention, so that the more overtly controlling nature of bed rest programs targeting the body explicitly conflict with the ideals of developing individual autonomy and self-control within psychotherapy, reproducing mind-body dualism across the intervention modalities. The following chapters now move on to an analysis of preventive intervention, paying particular attention to its scope for redressing individualising tendencies, gendered dilemmas and power dynamics that characterise psychiatric treatment.

Chapter 10

The Marginalisation of Eating Disorders and Emergence of 'Body Image Dissatisfaction' as a Public Health Problem in Prevention Discourses

Introduction

The need for preventive approaches to eating disorders has received increasing attention over the past two decades, despite an historical emphasis on treatment in this area (for example, Hsu, 1996; Huon, 1994; Shisslak et al, 1987; Striegel-Moore and Steiner-Adair, 1998; Vandereycken and Meerman, 1984). While many argue that eating disorders are preventable because socio-cultural factors and related dieting practices are implicated in causation (Button and Whitehouse, 1981; Katz, 1985; Levine and Smolak, 1998; Shisslak et al, 1987; Striegel-Moore and Steiner-Adair, 1998), there has been little critical examination of current practice approaches in this area. In consequence, this analysis represents the first critical exploration of approaches to the prevention of eating disorders. Health workers' approaches to prevention tended to differ in accordance with their disciplinary backgrounds. The accounts of clinical practitioners are briefly summarised first, followed by a more in-depth analysis of the approaches of the ten health workers involved in managing an Australian health promotion program focusing on body image dissatisfaction (BID) and eating disorders.

Clinical Practitioners' Constructions of Prevention

The way in which clinical practitioners characterised preventive intervention for eating disorders fell into three broad areas. Firstly, there was an emphasis on secondary prevention through the idea of early detection and intervention. Next, clinical practitioners based their descriptions of primary prevention almost exclusively on health education models, leading to a number of practice dilemmas. And lastly, practitioners addressed the idea of the primary prevention of "body image dissatisfaction".

Reproducing Surveillance and Control in Constructions of Prevention

In line with approaches in the literature outlined in Chapter 3, many clinical practitioners described early intervention and detection through the themes of surveillance and control, focusing on the idea of identifying individuals 'at risk' because of biological, psychological or familial vulnerability (Ruth, William, Vivien, Robert). For example, Robert suggests the use of questionnaires or encouraging "fellow pupils" to

act as "key informants" in schools, while William suggests searching "at risk families for cases" as methods of screening. As was argued in Chapter 3, in common with constructions of in-patient treatment for anorexia nervosa, women and girls are located as the relatively passive subjects of surveillance within the techniques of screening. However, the creation of a network of surveillance sites through the use of questionnaires, "key informants" and searching 'at risk' families extends these disciplinary techniques beyond the walls of the hospital and into everyday life, positioning subjects within a wider "field of surveillance" (Foucault, 1977a: 187). While screening and other methods of early detection are central aspects of a disease control approach to public health more generally (Tesh, 1988), their use in relation to eating disorders is somewhat paradoxical because post-structural feminist theorists such as Spitzak (1990) demonstrate that the pursuit of thinness among women in western culture is in part a function of the centring of the sexual gaze onto the female body. There is an irony in harnessing a 'medical gaze' (Foucault, 1975), in the form of supposedly gender-neutral techniques of public health disease monitoring and surveillance, to control disciplinary practices that are produced through specifically gendered forms of surveillance. In a further paradox, while women and girls become, at least theoretically, passive subjects in constructions of public health surveillance techniques, they are also constructed as 'resistant' because many will "avoid voluntary screening mechanisms" (Robert). In common with constructions of paternalistic treatment approaches, there is a tension between the positioning of women as passive recipients of care, and as actively resistant to care. Once again, the location of women as passive subjects is problematic.

As is argued by Tesh (1988), assumptions about the causes of health problems are always central in determining approaches to prevention. While professing to be multi-causal, it was demonstrated earlier that explanations of eating disorders are dominated by a pathologising psycho-medical discourse that is inherently gendered and individualistic, but at the same time gender-blind. When prevention is approached from within this discourse, attention invariably becomes focused on those factors closest to the outcome in question, that is, the individual (Krieger, 1994). As socio-cultural context is not perceived to be a 'true' cause of eating disorders in multi-causal explanations because "[c]ulture is mediated by the psychology of the individual" (Vandereycken and Meerman, 1984, p.194), the scope of preventive practice is consequently restricted. Further, because 'gender' and the 'social' are reduced to 'risk factors' bereft of interpretive meaning and located at a distance from the individual, it is the individualised subject and her family within whom 'risk' becomes located. The gendered meaning of female body management practices is obscured, then, by the search for 'pre-morbid' personality characteristics and 'risk' behaviours.

However, dilemmas associated with a pathological model of eating disorders are thrown into relief when prevention involves the extension of psychopathological categories to the ostensibly 'well', by means of screening, which seeks to transform them into 'sub-clinical' psychiatric cases. This dilemma is particularly striking when 'risk factors', such as dieting and intense forms of exercise, are widespread (Thompson, 1992; Wade et al, 1996) and culturally sanctioned for the population group in question. It is not difficult to see how attempts to extend a pathologising discourse in this context might encounter resistance from those it seeks to colonise.

The Marginalisation of Eating Disorders in Primary Prevention Discourses

While many clinical practitioners emphasise early detection and intervention as important preventive strategies, some presented them as the only credible form of prevention, portraying the possibilities for the primary prevention of eating disorders as limited at best and, at worst, detrimental. For some health workers, the scope of primary prevention is explicitly limited because the key causal factors lie within the individual (for example, Ruth, Vivien and Patricia). A number of psychiatrists locate primary prevention as generally outside the scope of psychiatry (Philip), as less important than early intervention (Eric and Paul), as unlikely to prevent "psychiatric illness" (Paul) or as ineffective (Robert).

Further to the idea that primary prevention of eating disorders is ineffective, ten health workers argue that primary prevention strategies in this area are actually harmful: Rebecca suggests that "you could cause more problems"; Helen and John argue that primary prevention can increase dieting; Patricia suggests that you "could actually be causing harm"; Sarah asks whether she might be "glamorising" or "normalising" eating disorders through primary prevention; Robert argues that by informing girls about eating disorders they'll think "Oh, that's a good idea, I hadn't thought about vomiting, I'll try that"; Eric suggests education "could almost be an attraction"; Paul argues that education "taught people how to go and get anorexia"; Philip argues that education leads to "more anorexia", and; Jennifer believes one her clients got some of her instructions" from an education program.

As noted in Chapter 3, the notion that eating disorder prevention programs are harmful is also common in the literature and, like those programs cited in the literature as 'dangerous', health workers who subscribed to this idea universally refer to education programs that focus on teaching young women and girls about the risks of developing eating disorders through dieting and other weight control practices. It is

well-known that some practices become attractive, particularly to adolescents, when they are constructed as 'risky' and 'dangerous' (Nettleton and Bunton, 1995). Furthermore, reports of dieting practices and negative body-related attitudes among young women are known to increase over the course of adolescence (Paxton, 1993), and increased reports following health education programs may not necessarily reflect only the iatrogenic effects of intervention. More importantly, as was noted earlier, it has been widely acknowledged that health education has limited efficacy in changing behaviour (for example, Taylor, 1979), and this is primarily because the environmental context of health behaviour also needs to be addressed for behaviour to change (Stokols, 1992; Crawford, 1977; Graham, 1979). More specifically, a health education approach completely fails to account for the intense social meanings attached to practices of female bodily control (Bordo, 1990) and their inter-subjective aspects. It seems unrealistic to hope that risk-based education programs focusing on individual behaviour could stem the trajectory of body dissatisfaction and weight loss practices among young women when they do not address their socio-cultural meanings and the inter-subjective context in which they occur. When individual behaviour is addressed as if it occurs in vacuum, programs may indeed run the risk of inadvertently magnifying unacknowledged socio-cultural processes. The idea that primary prevention efforts are detrimental is therefore based on a narrow view of prevention as 'education', and this potentially limits the scope for the development of primary prevention in this area more generally.

In summary, clinical practitioners' emphasis on early detection and intervention is consistent with the dominance of a pathologising psycho-medical explanatory discourse, so that preventive intervention invariably becomes focused on the individual as the 'factor' closest to the 'outcome' of an eating disorder. Psychopathological conceptualisations of women are therefore extended into the realm of prevention and the role of social context remains largely ignored. Clinical practitioners' focus on early detection and intervention as the central approach to the prevention of eating disorders also reproduces dilemmas associated with dominant psychiatric treatment paradigms. In particular, screening and case detection reproduces the position of women as objects of surveillance, so that a sexual gaze is replaced by a medical one. The emphasis on surveillance also represents an extension of the techniques of surveillance and control associated with dominant treatment paradigms to a wider section of the female population. Furthermore, an emphasis on early psychiatric treatment does not challenge the contradictory nature and de-powering effects of conventional therapy, and confines prevention within the boundaries of existing treatment models. When clinical practitioners turn their attention to the question of primary prevention, an

almost exclusive focus on health education leads to the marginalisation of eating disorders as an inappropriate target for intervention and, instead, 'body image dissatisfaction' becomes the focus. In the following section, the ways in which health workers construct 'body image dissatisfaction' as the target of primary prevention is examined further in relation to the specific example of an Australian health promotion program.

Addressing Body Image Dissatisfaction in a Health Promotion Program

While many of the programs aiming at the prevention of eating disorders draw on health education models that focus exclusively on behaviour change in individuals, there are examples of programs that also aim to change the social conditions understood to give rise to eating disorders. These generally identify with the concept of 'health promotion', which defines itself as concerned with a social view of health in line with international policies such as the Ottawa Charter for Health Promotion (World Health Organisation, 1986). As was indicated in Chapter 4, ten health workers involved in managing the largest and longest running Australian health promotion program focusing on body image dissatisfaction (BID) and eating disorders were included in the sample of health practitioners interviewed for this study. Nine of these health workers were voluntary members of the program's management committee who also worked in paid capacities elsewhere in private practice, health promotion and tertiary education. One health worker, a dietician, was employed as the health promotion officer with the program. The program under analysis will be referred to only as the body image dissatisfaction (BID) program in order to protect the identities of the participants.

The remainder of this chapter involves an analysis of the discursive themes through which BID workers explain 'body image dissatisfaction' in the context of the BID program. As yet, there has been little research into the sociology of professional health promotion knowledge and practice (Nettleton and Bunton, 1995). This analysis therefore provides one of the few explorations of the discourses informing health promotion theory and practice, and of some of the specific dilemmas associated with their application in the area of body image and eating disorders. Firstly, the way health workers construct 'body image dissatisfaction' as a public health problem, rather than a clinical disorder, are considered. Secondly, the implications of using cognitive-behavioural theory to define body image dissatisfaction are considered, followed by an examination of the ways in which body image dissatisfaction is constructed as primarily a

'women's problem', and the connections between the use of socio-cultural discourse and psychological reductionism (see Moulding and Hepworth, 2001).¹

Body Image Dissatisfaction as a Public Health Problem

Health workers involved in the BID program sought to delineate their program as a 'body image' rather than 'eating disorder' program in response to a series of questions about the nature and causes of these two 'conditions'. This delineation of body image from eating disorders, and the association of the BID program with the former, was achieved in a number of specific ways. Firstly, Julie argues that the program is not concerned with "anorexia or bulimia nervosa" but with "where body image dissatisfaction is linked to people eating in a disordered way":

..... this program's primarily concerned with.....[.]... not the clinically diagnosed people with anorexia or bulimia nervosa. We are actually more interested in disordered eating within the larger community and as that relates to the sort of cultural, um (sigh) the sort of prevailing cultural views about thinness. So what we're interested in is where body image dissatisfaction is linked to people eating in a disordered way. So that, we do see that, and I do see that as... as a definite link.

(Julie, Health promotion worker)

In this account, anorexia and bulimia are privatised illnesses separate from their wider social context and located under the rubric of psychiatry through the practice of 'clinical diagnosis'. In contrast, the problem of "body image dissatisfaction" is seen as being socially produced. This is similar to the location of eating disordered individuals in a different, subjective reality described in Chapter 7. Thus, eating disordered individuals are located in what Julie earlier called "their own little world", while other individuals are more culturally situated and linked through their shared experiences. It is the culturally situated individual that the BID program is specifically concerned with, not the inward looking eating disordered individual. Eating disordered individuals are variously constructed as either more or less influenced by the external world in

¹ These last three themes have been examined in a previously published paper entitled 'Understanding body image disturbance in the promotion of mental health: a discourse analytic study', in the *International Journal of Community and Applied Social Psychology*, 11, 305-317 (see Appendix 7).

health workers' accounts. Thus, there are different, and contradictory, ways of pathologising eating disordered individuals, so that they are both overly influenced by external forces *and* locked into a separate, subjective reality. However, rationality is always shared, while irrationality is not. In this way, then, culture can never explain psychopathology, only non-pathological behaviour.

Pamela uses another approach to distinguish those diagnosed with an eating disorder from other individuals, arguing that they are "really rigid and dichotomous", and that eating disorders are not in the BID program's "brief":

..... some of the things I'm thinking of that would [...] describe some people with eating disorders would be, you know, the really rigid and dichotomous and extreme behaviours when it comes to things like, you know, food and body size and dissatis[faction]... [...]. But I guess also this program, just to clarify, we don't... eating disorders is not... it's not in our brief... [...]... and we would hope, you know, that maybe in helping to improve body image it might help prevent eating disorders, but as I said there are so many other factors that come into play [in causing eating disorders] as well.

(Pamela, Dietician)

Pamela goes on to clarify that "poor body image is not a cause of eating disorders":

... poor body image is, you know, not a cause of eating disorders. Yes, you know, people are more likely to [develop eating disorders] if they have poor body image. Um, and obviously more personal and family influences can be, I guess, sort of can be at the root of some of the underlying causes of eating disorders.

(Pamela, Dietician)

Eating disorders are again privatised through their relation to "personal and family influences", while body image dissatisfaction is located in the public realm. The relevance of the BID program for the prevention of eating disorders becomes, at best, limited to an unintentional 'trickle down' effect from interventions that specifically target body image.

Rosemary distinguishes between eating disorders as “the business” of anorexia and bulimia nervosa support groups, while body image problems constitute the business of the BID program:

...I guess we've tried to put.....the two [issues of body image and eating disorders] quite separately. To me, eating disorders are more the business of the [anorexia and bulimia support groups] and.....they are disorders which are.....which are different from body image problems. The ordinary person on the street that doesn't have an eating disorder at all, and is probably not likely to have an eating disorder, could still have body image problems and I mean they might not be as debilitating as the anorexia and bulimia people, but they certainly do hold people back from doing things and from presenting themselves and just interacting socially. And so I see them as quite different.

(Rosemary, Fashion design lecturer)

A firm line is drawn between one type of problem and another, locating body image dissatisfaction in the world of the 'ordinary' and eating disorders in the 'extraordinary' realm: by extension, the BID program is concerned only with 'ordinary' problems.

Adam is even more emphatic that the worlds of eating disorders and body image are separate and different, stating that the former are not his “specialty” and represent an area he actively avoids becoming informed about:

Adam: [Eating disorders are] not an area of specialty of mine. It's an area I actually choose to find out as little as possible about. Um...um and it's why I don't think of eating disorders and body image dissatisfaction in the same contexts at all.

Nicole: Right. Would you like to explain that a little bit more to me in terms of your position?

Adam: Sure. Um, I think that historically there's been quite a bit done in the field of public health and personal health in relation to eating disorders. There's a lot of work done in the area.....a lot of research done in the area, there's a lot of specific help groups for bulimic, anorexia nervosa, etcetera, etcetera, etcetera. And I have no doubt that those things are associated with different degrees of body image dissatisfaction. But I have a feeling that, um, a lot of body image disorders and body image dissatisfaction that exists, um, is not

clinical...[.]...And I think as a public health body it's as important to look at the non-clinical side of [.] body image as it is to look at the clinical, maybe even more important. Because, I actually think you wouldn't find a person in the world who doesn't have some degree of body image dissatisfaction [and], you know, and if it's an issue that exists for everyone then we've got to deal with it.

(Adam, Market researcher)

While Adam concedes that eating disorders and body image dissatisfaction are most likely related, the widespread nature of body image problems is seen as underscoring their relevance as a public health problem, while "clinical" eating disorders are excluded because they are psychiatrically diagnosable and essentially private, individual problems within this framing. Body image becomes the territory of "public health", while eating disorders remain within the ambit of psychiatry. Adam goes on to argue that health promotion intervention with "body image attitudes" is likely to be more effective than with eating disorders:

I suspect that even if it's not an intended consequence... [.]... health promotion of positive body image attitudes will down the line affect the incidence of eating disorders. And I think that to focus on eating disorders, you're probably not going to change body image dissatisfaction because you'll miss the social and cultural context that exists...[.]...to recognise that I have a body image problem, probably you probably do too, and probably everyone else out there has too, and to treat it from that point of view I think we're much more likely to be effective.....

(Adam, Market researcher)

To focus on eating disorders is aligned here with "miss[ing] the social and cultural context that exists", which is underscored by the idea that body image problems are ubiquitous while eating disorders are not. Matthew also argues that body image problems and associated eating and weight control practices are "more epidemic" than "extreme eating disorders", and therefore require attention:

.....I actually think that, um, there's a lot of unhealthy eating practices and body image problems and weight control practices that are more epidemic in the community, rather than focussed on those who develop extreme eating disorders, [who] tend to have a complex

range of other risk factors. They're not just.....not just young women (laughs) who worry about their bodies. There are other factors [...] that contribute to the development of eating disorders [such as] very low self-esteem..[...]..... There are risk factors that are there, and I think.....if you look in the wider community, I think the problem with eating disorders [...] it draws attention away from the focus on problems of eating behaviour and body image in the wider community which I think is a serious problem, basically.

(Matthew, Psychologist)

Because the "risk factor" of internally located "very low self-esteem" is said to distinguish women with eating disorders from other women with body image problems, eating disorders become privatised experiences of the few, rather than public problems of the many. Further, Matthew says that a focus on eating disorders "draws attention away" from body image dissatisfaction, positioning the two problems in an antithetical way so that a focus on eating disorders undermines attempts to address the more common problem of body image dissatisfaction. The resolution of this dilemma is to exclude eating disorders as a target of preventive intervention. Matthew goes on to clarify that the BID program is "not clinical, not focussed on the individual", but on the "wider community by getting some structural changes":

...the focus of the [BID program] committee is clearly not clinical, not focussed on the individual, because we think that's probably, you know, being done, sort of slowly, but [...] our belief is that we want to have more impact on the wider community by getting some structural changes....

(Matthew, Psychologist)

Because body image dissatisfaction is essentially understood to be a socio-cultural problem, it can be addressed through "structural changes", while eating disorders are "clinical" and therefore require therapeutic intervention on an individual level. Gillian also distinguishes eating disorders as the "clinical end of the spectrum", locating body image in the "mainstream" and at the "health promotion end":

...our program has never had a focus on eating disorders really. Um but um the [anorexia and bulimia support group] were our first auspicing [...] body and...[...]...there were a couple of

reasons that we then moved, and part of it was because we didn't want to be involved at the clinical end of the spectrum and we felt a little bit as if that auspicing body was in a way preventing us from being a little bit more, dealing a bit more with the mainstream and for for being more um at the health promotion end rather than the clinical end.....

(Gillian, Psychologist)

While the idea of a "spectrum" links eating and body image as related conditions, they are nevertheless portrayed by Gillian as essentially dichotomous so that a focus on health promotion excludes the "clinical". Clare is also very clear that the BID program does not include a focus on eating disorders, asserting that, over time, it has become "divorced [...] from an interest in eating disorders":

...[the BID program] did have some emphasis on eating disorders [but] it's become much more clearly focussed as being an emphasis on body image and very much divorced in a sense from an interest in eating disorders. Obviously there's some overlap in the research areas on the development and relationship between the two, but its focus is not on disordered eating, um eating disorders, so much as on body image....

(Clare, Psychologist)

While Clare acknowledges "overlap" between body image and eating disorders, at least in terms of research, for the purposes of the BID program the two problems are separated from each other, effectively retaining eating disorders within the province of psychiatry and outside public health and health promotion.

An individual-society dualism structures this dichotomous approach to treatment and prevention, so that eating disorders are located in the psychopathological, individualised realm, while body image dissatisfaction is situated in the socio-cultural, public dimension. This dualism is reproduced in the health care system, whereby psychiatry is charged with responsibility for treating individual 'psychopathology', while public health and health promotion concerns itself with 'population' health. In contrast, the social model of health underpinning health promotion draws attention to the social and environmental aspects of health problems (World Health Organisation, 1986), and there is a wide literature on the socio-cultural antecedents of eating disorders, and the links between body image dissatisfaction and eating disorders

are widely acknowledged (Thompson, 1992; Wade et al, 1996; Silverstein and Perdue, 1986). However, BID workers draw a relatively uncompromising line between 'eating disorders' and 'body image dissatisfaction' that is, somewhat surprisingly, more rigid than that drawn in much of the eating disorder literature and, earlier, by psychiatrists in this study. This act of delineation resonates with Foucault's notion of "dividing practice" as a process within which "the subject is objectified by a process of division either within himself or from others" (Foucault, 1982, cited in Rabinow, 1984: 9). Foucault noted the use of dividing practices as central to the rise of psychiatry in the nineteenth and twentieth centuries based on "modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion – usually in a spatial sense, but always in a social one" (Rabinow, 1984: 9). In the case of the BID program, individuals with eating disorders are divided from the rest of the population through recourse to the psychiatric classificatory system, and are thereby excluded from mainstream public health interventions. This has the effect of 'claiming' body image as the specialist concern of health promotion and public health without encroaching on the disciplinary territory of psychiatry, and contributes to the continuing marginalization of eating disorders within the health care system. It also reproduces the psychiatric assumption that psychopathology can never be cultural (Gremillion, 1992).

Cognitive–Behavioural Explanations of Body Image Dissatisfaction

While body image dissatisfaction is constructed by health workers as a public health problem arising from cultural sources, health workers drew on psychological theory to explain the way in which these problems arise in individuals. In response to questions about how body image dissatisfaction might be defined, three health workers drew on cognitive-behavioural theory and the concepts of perception, cognition, emotion and behaviour. Firstly, Matthew defines "body image disturbance" as having "three dimensions":

....the definition I like of body image disturbance, if you like, has three dimensions to it. There's the concept of size perception accuracy, so how a person actually views their size, how accurately they view their size...[.]... The second one is the cognitive, the person's own attitudes towards their body. You can probably include in that the person's, you know, feeling, the way a person thinks about their body and the way they feel....[.]....a third dimension of body image which I think is actually really critical, and is often missed, is the behavioural component. This is one way that you can actually pick up whether there are

body image problems, and that's the degree to which a person avoids engaging in activities, or engages in activities because of a negative feeling about their body.

(Matthew, Psychologist)

It is the behavioural component that is emphasised as the observable aspect of body image disturbance and as "often missed". Pamela also asserts that body image has "three main components": how you perceive, feel and think about your body, plus a "behavioural component", so that like Matthew, the four cognitive behavioural components of perception, cognition, emotion and behaviour are identified. In a slightly different way, Gillian identifies "cognitive components, physical components, and emotive or affective components" as constituent of "body image", giving the "affective" a particular emphasis because it "drives destructive behaviours". Thus, three of the cognitive-behavioural components of cognition, emotion and behaviour are included.

The notion that body image involves perception, cognition, emotion and behaviour draws on long-standing ideas from cognitive-behavioural psychology. Within this theoretical approach, individuals perceive and respond to external and internal stimuli, think about them, react emotionally, and this determines behaviour (Lazarus, 1991). Explanations of body image disturbance in the literature most often draw on cognitive-behavioural theory, dividing body image into these same four constructs (Thompson, 1990). As noted earlier, cognitive-behavioural definition of body image draws on humanist discourse, which is predicated on a separation between individual and social aspects of phenomena (Henriques et al, 1984), so that while society's norms and values are said to be internalised by the individual, they are nevertheless understood to be essentially separate from the socializing effects of the wider collective (Davies, 1991). Constructing body image and body image dissatisfaction through cognitive-behavioural theory also relies on the assumption of a Cartesian split between mind and body because cognitive-emotional components located in the mind are presented as being able to perceive and appraise the physical body.

The importance of emotion, or “affect”, is also emphasised in Matthew’s, Pamela’s and Gillian’s accounts. This is elaborated further below, where feelings are used to describe the dynamics of body image:

....I think of body image as an umbrella term for all the other, in particular, our emotive responses, affective responses to our bodies. That would be how we feel about, how we relate to our own bodies. So that is about body satisfaction, love or hate, acceptance or enjoyment....

(Gillian, Psychologist)

Gillian centres emotion as the overriding characteristic of body image when she defines it as “an umbrella term for, in particular, our emotive responses, affective responses”. In a continuation of this theme, Steven focuses on the individual’s feelings during consultations with patients who have body image problems:

One of the questions that I would ask at a first consultation ...[.].... is how do they feel about their body or body image, and most people feel it’s disgusting, yuk, that level of dissatisfaction, so...on a continuum it’s pretty much down the bottom of feeling negative.

(Steven, General practitioner)

While emotions are emphasised as an important aspect of body image dissatisfaction, they are “negative” because most people describe their body as “disgusting” or say “yuk”. Joanne also emphasises negative emotion as a defining feature of body image dissatisfaction, stating that people feel “hate” towards their bodies and “jealousy” towards other people:

.....I do think some people would feel hate towards either their whole body or part of it. I think there would be a jealousy that they would want, you know, they would be jealous of other people who have the body they think that they would want or would like.....

(Joanne, Dietician)

Earlier, Gillian portrayed emotion in body image in negative terms because its effect on behaviour was “destructive”. The portrayal of emotion as negative and destructive in these accounts of body image dissatisfaction is also steeped in humanist discourse, with its emphasis on rationality and suspicion of

emotion (Davies, 1991; Jaggar, 1989). As was argued in Chapter 6, within this conceptualisation, the emotions are counter-posed against rationality (Jaggar, 1989), and are treated with suspicion because they are conceived of as bodily and therefore as impediments to rationality (Spelman, 1989). While emotion is commonly divided from reason in humanist thought, in cognitive psychology it is at least conceived of as being "about" something, and therefore as involving intentional judgement rather than being simply "dumb" (Jaggar, 1989: 133). However, Jaggar (1989) argues that the splitting of cognition and affect in cognitivism positions the former in the "shared, public, objective world of verifiable calculations, observations, and facts", and the latter in the "individual, private and subjective world of idiosyncratic feelings and sensations" (Jaggar, 1989: 132). This fails to explain the relation between cognitive and affective aspects of emotion, privileging intellect over feelings in line with the traditional western reification of mind over body, and relegating emotion to the periphery in terms of its explanatory power and meaning (Jaggar, 1989). In line with this, while emotion is presented as related to cognition in health workers' accounts, its meaning is not elaborated and, instead, it is presented only as "feeling" or "affect" that is intensely problematic and disruptive in its own right. Because of the separation of cognition from affect, cognitive accounts fail to link emotion with its specific social context, producing an internalised, individualistic and essentially asocial explanation (Crawford et al, 1992). In addition, emotion is portrayed as driving behaviour not in an intentional way, but compulsively, involving driven-ness and self-destructive-ness. This is indicative of an association between emotion, irrationality and lack of self-control in these accounts.

A number of BID workers also draw on the notion of 'body image distortion'. In an earlier extract, Matthew emphasised the "accuracy" of perceptions of the as an important aspect of "body image disturbance", while Pamela presented body image as "...just how accurately I might perceive my body shape and size...you know, over-estimating, under-estimating...". Normal perception is therefore constituted as the similarity between a person's estimate of the physical dimensions of the body and its actual dimensions. The following extracts from Adam and Rosemary also illustrate this notion:

....to talk about body image problems, then I think there's [] a definition of some issue which is usually a distortion of any of those factors of how we perceive ourselves, so some.....er....our perception is not the same as the reality.

(Adam, Market researcher)

Rosemary also identifies incongruence between perception and reality:

...I think it is different for everyone depending on where they visualise their problem is, which frequently isn't a problem to someone looking from the outside...[.]..the perception of the person who thinks they have this problem and what really is a problem.

(Rosemary, Fashion design lecturer)

In this account, the difference between "the perception of the person who thinks they have this problem and what really is a problem" defines the subjectivity of the person with a body image problem against an objective measure.

As noted in Chapter 3, it is argued in the literature that body image distortion has become a normative feature of the female population (Powers and Erickson, 1986, cited in O'Dea, 1995). Health workers also present body image distortion as 'normative', however, as is pointed out in Chapter 3, such accounts nevertheless construct women with body image distortion as having subjective realities that are fundamentally and objectively *wrong* because of the assumption of an objectivist ontology which posits 'reality' to be 'out there', stable and accessible to the individual, and perceived uniformly by all (Sarantakos, 1998). Thus, the body's dimensions are taken as perceived unproblematically in terms of their objective physicality, and in relation to a single standard of weight, and any seeming perceptual deviation is defined as faulty. Furthermore, failing to have an objective grasp on reality is widely understood within Western humanism to be indicative of irrationality and psychological dysfunction (Jaggar, 1989).

Body Image Dissatisfaction as a Women's Problem

Gender was another discursive theme in health workers' accounts of body image dissatisfaction. While most health workers describe body image dissatisfaction as experienced by both women and men, it is presented as primarily a 'women's problem', and as having more serious effects for women. Firstly, while

Adam includes himself as affected by body image issues, his reference to “mothers, sisters, girlfriends” reinforces the commonality of women’s experiences of body image problems:

...I mean I’ll put it also in the context of personal beliefs, personal values, personal history.
Um, as in mothers, sisters, girlfriends, all of those sorts of things, and myself, have all had issues related to body image...

(Adam, Market researcher)

Matthew constructs body image disturbance as a problem for women in general by portraying it as present in “the sub-clinical group” and as a problem for “most women:

...estimates range between ten to fifteen percent of young women have actually tried self-induced vomiting to control their weight. Then you’re looking at a body image problem that’s much more severe than just what presents in extreme forms. But then if you go beyond that sub-clinical group, most women are uncomfortable about their shape in this community.

(Matthew, Psychologist)

Matthew goes on to argue that body image problems, while “increasing” among men, do not share the same aetiological characteristics as for women because being large is more socially accepted for men:

...with men (body image) is actually an increasing problem, potentially it could be, even though for men I guess body image isn’t associated with fundamental self worth which is the difference. Men can be big and seem to carry on functioning in life without being so affected.

(Matthew, Psychologist)

In a similar fashion, Julie's presentation of men as not being so "dissatisfied" with their bodies excludes them as the primary group for body image dissatisfaction:

Men are not so dissatisfied with their bodies, there's just no doubt about it. So they're really not the priority for us.

(Julie, Health promotion worker)

For both Julie and Matthew, men have a similar potential to develop body image dissatisfaction, but it is women who develop the most severe problems, aligning body image dissatisfaction with femaleness. It is not being suggested here that men experience similar levels of distress in this area. However, the emphasis on negative emotion in health workers' constructions of body image dissatisfaction maintains and reproduces the idea that psycho-emotional problems, *in particular*, are women's province, and that 'women's problems' are primarily psycho-emotional in nature. It is significant that it is mainly women who are deemed to suffer from the 'disturbances', 'distortions', 'negative emotional states' and 'destructive behaviour' associated with body image dissatisfaction in health workers' accounts. In common with constructions of emotion in eating disorders, body image problems are constructed through recourse to a traditional discourse of femininity where there is a "differential assignment" of emotion to women based on historical associations between emotionality and femaleness (Jaggar, 1989:142). At the same time, there is a convergence between this discourse of femininity as equivalent to emotionality, and the masculinised assumptions that characterise cognitive-behavioural theory, where emotion and the 'feminine' are pathologised and rationality, autonomy and self-control idealised (Buman, 1996b).

Health workers on the whole apply gendered assumptions to understandings of body image dissatisfaction in a similar way as they do for eating disorders, that is, through the use of supposedly gender-neutral psychological theories. However, also in common with eating disorder explanations, a small number of health workers draw on the idea of inherent gender differences as an explanation for why body image problems are more common in women. Firstly, Rosemary argues that both eating disorders and body image dissatisfaction are more common in women because women take other people's opinions "to heart". An essentialist conceptualisation of femininity therefore actually draws eating disordered women and women with body image problems together, and contradicts the idea expressed earlier by many BID workers that the two problems are intrinsically different and separate. Gillian also explains body

image dissatisfaction through the same socio-biological theory of inherent sex differences that she earlier used to explain why eating disorders are more common in women. Within this view, women are “naturally programmed to compete” on the grounds of body image, again drawing eating disordered women and those with body image problems into the same explanatory discourse. In Rosemary's and Gillian's explanations of body image problems, like their explanations of eating disorders, rather than separating women from each other on the basis of characteristics such as 'emotionality' and 'pre-occupation with body weight', these characteristics are used to distinguish women from men so that women in general are defined as more vulnerable to psycho-emotional problems such as body image dissatisfaction, as well as eating disorders. As noted in Chapter 7, theories of innate gender difference have been used to legitimise gender inequality more generally (McNay, 1992), and run the risk of naturalising eating disorders and body image problems as inherently 'feminine' problems bound up with women's nature and, therefore, not amenable to change.

Socio-Cultural Explanations of Body Image Dissatisfaction

Most health workers involved in the BID program did not portray women as inherently different to men because, as was noted earlier, body image problems were simultaneously understood to arise in a particular socio-cultural context. Thus, while most respondents drew on cognitive-behavioural theory to define and describe body image dissatisfaction, many offered socio-cultural explanations of its causes. Each of the following extracts identifies the causes of body image dissatisfaction as beyond the individual, although each has a different emphasis. Firstly, Julie describes body image dissatisfaction as a cultural phenomenon:

....the body image part of it I think is about people not being comfortable with their own reality and also having a sense that their body is a fixed thing and not a fluid thing and so therefore they can't cope with changes to their body. They have a sense that...[.]...well, when you think about women getting pregnant and after they've had a child, the concept that's frequently used is getting your body back, as if you've as if it shouldn't look as though you've ever had a child, and that's really a modern and a sort of foolish idea, like you shouldn't have wrinkles because they show your age, well they've also showed you've lived.

It's that sense of not acknowledging the reality of living and aging so, you know, about all these dislocations between reality and ideals.

(Julie, Health promotion worker)

Rather than define body image problems in terms of individual perceptual distortion, Julie identifies a discrepancy between individuals' perceptions of their bodies and cultural ideals as "all these dislocations between reality and ideals". In common with cognitive-behavioural explanations, this construction is also supported by the mind-body separation and the view that there is a constant, stable reality that individuals can access, however, unlike earlier constructions of body image distortion, individuals with body image dissatisfaction are constructed as having access to this reality.

Other health workers identified a range of specific socio-cultural causes. For example, Steven identifies "the environment" as a source of "risk factors" for women to develop body image dissatisfaction. For Matthew, "marketing" is identified as the source of body image problems for women. Adam focuses on the "promotion" of the body ideal for women being "stronger" than for men. Clare identifies "a very strong promotion of slim body types", while Rosemary and Georgia point to "the media" and Joanne emphasises "the social pressure on women to look good". These accounts construct body image dissatisfaction as a social, rather than an individual, problem arising through marketing and other cultural forces. As in multidimensional explanations of eating disorders, the potentially complex, dynamic realm of culture and its relationship to the individual is reduced to a 'factor', rather than an interpretative perspective, which exerts a one-directional influence. Women therefore become the relatively passive victims, even dupes, of cultural ideals and expectations.

In a variation, Pamela offers a multi-causal explanation of body image dissatisfaction that is more similar to those provided by other health workers to explain eating disorders, where a more complex interaction of individual, family, sub-cultural and social factors are identified as the causes. In common with some accounts of multi-causality in eating disorders, the way different factors "interact together" is understood as "very different for each individual". Similarly, social factors are placed at a distance from the individual

as “the big ones that always get named and blamed for everything”. Pamela goes on to question why some individuals are susceptible to these pressures while others are not:

...why is it [.] that some people are protected from these influences and others seem really vulnerable to them? And it just seems to me that things like self-esteem seem to be the really key ones which do determine whether people are more or less vulnerable to some of those other influences.

(Pamela, Dietician)

“Self-esteem” protects some individuals from external influences in this account, while a deficiency leads to vulnerability so that, as in accounts of eating disorders, the individual with the ‘problem’ is constructed as less bounded from external forces. Again, a link is drawn between eating disordered women and other women that earlier was denied. Also in common with explanatory accounts of eating disorders, the individual becomes the anchor for the explanatory framework through reductionist humanist discourse. Other BID program health workers also locate self-esteem as the root cause of body image dissatisfaction. For both Adam and Rosemary, body image dissatisfaction acts as “a convenient hook” through which problems of self-esteem become manifest:

I think that body image dissatisfaction is an expression of a greater sense of self-esteem problems that manifests through body image dissatisfaction because we exist in a world where that's a really easy hook to hang your issues about yourself on.

(Adam, Market researcher)

I think it's very much centred around self-esteem. I'm not sure what the causes of self-esteem are but I think self-esteem has to do with it. I think it contributed to it. [It] is certainly fashion and society and media and all those images forming things that we're bombarded with..... []..... I think then those kind of images begin to act on poor self esteem and help to form, I guess, poor body image.....

(Rosemary, Fashion design lecturer)

Again, social pressures are said to operate on a pre-existing vulnerability in the individual in these accounts. The positioning of self-esteem as the root cause of body image problems in these accounts gives primacy to intra-psychic processes as an explanation of body image problems and helps to maintain the separation between the individual and wider socio-cultural factors. In the final instance, then, cause rests with particular individuals in a similar way to reductionist accounts of eating disorders, and a socio-cultural discourse through reference to "fashion", "society", "media", "pressures" and "influences" is also drawn upon to explain how body image dissatisfaction is triggered in vulnerable individuals.

While some explanatory frameworks used to explain body image dissatisfaction share reductionist tendencies with eating disorder explanations, socio-cultural context is nevertheless given much greater primacy in the former. This is because the perceptions, cognitions, emotions and behaviours associated with body image dissatisfaction are essentially understood to arise as a result of inappropriate socialisation processes, even though some individuals are sometimes positioned as more vulnerable than others. In effect, socio-cultural discourse functions as the dominant explanatory discourse for body image dissatisfaction, augmented by the idea that some individuals are more vulnerable because of low self-esteem. For eating disorders, biological or psychological vulnerability in the individual functions as the dominant explanatory discourse, augmented by the idea that socio-cultural factors provide a somewhat distant, contextual backdrop. In the final instance, body image dissatisfaction is primarily understood as a socio-cultural problem with individual elements, while eating disorders are understood as individual problems with socio-cultural elements.

In a variation on these themes, two health workers involved in the BID program draw on feminist ideas to explain the causes of body image problems:

Julie: It's very much based within the cultural expectations of women [as] compared to men. And also women aren't meant to be.....women are meant to be more controlled. They're meant to be good..."

Nicole: So some sort of a moral component there?

Julie: Oh yeah, yeah I think there's definitely a moral component to what's perceived as being ideal for women. [It] is very much morally based.

(Julie, Health promotion worker)

Julie draws on the idea that women are “meant to be good” as a moral imperative arising out of “cultural expectations”. Feminist theorists have argued that eating disorders are linked to moral ideas about women, food and the body. For example, MacSween (1993) shows how portrayals of female sexuality as dangerous in western Christianity are tied to the notion that women must control their desires. Matthew draws on a different aspect of feminist discourse to explain why body image problems are more common in women:

.....it's more I think that women have, I suppose traditionally, it's very complex, ... traditionally the roles of men and women, and I suppose you go back a couple of hundred years, women were largely viewed as the property of men, didn't have an identity and rights in and of themselves, and so women were there to basically be available to and please and serve men. Although I don't know that that's consciously there in the culture, I'm sure that those sorts of things I think hang on for much longer.....

(Matthew, Psychologist)

In referring to historical gender power relations, Matthew draws on a feminist discourse where women's oppression is understood as resulting from unequal gender power relations in patriarchal societies, with women positioned as subservient to the needs of men (Rawlings and Carter, (1977), cited in Ussher, 1991). In contrast to socio-cultural explanations, which narrowly define the causes of body image dissatisfaction in terms of the promotion of the thin female body ideal, feminist discourses locate the causes in wider gender power relations and patriarchal ideologies and structures.

Summary

In summary, clinical practitioners' emphasis on early detection and intervention is consistent with the dominance of a pathologising psycho-medical explanatory discourse, extending psychopathological conceptualisations of women into the realm of prevention and reproducing contradictions and dilemmas associated with dominant psychiatric treatment paradigms. In relation to primary prevention, clinical practitioners' almost exclusive focus on health education leads to the marginalisation of eating disorders as an inappropriate target for intervention and, instead, 'body image dissatisfaction' becomes the focus. In moving on to examine the way that body image dissatisfaction is constructed in a health promotion

program, I demonstrated that BID workers effectively continued this marginalisation of eating disorders within primary prevention. However, in a similar way to psychopathological constructions of anorexia and bulimia, supposedly gender-neutral psychological theories were used by BID workers to construct body image dissatisfaction as a 'women's problem' through gendered assumptions about emotionality as equivalent to irrationality and lack of self-control, and an idealisation of autonomy and self-control. At the same time, socio-cultural explanations are used to characterise body image dissatisfaction as a culturally situated problem with individual elements, while theories of gender difference and feminist explanations remain subsidiary. The next chapter examines the ways in which these constructions of body image dissatisfaction operate in practice, with particular reference to dilemmas associated with the application of health promotion theory and practice in this area.

Chapter 11

Discourses of Self-Care and Social Marketing in the Promotion of Positive Body Image

Introduction

This chapter examines the ways different conceptualisations of 'body image dissatisfaction' relate to practices within the BID program. The dominance of humanist and socio-cultural discourses in respondents' constructions of body image dissatisfaction is reflected in a 'multidimensional' approach to prevention that is common within health promotion (O'Connor and Parker, 1995). The 'PRECEDE' model (Green and Krueter, 1991) is an example of this and is directly referred to in the BID program's documentation, as well as by BID workers in their interviews. The model is based on the premise that health and health behaviour are caused by multiple factors, both individual and social/environmental, and that health promotion needs to address both these levels to be effective (O'Connor and Parker, 1995). In line with the PRECEDE model, the BID program involves strategies to raise individuals' awareness about body image and appropriate eating behaviour, and social change strategies such as assisting the fashion, advertising and media industries to identify appropriate changes in their practices. This chapter critically examines three dimensions of individual and social change strategies: the promotion of 'self-care' as a solution to body image dissatisfaction and eating problems; the application of social marketing principles to a problem constructed as a function of marketing; and, the gender implications of marketing positive body image. The approach of the BID program to the Ottawa Charter for Health Promotion (World Health Organisation, 1986) principles of community participation and empowerment, and the implications for power dynamics in practice, are also considered.

The Promotion of Self-Care

The individualistic nature of cognitive-behavioural and humanist accounts of body image dissatisfaction are reproduced in the BID program through behaviourist education strategies that focus on changing the individual through media campaigns, brochures and other one-off or small-scale promotions. Generally speaking, health promotion is characterised by individual behaviour change interventions (Bunton and Burrows, 1995), and these typically promote the prevention of disease and risk reduction through adherence to prescriptive eating and exercise regimes. The BID program differs, however, in that it attempts to promote positive, less prescriptive messages and practices. For example, Adam argues that

“most health promotion is negative [...] disease prevention”, while the BID program has a “focus on positive health”. In an effort to distinguish the BID program as positive and non-disciplinary, health workers emphasise the ideas of promoting ‘self-acceptance’, ‘self-nurturing’, ‘listening to the body’, ‘natural eating’ and ‘self-esteem’. Firstly, Adam counter-poses the negatively defined practice of “dieting” and ideas of “good foods and bad foods” against the BID program ideal of ‘nurturing’ and ‘enjoying’ the body:

....[we] talk about eating as something we do to nurture and enjoy [our] body, [...] not talk about eating in terms of good foods and bad foods....to move away from the idea of diets and dieting as an appropriate way of eating....to talk about being in touch with your body's needs, so trying to be actually able to get to a point where you can say “Right, I know what my body needs to take now, or today, or whatever”.....

(Adam, Market researcher)

Caring for oneself is “being in touch with your body’s needs”, and while the body becomes a health rather than an aesthetic project, the individual remains its guardian. Thus, the body is prior to and conceptually separable from ‘the mind’, which observes, reads and responds to ‘it’. Furthermore, individuals demonstrate a healthy relationship with the body when they appropriately respond to its needs. Adam goes on to emphasise the idea of promoting “self-esteem” as the central aspect of the BID program approach, presenting this as the key to health and a cure for every ill:

.....ultimately..[...]...I see the potential of [the BID program] to be something that I haven't seen in health promotion before, which is a very positive focus in a way [...] that's really broad contextually, and if ultimately what comes out of this is a a is a health promotion program that's focused primarily on self-esteem and body image being part of it, that would be like the best [...] outcome that I could think [of]. We could probably get rid of all the other health promotion programs (laughs), because they would become redundant.....

(Adam, Market researcher)

While Adam jokes that other health promotion programs “would become redundant”, he nevertheless characterises “self-esteem” as the root cause of health problems and the key to positive health and body image. Caring for the self in a nurturing way therefore becomes symbolic of the extent to which the

individual values him- or herself, and is a public demonstration of one's accountability for oneself (Petersen, 1997). In the following account from Pamela, self-care involves three core components of self-love, exercise and eating, with an emphasis on the idea of promoting "a life-term approach" to self-care:

..... it is [about] encouraging a longer term, a life-term, approach to healthy eating that's not guilt-ridden and success/failure-ridden.....[.]... and it is about physical activity but [.] doing something that you enjoy. It doesn't necessarily have to line up with the no pain, no gain. It doesn't have to be standard exercise, it could be ballet dancing but, yeah, that you feel good about moving your body in some way [.] and getting away from other people's rules and restrictions. So I really like this nice little article, it is very American but I thought it was a really good summary. She just talks about love your body, move your body, feed your body, and I think those [.] would [.] be the three core components.

(Pamela, Dietician)

The three components of self-care, "love your body, move your body, feed your body", function as a mantra for ideal body praxis. The individual is exhorted to undertake constant care of themselves through practices that are nurturing and enjoyable, rather than based on the more disciplinary "no pain, no gain" motto, delineating the BID program from more traditional health education based on "rules and restrictions" and a self-disciplinary ethic. In a similar way, Julie argues that promoting healthy eating means "not being prescriptive about eating" and, like Adam, she goes on to suggest that this involves responding to the body's needs by "controlling intake" through "your sort of natural urges to eat":

..... [disordered eating is] eating in a way which is mind over body for a start. So that you're controlling your intake with your brain not with your sort of natural urges to eat. Um limiting the foods that you eat....[.]....It's where the food, the content of the diet, the actual food, is more important than the way you eat. I mean that would be a distinction between...[.]... healthy eating and unnatural eating....[.]... And then the next step would be to be disordered eating, where you've kind of lost the plot altogether.

(Julie, Health promotion worker)

The construction of “mind over body” eating as equivalent to “disordered eating” is clearly steeped in dualistic assumptions, however, the Cartesian schema where the superior mind is elevated over bodily desire is problematised rather than idealised, and “healthy eating” is characterized as following “natural urges to eat”. This idea in part draws on a discourse about the oppressive effects of culture on ‘modern man’, where the rules and regulations governing contemporary life are seen as having led to disconnection from natural, bodily drives. Here, the body is given and aligned with nature, its drives arising separately and unproblematically from social and psychological processes so that the problematisation of the Cartesian privileging of mind over body leads to the solution of ‘heeding the body’. However, while this appears to reify the body over the mind, following the body’s cues leads to more effective bodily control because “mind over body” eating ultimately leads to loss of control “where you’ve kind of lost the plot altogether”. In the final instance, body-over-mind eating paradoxically functions to actually *strengthen* the individual’s bodily control through tuning the mind to the body’s signals and, ultimately, the mind retains control of the body’s consumption. Clare also draws on the idea of “listening to the body”, idealising the notion of a symbiotic rather than conflicted relationship between mind and body:

.... the idea of self-esteem [is important, and that] you can be comfortable with your body [.] independent of size and shape [.] and using the media [.] to promote natural eating, and appropriate natural eating...[and]...listening to the body....[.].....encouraging people to listen to what their body is saying, combined with broad guidelines to have a certain, like more of certain foods and less of others, rather than having a situation where food is regarded as good or bad... [.]...we would be into moderation, with you know high fat food, for example, but more emphasis on listening to what you need, and giving yourself permission to eat what you need and having less restrictions and rules... [.].....so it's about balance and it's about listening to what you need... [.]...so broad guidelines but applying them reasonably rather than highly perfectionistically or restrictively and listening to [.] what your body is saying and combining those two.

(Clare, Psychologist)

This symbiosis between mind (“guidelines”) and body (“needs”) is presented as “balance”, where ideal

self-care results in a state of homeostasis and control, rather than imbalance and chaos. Clare goes on to clarify that “natural eating programs” provide an escape from the cycle of “disorder”:

....I think natural eating programs are a way of getting off the yoyo, off the roundabout of disorders, you know, dieting, weight gain, dieting, weight gain. And em, so I think I think there also needs to be some fairly fierce education on our part more generally, about weight loss and how that is done well, and where to go to do it well, and about what not to do.

(Clare, Psychologist)

Natural eating is constructed as a more effective mode of bodily control because it can result in weight loss “that is done well”. Rosemary also presents the idea of getting individuals to “tune in to what their body is telling them” as a method of more effective self-control:

...we do information sheets for people...[.]...and I guess the best way to describe it would be to say that we give basic sensible nutrition and eating patterns. One of the things we're trying to do is to get people to tune in to what their body is telling them, instead of overriding it and filling, filling, filling, listen to the fact that you're full and stop eating, and it's amazing how many people don't listen to those body signals, and how many people are not even tuned in to that, and that kind of thing, so it's not really eating advice or nutrition advice, but it's really being more tuned to natural limits....

(Rosemary, Fashion design lecturer)

Natural eating is posited as a “sensible” approach because it is a more effective method of moderation and self-control in contrast to loss of control through over-indulgence and over-restriction.

Other accounts also link the promotion of self-esteem and self-acceptance to more effective bodily control.

Firstly, Pamela argues that promoting “healthy, robust self-esteem” will mean that individuals “want to look after themselves and their body”:

....the main enabling factor that we try to promote [...] would I guess just be the importance of healthy, robust self-esteem. So if that's there, [if] people, you know, feel good about themselves, they're going to want to look after themselves and their body...

(Pamela, Dietician)

The goal of building individual self-esteem is ultimately associated with the establishment of appropriate self-care practices and is not an end in itself. In a similar fashion, Steven also emphasises that self-acceptance “doesn't mean we can't look after ourselves”:

.....I think there's huge scope [...] for a balanced perspective [...] that says “Look, diets don't work and we do need to be accepting ourselves but that doesn't mean we can't look after ourselves in the most appropriate healthy way in the environment that it is today”....[...]...and so the non-diet approach I'd like to see pegged in between that.

(Steven, General practitioner)

Steven characterises the “non-diet approach” as a “balanced perspective” – a third way - where self-care comprises both self-acceptance *and* healthy behaviour. Thus, accepting yourself is not tantamount to ‘letting yourself go’ and being out of control. Like Julie’s and Clare’s idea of natural eating, the non-diet approach is based on “that natural intuition of what their body’s desiring” – a following of the body’s cues as a form of moderation. Similarly, Rosemary argues that a “balanced view” doesn’t mean “pig out and let yourself go”:

....we're trying to get people to think of all foods as being acceptable and the amounts that you eat of some foods with kids.....[...]...party foods that you have once in a while.....and that's fine and you enjoy them while you're having them, but you don't have them all the time...[...]...So to try and give a balanced view...[...]...I guess what we're trying to do is to give people a sense of “Hey, it's okay”...[...]...and that doesn't mean pig out and let yourself go and, you know, don't strive for a healthy diet and a healthy lifestyle...[...]...diets have

been proven not to work. They work in the beginning but inevitably people put the weight on in various time periods, but it does go back on because they haven't made changes in their lifestyles, so it's not sustainable.

(Rosemary, Fashion design lecturer)

Balance and lifestyle change are promoted because they represent sustainable methods of self-discipline and control, while both dieting and over-indulgence represent being out of control. Steven and Matthew also argue that self-acceptance is important because it results in a more "sustainable" approach to self-care:

.....it's vital that [individuals] are as accepting of themselves as they can be right now, in order to help them look after themselves, so they're able to look after themselves in a sustainable way.....

(Steven, General practitioner)

.... the [BID] program discourages people engaging in short term rapid weight loss programs which are seldom successful amongst people [...] and encourages people to look at weight as a more complex problem that's contributed to at many different levels... [...]... focusing on weight alone won't resolve the problem and [we] encourage[e] people to actually feel good about their bodies so they can actually engage in more healthy and sustainable weight control strategies over time.

(Matthew, Psychologist)

For Steven, the more self-nurturing, less restrictive message of the "non-diet approach" is clearly premised on a goal of more effective self-discipline, while dieting ultimately results in a loss of bodily control in the longer term. For Matthew, 'feeling good' is not an end in itself but is promoted because it is more likely to result in appropriate and sustainable self-care practices, while dieting represents an

ineffective means of bodily control. In a similar vein, Gillian argues that the goal of health promotion should be to encourage people to "enjoy their bodies sufficiently to look after them":

....we know that a diet is often the problem and [...] we're looking for lifestyle changes... [...]... for instance, not worrying about your weight but worrying about what you eat and how much you exercise... [...]... what we're encouraging is that people enjoy their bodies sufficiently to look after them by eating as well as they can within their ability, without depriving themselves, and to exercise in moderation.....that's really all you can say.....

(Gillian, Psychologist)

Enjoyment is a means to the end of self-care because deprivation and restriction are ineffective modes of bodily control. In the final instance, while the BID workers characterise their program as liberating, non-repressive and non-disciplinary, and seek to delineate it from more disciplinary and controlling forms of health promotion, the achievement of more effective self-discipline and control is the end goal of intervention, underpinned by an idealisation of bodily control and a repudiation of loss of control.

Self-care, Identity and Governance

The inclusion of individual change strategies as part of the BID program approach to health promotion is based on humanist assumptions about the rational subject and their ability to make choices, and appeals to a dualistic notion of 'the mind' being able to monitor and control 'the body'. This reflects health promotion's origins in liberal-humanism with its emphasis on notions of individual responsibility for health (Gardner, 1995). While respondents' drew on humanist discourses to construct body image dissatisfaction as an out-of-control emotional state, the approach to intervention is based on the complementary humanist idea that individuals nevertheless have the capacity for rationality and agency.

The heavy emphasis on continuous self-surveillance and self-control in the BID program represents a form of population regulation that is peculiar to contemporary neo-liberal societies. Petersen (1997), drawing on the work of Castel (1991), argues that the development of new preventive strategies such as those of health promotion represent a shift from controlling "the dangerous individual" to a focus on abstract "risk factors" (Petersen, 1997: 192-193). While BID workers characterise their program as a departure from 'negative' and prescriptive risk-oriented health promotion, individuals are nevertheless

exhorted to particular forms of self-care precisely because they are seen as reducing the risk of uncontrolled emotions and behaviour, with their negative health consequences.

The neo-liberal rationality on which the notion of self-care is premised assumes the individual to be an autonomous consumer, able to care for her- or himself by making sound choices (Rose, 1993). Within this conceptualisation, the individual's life becomes "the enterprise of oneself" (Petersen, 1997: 194) that is "part of the continuous business of living" (Gordon, 1991: 44, cited in Petersen, 1997). Indeed, the life-long nature of this enterprise is reflected in Pamela's comment that healthy eating should be practiced for the "life-term". Petersen (1997) argues that health promotion's emphasis on individuals protecting themselves from risk privatises health so that if negative health outcomes are not prevented, it becomes "a failure of the self to take care of itself" (Petersen, 1997: 198). Presenting oneself as 'healthy' therefore functions as a signifier of identity (Petersen, 1997; Nettleton and Bunton, 1995), - the identity of "the health promoting self" (Nettleton and Bunton, 1995) - and is based on an idealisation of the individual as self determining and self-controlled (Crawford, 1994). Petersen (1997) argues that this emphasis on individual management of risk resonates with Foucault's concept of governance, which acknowledges "the role of expertise in regulating subjectivity" and recognizes "a more complexly structured and intensely governed self" (Petersen, 1997: 202), drawing attention to the way that "[n]eo-liberalism calls upon the individual to enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement" (Petersen, 1997: 194). The language and techniques of health promotion can therefore be thought of as "technologies of the self", which constitute a form of contemporary governance and social regulation (Nettleton and Bunton, 1995: 53), rather than a liberation from self-discipline and control. In common with constructions of self in dominant treatment paradigms for eating disorders, there is a reification of the liberal-humanist ideal of autonomy and self-control within the approach to prevention. Thus, while BID workers characterize the approach to health promotion as non-prescriptive and non-controlling, health promoters' promulgate a very particular view of what constitutes responsible 'healthy' behaviour, effectively "employing the agency of subjects in their own self-regulation" (Petersen, 1997: 203). Furthermore, also in common with treatment interventions for eating disorders discussed in Chapters 8 and 9, the reification of autonomy and self-control is based on a masculinised ideal of self and a derogation of the feminised body and its desires.

The Marketing of Self-Care and Positive Body Image

The BID program approach to the promotion of self-care carries with it an ideal of "positive health" as an absolute concept that is more than the absence of disease (Kelly and Charlton, 1995: 83). Indeed, Adam explicitly defined the program as promoting "positive health", and BID workers completely eschewed the idea of 'illness' by quarantining eating disorders from their health promoting activities. This 'positive' conceptualisation also posits health as "a fundamental good" so that it becomes "a commodity and like all commodities is available in the marketplace" (Kelly and Charlton, 1995: 83). In line with this commodification of health, BID workers situate the practices of self-care within a wider marketing discourse of health promotion. Firstly, Pamela draws on the language of marketing to argue that individuals must be offered "an immediate reward" before they will adopt self-care practices:

....we haven't really got an immediate reward that we can offer people if they adopt a non-dieting approach to weight because they're not going to get the immediate weight loss. So our challenge has been, you know, how can you make the longer-term benefits a bit more sexy and appealing....

(Pamela, Dietician)

Self-care is a commodity that can be bought and sold in this account. Similarly, in the next extract, "people must be getting something out of it" before they will respond to the messages promoted by the BID program:

.....we really have to think about, you know, what are the actual benefits to people. It's no good just telling them it's not good for you. People must be getting something out of it.....

(Gillian, Psychologist)

Individuals are defined as consumers who need to be 'sold' the benefits of self-care through effective marketing strategies. The following account further elaborates the techniques involved in a marketing approach to self-care through the practice of 'market research':

....we'll say "Okay, this might be a message to have with No Diet Day", and [our market researcher] will say, "Well, we've got to test that first and make sure that it's appropriate,

and see what people think of it". And... [...]... there was some message for No Diet Day last year that he did some testing on, and um it came back that it wasn't a very effective message at all because people took it as, "That means I can eat whatever I like. Uh, I think it was like, something like". "Healthy at any weight, not thin at any cost"... [...]...OK, that really makes sense to us, but people didn't believe it (laughs) in the community. "Oh, that's not right, that's not true, you can't be healthy at any weight, you have to be thin, or you have to be, you know, you can't be fat and be healthy". So that even though we understand this and we know that research is certainly showing this, the community isn't ready for that message yet even though it's like a message that we believe is true.....

(Steven, General practitioner)

The testing of health promotion messages is based on the assumption that their content must be acceptable to the consumer. Within a marketing approach, people can therefore only be sold products that correspond with pre-existing meanings (Nettleton and Bunton, 1995). By nature, then, a marketing approach to health promotion should not challenge existing beliefs or practices, or create new meanings.

Strategies focused on social and environmental change represent the main area of activity for the BID program, and this includes working with fashion retailers and gym operators to modify their approaches to customers in an attempt to reduce body image dissatisfaction. A focus on social/environmental change is consistent with the view promulgated by BID workers that particular social conditions trigger body image dissatisfaction in vulnerable individuals, and distinguishes this program from others that focus only on educating individuals (for example, Shisslak, Crago and Neal, 1990; Killen et al, 1993; Paxton, 1993). In this sense, the BID program includes an emphasis on the social aspects of body image and eating, and incorporates the health promotion principle of creating healthy environments outlined in the Ottawa Charter (World Health Organisation, 1986). However, while these interventions are constructed as "structural change" or "environmental change", individual behaviour nevertheless remains the end-point target of intervention. As is argued by Adam, it is necessary to "change the people who [...] they will be picking up the stuff from", while Matthew argues that health promotion is about acting on "various institutions [...] to actually modify people's practice". The "structural change" strategies outlined by BID workers also remain situated within a marketing discourse of health promotion because body image dissatisfaction is seen as a function of "an imperfect market" (Kelly and Charlton, 1995: 84), and modifying

the market in line with health goals functions as the rationale for intervention. This is apparent in the following extract from Pamela, where she describes the program's work with the fitness industry:

.....we're also doing sort of like piloting and intervention in the gym where we're involving like the marketing and the gym instructors and the managers, and looking at how to, you know, I guess encourage the physical activity, you know, more for the sake of enjoying it, looking after your body, rather than whole weight loss [thing]. You know so we're looking at developing more intervention with them which again has been very well received, we thought "aghhh", they're not going to buy it because you know, they base so much of their marketing on people feeling bad about their bodies but again it's, um you can easily develop a case for saying, look poor body image actually reduces your membership and makes people drop out sooner, so you know, it makes financial as well as ethical sense to take it on....

(Pamela, Dietician)

Health promotion becomes the pursuit of more effective marketing techniques that make "financial and ethical sense". A convergence of interests between health promoters and industry – the "win-win" tenet which is central to the theory of social marketing (Lefebvre, 1995: 154) - therefore leads to a harmonious process of change. Women themselves, as the ultimate targets of intervention, are positioned as passive consumers to be managed in more effective ways by the marketers, while 'society' is conceived of only in terms of 'the market place'. The following extract from Clare also describes a collaborative approach with the fashion industry to encourage them to modify their marketing strategies:

.....[the fashion industry] value the smaller sizes and they're very, you know, "what size are you dear?" Um, you know, as opposed to accepting whatever bodies there are and being appropriately comfortable with all that. So that involves not only working with shop floor, with changing attitudes there, but also working [.] at a higher [level], fashion store chains and with the fashion industry in general to promote fashion strategies and marketing that actually are more reasonable in their stereotypes that are provided and less thin.

(Clare, Psychologist)

The approach rests on the idea of promoting “more reasonable [...] stereotypes”, where it is the nature of the image that is in question, not the objectification of women’s bodies *per se*. Such an approach is premised on the idea that more ‘realistic’ images of women will somehow translate into body satisfaction through identification. However, this still positions women as passive recipients of media images. Matthew also emphasises a collaborative, “inclusive” approach to environmental change:

..... trying to be inclusive [is really important], you know, we really struggle, I think, with, you know.....we haven't yet attempted the weight loss industry. We were starting to work with the fitness industry which is almost as bad, because they exploit people's bad feelings about their bodies and say well it's their bread and butter (laughs) that's how they've done it in the past so um, for them to change because, but, you know, so..[...]... we started off with a group, with a gym which likes to think it's got a yuppy, up-market, new age kind of image, and we reinforce that and be part of the leading edge (laughs) you know of, so you pick up a group like that, and just start a bit of momentum, so that's our idea, to start things at a broader level, not just at the micro level, maybe at the community level and at the industry level.....

(Matthew, Psychologist)

The approach with the fitness industry is to find a marketing angle that makes the message of the BID program appealing, while intervention with the weight loss industry is considered problematic because it would involve conflict rather than inclusiveness. Thus, change comes through the collaborative modification of marketing techniques, where environmental change does not challenge the forces of marketing and consumer capitalism, but instead attempts to harness them to its own ends. Similarly, Julie emphasises working collaboratively with industry, arguing that in the case of body image dissatisfaction, a conflict-oriented approach “may not be so useful”:

...[the social advocacy approach] may in some cases involve you in, you know, being at loggerheads with, say the tobacco industry, or um, the gun lobby or something like that but in this case it may not be so useful to be at loggerheads with the fashion industry. I mean there might be times where you are, and there might be times when you're actually working with them. But it's kind of keeping all those options open. And the other, um, thing that I

would include is social marketing. Using the social marketing model so you're using [...] marketing techniques, modern marketing techniques, to actually promote your program, and promote your products.

(Julie, Health promotion worker)

While it is acceptable to "be at loggerheads" with the tobacco industry or the gun lobby, conflict is eschewed in the case of the fashion industry and a more collaborative approach pursued. The fashion industry is not aligned with industries understood to be unethical and noxious to health and well-being and, instead, a marketing approach is taken where one must "promote your products" in an entrepreneurial way.

Expert and Community Discourses in Health Promotion

While social marketing represents the dominant model of environmental change within the BID program, BID workers also draw on the concept of a 'social model of health' (World Health Organisation, 1986) in aspects of their explanations of social change strategies. Matthew captures the essence of this approach when he describes health promotion as "not just acting on the individual" but "acting on various institutions in society":

....I suppose from a structural point of view health promotion is about not just acting on the individual. Health promotion in a broader way is acting on various institutions in society to actually modify people's practice because basically... [...]....women's attitudes toward their bodies [are] influenced by many things way outside their control..... [...]....so society has to take collective responsibility for modifying some of the things that maintain negative body image. I think health promotion certainly [...] sort of [works] out through research and practice what are healthy messages to give, and then sort of [works] out which points, where, how to intervene in the community in a way that actually results in changed behaviour.....

(Matthew, Psychologist)

This account positions women as passive victims of "institutions" and "people's practices", which are "way outside their control". In addition to being passive victims of social processes, women are also the passive recipients of health promotion interventions as "society takes collective responsibility" and health

promoters work out “what are healthy messages to give”. Within the social model of health, then, ‘society’ is “reified” and presented as “acting on people in a highly deterministic fashion” where the individual becomes “a system outcome” and “victim”, rather than “a thinking and acting human” (Kelly and Charlton, 1995: 83). This conception of the person is clearly at odds with the earlier construction of the ‘health promoting self’ as an autonomous, self-contained individual, and a consumer who ‘chooses’ (Grace, 1991; Crawford, 1994).

In a further example of the idea of undertaking social change on behalf of the community, Julie outlines the theoretical assumptions of the “social advocacy model”, which informs her work with the BID program:

...[the social advocacy model] is more a way of operating which is to look at...[.]...for instance in this case [...] so if we say “Alright, fashion has a role to play in body dissatisfaction. Let’s look at the issues, do some research, find out what women perceive are the issues, look at the way the industry’s structured, look at whether there are ways to actually work with the industry to make change and also look at using the media to promote the changes, or promote the problems within a broader context.” So get it onto the social agenda, onto the public agenda.....

(Julie, Health promotion worker)

The social advocacy model is portrayed as a guide for intervention where health workers assess the problem and intervene on the behalf of community members, whose role is restricted to a consultative one.

The positioning of individuals as the passive recipients of intervention is further underscored in the BID program approach to community participation, providing further insights into the ways in which the relationship between health promoters and the wider community is envisioned and realised in practice. The Ottawa Charter on Health Promotion includes the principle of strengthening community action and empowerment (World Health Organisation, 1986), emphasising the idea of communities having power and control over program initiatives and activities (O’Connor and Parker, 1995). The BID program incorporates this principle to some extent through working with community groups to develop strategies at the local level, and through undertaking community consultations and focus groups. However, community

participation is largely a discrete area of intervention, while community involvement in the overall management and implementation of the program is relatively limited. This narrow approach to community involvement is reflected in BID workers' accounts through the assumption of community participation as "consultation". Firstly, Adam outlines the purpose of community consultation and how it informs the BID program's social change strategies:

.....what we used [focus group research] for was [to] say, "Right, youse [sic] guys identify the issues, we'll work out what we can do about them". So a lot of people in those groups were talking about shopping a few times as one of the times when they feel worst about their body, and they might then go home and say start to eat a tin of milo or then go on a diet for three weeks or whatever. So we thought "OK, that's not good, there's a problem, there's an issue going on there what can we do about it?" So one of the things that [one of the other workers] is doing and I've given some help with is develop training workshops for sales assistants in fashion houses...[.]...so it's working with that social structure sort of problem.

(Adam, Market researcher)

The role of the community is consultative, identifying the nature of problems, and it is the experts who "work out what we can do about them". The health professionals decide on and implement the solution, while the community members become the relatively passive recipients of positive marketing, just as they were the passive victims of negative marketing. Julie's account of community participation, in common with Adam and with Pamela earlier, also constructs the role of community in this way:

...we have a community member [on the Board of the BID program].....we have two community members now. That's the other area I'm trying to build up...[.]...I think now we all see that it needs to become a broader based committee, and we're restructuring the management of the program so that people can be involved in particular aspects of the program without necessarily being involved in the running, the management of it. I suppose that's the thing. I think you can waste a lot of people's time having them sitting around in meetings. Especially, you know, it's pretty intimidating for a lot of community participants in committees with a bunch of experts, totally intimidating, and so they don't say anything and

they feel even less confident than when they started.... So I think it's really important to match the roles that you ask people to play with, with them feeling confident and comfortable too. So that's what we're really looking at, ways of doing that.

(Julie, Health promotion worker)

This account is structured around a central tension because while Julie argues that community participation needs to be increased, she also suggests that the community could participate "without necessarily being involved in the running, the management of it". Thus, community members could be involved, but without decision-making power. This position is justified by the idea that community involvement "can waste a lot of people's time" and is "pretty intimidating". In the next extract, Julie argues the need for both "expert" knowledge and "community involvement":

.....I suppose I think that there is really a role for, in an area, a specialised area like this, there is a role for a group which is an expert group. And it's um responsibility is to make sure it stays in touch with the community so that any time..... I mean things like focus groups aren't really community involvement. They're getting information from the community but they're not actually involving the community. So [...] they're a way of keeping in touch with what people think, but [...] you've got to have that other step which is keeping more closely involved with the people who are doing the delivering of either, um clinical stuff, or community health stuff, or whatever....

(Julie, Health promotion worker)

While expert knowledge is emphasised, ambivalence about community participation is evident when Julie argues that "things like focus groups aren't really community involvement". This implies that 'real' community participation should involve greater levels of power and control by communities, contradicting her earlier argument that community involvement is not useful. However, Julie then goes on to construct health professionals as the community of interest for the program and, through this idea, it becomes possible to define the BID program as a 'community-oriented' program. This also situates BID workers one step back from the public as servicing the health professionals who, in Joanne's words, do "the liaison with their community". This is a top-down approach to health promotion that locates community members at the furthest point from decision-making power and control. Thus, as is pointed out by Petersen (1997),

health promotion workers see themselves as “working at a distance through the efforts of others by way of forging collaborative ventures”, where they become “expert mediators” (Petersen, 1997: 195).

There is also a tension within Julie’s account between notions of expert knowledge and community participation. For example, earlier Julie argues that “there is a role for a group which is an expert group”, but that it must “stay in touch with the community”. In the next extract, while Julie continues to argue that both “expertise” and “community consultation” are important, broadening the committee to include more non-professional community members potentially conflicts with the need to maintain “expertise”:

....well, to my mind this is a community program. It’s made up of interested people in the community who got together and wanted to set up a committee, and manage this program. It’s a group of people who had expertise in this area, and that’s the basis of it’s kind of dynamic if you like. What the challenge at the moment is to actually broaden out the committee, um, but to keep it’s expertise, so to, so I suppose what I’d say is that community consultation definitely is important, but equally if you’ve got an expert group you do actually have a.....the bigger picture. So for certain things you’d always want to get input from the people who know more than you do about the coalface.....

(Julie, Health promotion worker)

Expert knowledge is given primacy in this account because it is aligned with “the bigger picture” (the global), while community involvement is associated with “the coalface” (the local). While the latter is presented as important, expert knowledge is the central “dynamic” of the program and local knowledge is reserved only “for certain things” – for the particular. Furthermore, to justify her emphasis on the importance of expert knowledge, Julie again attempts to redefine the BID program as a community-oriented program through the idea that the health professionals involved in the management committee are also “interested people in the community”. The next extract also involves some re-definition of the concept of community to accommodate the expert-driven emphasis of the BID program:

...when I’m talking it sounds as though the community’s not really part of it, but [...] that’s because I see the community as being [the state as a whole] and when you look at things like the Ottawa Charter for Health Promotion, those sorts of documents, and you look more

closely at what they're talking about, when they talk about a community they are talking about cities of 12 million people, things like that. So I feel [...] in a way, even though we've got sort of [country and city], in reality most of [the state] is, most of the population is in fact in the urban area. And not only that, most of the population all around [the state] uses the same media now. So, yeah I mean people in the country still read [the same newspapers] as people in the city, as well as their local papers. So [...] the strategy has to be a kind of umbrella strategy.

(Julie, Health promotion worker)

Julie argues that while the BID program is a centrally organised, state-wide program, it can also be seen as a community-oriented program because the whole state comprises its community and, because most people have access to the same media, central organisation and control of the program is justified. The following extract further illustrates the tension between notions of expert knowledge and community involvement in Julie's account:

Julie: We have worked with the local community in [a country town]....[.].....It was quite.....our aim was to help them develop a local program. And it didn't, it didn't really work all that well because they weren't .. (laughs) .. they didn't.. they didn't seem to appreciate the value of doing their research before they ran their campaign.

Nicole: Right, they wanted to jump in sort of thing?

Julie: Yeah, and then do a survey. And it..... it was just all.....I mean I think there will certainly be some useful outcomes from it, but um we wanted it to be their project, but equally we had to say, "Well, you know, how does this fit in with setting up a model for other communities to follow?", and it wasn't particularly successful. But that's alright, they've got their own small program and a lot of interested people and I think they'll keep going...[.].....Although [the health worker from the BID program] seemed to think there was some internal problems...(both laugh)..with the committee which is what he thought, the reason it wasn't working. But it was a good example of why it's difficult to be trying to work with the local community from [the city]. And the Quit campaigns have the same experience where they've tried to run [...] large local campaigns, and it just, you know, with media and everything, and really it isn't as successful as running state-wide media campaign, and then

working sort of more strategically I suppose with different health professionals in the area or community groups where they exist.

(Julie, Health promotion worker)

In this account, community participation is associated with three different types of conflict. Firstly, expert and community notions of health promotion processes are presented as being at odds because community members "didn't seem to appreciate the value of doing their research before they ran their campaign". Next, the agendas of experts and community members are conflicted because while the project is presented as community owned ("their project"), for the health workers it also represents "a model for other communities to follow" which "wasn't particularly successful". Thus, the professionals had a more important agenda that went beyond local community ownership, and the comment, "but that's alright, they've got their own small program", indicates that the local program is less than was hoped for by the health promoters. Lastly, the local committee is presented as conflict-ridden through its portrayal as having "internal problems". Community participation is an inherently problematic process in this account, underscored by the example of similar experiences in another health promotion program. In the final instance, an argument is made for the retention of central control and limiting work with local communities to the 'more strategic' in line with expert-defined health promotion goals. In the final instance, the approach to community participation works in concert with the expert-driven social advocacy and social marketing models, reproducing a paternalistic approach to "environmental change" that is not uncommon in health promotion (Grace, 1991: 333).

Social Marketing, Culture and the Reproduction of Gender

The emphasis on social marketing within the BID program reflects the increasing use of this approach within health promotion more generally (Lefebvre, 1992). Bunton and Burrows (1995) suggest that within a social marketing approach to health promotion:

...[t]he propensity towards various forms of ill health is reformulated as a function of the supposed 'health-giving' or 'sick making' properties of various commodities and/or activities, almost all of which are now firmly located in the symbolic domain of consumer culture.

(Bunton and Burrows, 1995: 210)

The BID workers clearly locate the source of body image and related eating problems in consumer culture, with its emphasis on thinness for women and, in line with this, the approach to practice focuses on modifying individual consumer choices and the marketing practices of retailers. A social marketing approach to health promotion therefore attempts to "cultivate consumption preferences" through a "re-calibration of commodity inputs in the pursuit of health" (Bunton and Burrows, 1995: 210).

The marketing discourse of health promotion produces the individual as "a needing, wanting individual" who can meet her/his own needs by purchasing the necessary goods and services (Grace, 1991: 334). The self of marketing discourse is therefore consistent with the autonomous 'health promoting self' of health promotion discourse on which the notion of self-care is predicated. However, Grace (1991) shows how marketing discourse has a contradictory structure because the consumer is at once a "chooser" *and* a potential buyer who is created by the marketer, while the marketer is at once a "provider" who fulfils the consumer's desires *and* "an agent of persuasive techniques who attempts to fashion the consumer into precisely that chooser with particular wishes, desires and needs" (Grace, 1991: 335). As an extension of this argument, Grace (1991) identifies a contradiction in the dual construct of "surveying/meeting needs" and "constructing/modelling needs" through the use of media promotion techniques in health promotion (Grace, 1991: 341). This contradiction is present within the BID program through the dual strategies of market research and the marketing of self-care.

The BID program involves further complexity in the subjectivities it produces through its simultaneous adoption of a social advocacy model of social change, and an expert-driven approach to the management of community involvement that locates individuals as the socially determined, relatively passive subjects of intervention. This positioning is similar to one side of the marketing discourse that constructs individuals as the objects of the persuasive marketing techniques. Thus, health promotion discourse also has a contradictory structure and, in common with constructions of psychiatric treatment for eating disorders, BID workers construct intervention around the paradoxical idea that individuals are simultaneously active *and* passive, autonomous *and* socially determined/dependent. The 'multidimensional' nature of the BID program, which attempts to address both individual behaviour change and environmental change, therefore fails to come to grips with the divergent premises of these two aspects of health promotion (Grace, 1991). This is in part a function of the individual/society dualism implicitly underpinning health

promotion discourse, whereby interventions targeting individuals are treated as distinct from those addressing social change. This culminates in a dichotomous approach to health promotion structured around contradictory aims of strengthening individual autonomy (mitigated by the health promoters' view of what constitutes responsible 'healthy' behaviour), and a controlling paternalism.

Another feature of the marketing approach to health promotion is its tendency to dissipate resistance (Grace, 1991), and this is exemplified in the BID program. As is argued by Nettleton and Bunton (1995), "[i]t is likely that promotional activities are most effective if they tap into a corpus of existing meanings, rather than attempt[.] to create new ones" (Nettleton and Bunton, 1995: 55). The emphasis on modified forms of self-care, and making small modifications to the marketing of body image, fits within existing consumerist frameworks and falls short of a more radical challenge to the objectification of women's bodies for profit. The social marketing approach to social and environmental change also produces an emphasis in BID workers' accounts on inclusiveness and collaboration - the 'win-win' tenets of marketing - resulting in an approach that eschews conflict and opts, instead, for a 're-calibration' of the market. The simultaneous emphasis on expert knowledge and a downplaying of community participation also has the effect of reducing potential for more radical social action. On the theme of political resistance, Clare talks almost wistfully about the possibilities for "community grass roots stuff" in the BID program:

One of the things I haven't talked about which is....[.]...not really developed in the program yet, but [someone] is going to be working on more [is].....[setting] up a support group, and I'm hoping that the support group will also include a lot of, um, if you like, community grass roots stuff. I would really like people in the local community complaining to their local shopping centre when there are inappropriately thin models in the windows. And I really quite like the idea of action on the part of people, you know, more broadly so that they then become more involved and it's not just a bunch of us somewhere in a room in the city doing something, but that it's a broader program where women actually take back the right to define what's okay.

(Clare, Psychologist)

While Clare raises the possibility of feminist forms of social action, this is not the focus of the BID program in practice and sits in a contradictory relation to its expert-driven, social marketing approach. Furthermore,

the "relationship of provider to consumer effectively dissipates the political antagonism of resistance" shifting the ground from "the sphere of political challenge and struggle to the ground of market relations" (Grace, 1991: 334), so that social resistance and community empowerment becomes marginalised. Interestingly, while Grace (1991) points to a central discourse of empowerment in her interviews with health promoters in New Zealand, albeit a contradictory one within the framework of a marketing approach, the accounts of the BID workers are distinctive for their almost total lack of attention to the health promotion principles of empowerment and social action. Other than the above extract from Clare, BID workers' accounts are distinguished by a relatively unambiguous assertion of an expert discourse, which continues to characterize most contemporary health promotion (Kelly and Charlton, 1995). The fact that feminist discourses of health care, within their emphasis on empowerment and grassroots social action (Broom, 1991), were uncommon in health workers' accounts and do not explicitly inform the approach to practice, can be partly explained by the historical and continuing marginalisation of feminist approaches to health care in the Australian health care system more generally. Overtly feminist programs and services experience ongoing difficulties securing government funding and support (Broom, 1991), and remain on the periphery of the health care system. The BID program, instead, draws on a mainstream social marketing approach to health promotion that is embedded in wider systems of institutional organization and support.

A number of observers have pointed to the inexorable links between health promotion and other cultural processes in contemporary consumer societies (Nettleton and Bunton, 1995; Bunton and Burrows, 1995; Glassner, 1995). In particular, Bourdieu (1984) examines the relationship between health, lifestyle and consumption, suggesting that lifestyles are "patterned assemblages of different goods" which function as "markers of social difference, or distinction" (Bourdieu, 1984, cited in Nettleton and Bunton, 1995: 49). Thus, "health now forms part of lifestyles which in turn are shaped by the consumer culture in which we live" (Nettleton and Bunton, 1995: 49), so that "health, self-identity and consumption are increasingly entwined" (Bunton and Burrows, 1995: 210). However, the construction of identity in contemporary consumer societies is tied not only to consumption, but also to the body, because in contemporary societies bodies are increasingly used as "markers of distinction" (Bunton and Burrows, 1995: 212) or symbols of identity. Thus, the enterprise of the self is also predicated on the idea of "the body as a project" (Bunton and Burrows, 1995: 212). While the BID workers attempt to disentangle health from bodily

aesthetics through the rationalistic discourse of health promotion, the extent to which these are closely entwined in contemporary societies presents a critical dilemma for health promotion in this area. More specifically, health promotion and the commercial promotion of body maintenance increasingly echo and reinforce one another. 'Health' practices like those promoted by the BID program are intrinsically linked in western societies to the "idea of the body as a commodity that can be reshaped according to fashion" (Petersen, 1997: 1999), where images of 'health' and 'body image' have become inseparable (Nettleton and Bunton, 1995: Glassner, 1995). As Glassner (1995) notes, images of health and body images promoted by the beauty industry are often analogous and become a means of communication of status and group identity. However, this 'aesthetisation' of health in consumer culture focuses most specifically on producing coalescence between health and the maintenance of *female* body aesthetics, where 'appropriate' body weight represents "but one element in a normative system that combines feminine appearance, health, and behaviour" (Spitzak, 1990: 36). The BID program's attempt to disentangle health from its aesthetic meanings is, therefore, "fettered by other powerful cultural forces also at play at the same sites of consumption" (Bunton and Burrows, 1995: 210). While BID workers acknowledge the power of vested interests in maintaining practices that create negative body image and the pursuit of thinness, the extent to which these are productive of identity is not acknowledged, nor is health promotion understood to be a cultural artefact that participates in wider cultural processes itself.

The use of social marketing to address a problem that is in part a function of marketing therefore represents a crucial dilemma for the BID program. Because consumer healthism is so dominant, it "all but engulfs the specificity of health promotion" and "drowns out any independent efficacy health promotion discourse might have" (Bunton and Burrows, 1995: 210). The nature of health 'products' also renders their marketing problematic. Most successful marketing uses "floating signifiers" with deep cultural significance, such as youthfulness and glamour, to sell products (Nettleton and Bunton, 1995: 55). It is difficult to market less "sexy" products (Pamela) such as 'self-acceptance', 'diversity of body size' or 'natural eating' in these ways. By its nature, then, health promotion cannot hope to compete with consumer capitalism and is unlikely to successfully challenge the excesses of consumer healthism based on body aesthetics. However, a collaborative social marketing rationality dominates the BID program to such an extent that other health promotion approaches are marginalised. This is most clearly illustrated through the BID workers' reticence to challenge the weight loss industry through legal channels. An attempt to regulate harmful products acknowledges that there is often a conflict of interest between consumers and producers

(Bunton and Burrows, 1995), such action falling completely outside the marketing paradigm. Instead, the approach to health promotion used in the BID program is complicit with consumer culture to the extent that it seeks more effective marketing of body maintenance practices. In this way, then, health promoters constitute what Bourdieu (1984) calls the 'new cultural intermediaries' who do not have contact with the individuals they seek to change but are "party to the creation and marketisation of a certain way of living" (Bourdieu, 1984, cited in Nettleton and Bunton, 1995: 49).

While the BID program can be seen as promoting a form self-management that is complicit with consumer culture, even more problematically, the dictates of contemporary consumer capitalism produce "an unstable, agonistic construction of personality" based on the contradictions of consumption and production (Bordo, 1990: 97). This is because while constantly "besieged by temptation" as consumers, as producers individuals must also resist over-indulgence through the "regulation of desire" (Crawford, 1985: cited in Bordo, 1990: 97). Within this context, "bulimia emerges as a characteristic modern personality construction" that is inherently unstable (Bordo, 1990: 97). Thus, "contradictions of the social body" in contemporary consumer societies "make self-management a continual and virtually impossible task" (Bordo, 1990: 88). The task of self-management is particularly problematic for women because "the axis of consumption/production is gender-overlaid [...] by the hierarchical dualism which constructs an uncontrolled, appetitive, bodily 'female principle' that is in direct opposition to a controlled, masterful 'male will'" (Bordo, 1990: 105). As noted earlier, the BID program's emphasis on self-management as the central defining feature of 'the health promoting self' reproduces in a hierarchical way this idealisation of male will as autonomy and control and repudiates feminine-defined characteristics of negative emotion and lack of bodily control. In a similar way to psychiatric treatment intervention, this leads to a reproduction within health promotion practice of the gendered double-bind structuring eating disorders and associated practices of body management (Bordo, 1990). It is ironical to promote self-care through gendered forms of disciplinary body management as a solution to body image dissatisfaction and disordered eating when the pursuit of the thin female body itself represents a quest for self-mastery and the ascendancy of the 'male' over the 'female', and dissipates the possibilities for critical reflection and resistance to these disciplinary techniques.

Summary

This chapter has demonstrated that health promotion workers construct intervention around the paradoxical idea that individuals are simultaneously active *and* passive, autonomous *and* socially determined/dependent, and that this is a function of the individual/society dualism underpinning a multidimensional approach that does not come to grips with the divergent premises of individual and social change. This culminates in a dichotomous approach to health promotion structured around the contradictory aims of strengthening individual autonomy and a controlling paternalism. Furthermore, I showed how the dominance of social marketing discourse in health promotion workers' accounts is based on an idealisation of a masculinised notion of the self-controlled, self-caring individual and a derogation of the feminised body and its desires, ultimately contributing to the reproduction of the gendered disciplinary techniques implicated in eating disorders and body image dissatisfaction. I also demonstrated that a social marketing approach to health promotion dissipates resistance so that individual change and a recalibration of the market that produces body image dissatisfaction become the only goals of intervention.

It is positive that the BID program has broadened the range of health care interventions in the area of body image and eating disorders to include a focus on prevention as well as treatment, and on social as well as individual change. However, rather than challenge the socio-cultural processes that produce eating disorders and body image dissatisfaction among women, the program actually reproduces the dualistic gender-double bind which structures female body management practices. The following chapter will examine health care practices which are positioned as 'alternative' to dominant treatment models and approaches to prevention, with particular attention to their potential for overcoming the practice dilemmas associated with dominant intervention paradigms, particularly the reproduction of an inherently contradictory, irreconcilable femininity.

Chapter 12

Counter Discourses and Practices: Power and Agency in Mental Health Care

Introduction

In this chapter, the ways in which a small number of health workers invoke explanatory discourses that are counter to dominant paradigms are analysed, and their effects in practice examined. Health workers using alternative approaches were located in women's health centres or worked as therapists in private practice. These health workers primarily drew on feminism and post-structuralism, resulting in different understandings of eating disorders and some innovative constructions of health care practice, including the idea of counter practices that challenge the negative effects of dominant pathologising paradigms. As noted in Chapter 1, in Australia, interest in narrative therapy based on the work of White and Epston (1989) has increased among health workers based in non-traditional health care settings. To briefly summarise the overview of narrative therapy presented in Chapter 2, White and Epston (1989) utilise the idea of 'stories' or 'narratives' around which individuals organise their lives, and draw on the Foucauldian idea of the normalising judgement of modern power to engage individuals in their own subjugation (White and Epston, 1989). These ideas are brought to the therapeutic 'conversation' by encouraging individuals to identify the "truth discourses" that are subjugating them and instances where they have resisted subjugation (White and Epston, 1989: 34). Thus, narrative therapy is counter to dominant psycho-medical approaches through its embrace of post-structural ideas of the production of subjectivity in language, its reflexivity and its rejection of humanist assumptions of selfhood.

The central themes examined in this chapter include the role of power in health care intervention, conceptualisations of individual agency, and approaches to ideas of truth and diversity in health care practice. Tensions associated with feminist and post-structural approaches are also considered, particularly the way certain assumptions about power and agency might impact on the transformative potential of counter practices. Because the number of health workers using alternative approaches is relatively small, explanatory discourses and constructions of therapeutic and preventive practice will be examined in the same chapter.

Counter-Explanations and Social Determinism

Health workers using feminist and post-structural ideas were cautious about universalising the meaning of eating disorders. For example, when asked how she understands eating disorders, Elizabeth relies on a woman's own definition:

....I would probably define [an eating disorder] in the way that a woman defines it to me, that would be one of the first things. So if someone described themselves as having difficulties or issues around food, or they might even name themselves as anorexic or whatever, that's how..... I mean I'd probably take the definition of the woman around the issue...[.]...I would probably see [.] an eating disorder, broadly, as someone who has issues that are related to, you know, anorexia, bulimia or there's some stuff about inability to accept their size or issues around weight...[.]...how they feel about their body, and how they see themselves, how they perceive themselves, which is often not necessarily what I would see.

(Elizabeth. Social worker)

This account avoids universalisms, and is based on a feminist valuing of subjective experience (Stanley, 1990) through centring a woman's own perspective. The psychiatric categories of anorexia and bulimia are kept at a distance through the idea that the woman's experiences are only "related" to them, rather than contained and delimited by them. In line with this, eating disorders are seen through relatively loose constructs, such as 'having difficulties with food', an 'inability to accept one's size', 'feelings about the body' and 'self-perception'. When asked to describe eating disorders and their origins, Andrew also avoids universalisms:

....I think what's called eating disorders are a range of different experiences. [.]...I'm a little bit wary of global theories...[.]...that contribute to the interpretation of other people's lives rather than consulting them...[.]...but that doesn't mean I don't have some ideas about it, but I'm still wary of any sort of global pronouncements about any experience that people consult me about.....

(Andrew, Social worker)

Andrew also validates the subjective by placing an emphasis on clients' experiences and perspectives, and the category of "eating disorders" is used advisedly and described broadly. Irene uses a similar approach:

.....in a context where I sort of come across people who [...] either [...] identify themselves or someone around them identifies [an eating disorder]..... [...]....my understanding of it is based on other people's understanding of their experience.....

(Irene, Social worker)

In addition, Irene characterises the practice of drawing distinctions between eating disorders and body image problems as reflective of psychiatry's concern with differentiating individuals and their experiences from one another. Her refusal to categorise individuals according to authoritative, expert knowledge is also a refusal of dominant pathologising discourses.

An emphasis on client rather than worker knowledge, and on the idea of multiple subjective experiences of eating disorders, is consistent with a feminist approach, and with a post-structural repudiation of notions of absolute truth and a valuing of diversity (McNay, 1992; Rabinow, 1984). Furthermore, Elizabeth, Andrew and Irene are all social workers, a discipline that has historically placed a premium on the idea of client centred, or "person-centred", perspectives and interventions (Payne, 1997: 178).

Another way that health workers challenged a pathologising view of eating disorders in their explanations was through a focus on the social, rather than the individual. In the next extract, Irene explains how her emphasis on the "social context" of eating disorders avoids pathologising:

....I guess I tend to try and look at the origin in a wider sort of social context rather than on an individual level, because I think with a number of these sorts of things it's really problematic to look at why a particular individual, um (sighs) [is] struggling with issues to do with eating because I think [...] what that opens up is a whole possibility [...] in terms of pathologising and very negative descriptions of a person. And I think probably in my head

I'm more likely to see that these things come in to a number of different people's lives and it's not a reflection of their strength or weakness or, you know, none of those things. I think it's helpful to understand these kinds of experiences.....[as] more like it's part of culture and that it happens to some people for a variety of reasons that I don't fully understand. So I guess [...] the origin....I then see [eating disorders] as societal [in] origin, and it's to do with attitudes, particularly attitudes toward women in the wider society....

(Irene, Social worker)

To emphasise the social aspects of eating disorders, and their gendered nature, is presented as resulting in a counter-explanation that challenges the damaging effects of dominant individualising approaches. The question of why eating disorders happen to some women and not others becomes secondary within this conceptualisation, then, and not central in the way it is in multi-causal models based on humanist and biological theory. Andrew also looks to social processes to explain eating disorders, but draws more explicitly on a Foucauldian analysis of the "self-policing" effects of "modern power":

.....the [Foucauldian] analysis has do with modern power and to do with the normalizing judgment of life. So the extent to which modern systems of power recruit people into a whole range of acts, self-policing, self-surveillance. You can look at [...] precise documentation of all sorts of inputs and outputs in your life, including weight, but not just that, and [...] it can become very rigorous, incredibly rigorous, and a very cellularising [sic] life and [...] so I think that the whole notion of body disempowerment [...] as an effect of modern power can be very helpful as sort of like a back drop.....

(Andrew, Social worker)

Here, the behaviour of individuals is seen to be reflective of the self-disciplinary effects of modern power, so that practices understood to reflect internal psychopathology in psychiatric discourse are given a social meaning. Andrew's emphasis on the idea that practices of self-surveillance are "dis-empowering" is most consistent with the earlier ideas of Foucault where, despite an assertion that power is diffuse and

productive, its depiction is often "monolithic" and "repressive" (McNay, 1992: 38). Andrew elaborates further the way in which he understands modern power to operate in eating disorders:

Andrew: It's clear that women struggle more with what are called eating disorders and I think this...[.]...has to do with the interaction of traditional structures of power and modern power. So the power relations of gender and so on are very much a part of this. And I guess they're more traditional structures of power and so I think that in some ways we can see modern power and the more traditional structures coming together and [in] some ways the traditional structures of power rely on modern power more and more.

Nicole: When you say the traditional structures of power in relation to gender power relations, could you explain for me your understanding of that?

Andrew: I'm talking about power relations of domination and, you know, the power relations that are often referred to as the structures of patriarchy, the institutions of gender....

Nicole: The structural inequalities between the genders?

Andrew: Yeah, yeah. And everything that is ordered to maintain those structural inequalities, you know, the construction of women's lives and men's' lives differently and the emphasis on the body for women....[.]... I think that boldly coercive practices [.] still exist but [.] it's getting increasingly difficult for people to justify them. And so I think that the power structures are now relying upon in some ways, not in any conscious way, [.] modern power [.] because it has such an effect of engaging people in policing their own lives according to its norms.....

(Andrew, Social worker)

In this account, eating disorders are understood to be products of the coalescence between "traditional" and "modern" power, where the former relies on the latter for its efficacy in engaging individuals in their own surveillance and discipline. This conceptualisation is, again, more in line with Foucault's earlier thinking, because the individual is granted only limited agency in relation to a power that operates in one direction only within the practices of an eating disorder itself. This results in a determinism where the individual is relatively passive, and is based on a formulation of power as only negative and oppressive (see McNay, 1992). There were other examples where determinism structured the accounts of health

workers' using counter discourses. For example, Elizabeth also implicates "patriarchy" in pressuring women to make themselves attractive to men:

Elizabeth: It's part of popular culture that women should be a certain way to be attractive to men, yeah, so that it's more oppressive for women....

Nicole: And that then explains why eating disorders are more common in women?

Elizabeth: To me it does, yeah, yeah, patriarchy generally helps out, I think, there! (laughs).

Ah, but it's interesting 'cos it's also what you were saying before, that stuff about self-surveillance, so it's like um there's levels where women are so much more conscious of themselves in ways that men aren't, so that could lead to, you know, initially something that's reasonable in terms of going on a diet and it can be come hopeless for a whole range of reasons.....

(Elizabeth, Social worker)

Unequal gender power relations result in male-determined requirements for physical attractiveness in women, where power is specifically conceptualised as an entity men possess and women do not, which operates in a top-down and repressive way. I do not wish to elide the existence of gender power relations here, nor their relevance to eating disorders. Instead, I am drawing attention to the fact that power is understood in one way only, that is, as residing in the hands of men and not women, and as having negative and repressive effects, one of which is eating disorders.

A similar positioning of women as oppressed by unequal gender power relations occurs through feminist discourses linking sexual abuse and eating disorders. Overall, thirteen health workers involved in the study identified sexual abuse as a cause of eating disorders, with most locating it as one risk factor within a wider reductionist multi-causal framework. However, Elizabeth characterises eating disorders as a direct legacy of sexual abuse, and as a central cause, using feminist ideas to situate it within the context of wider gender power inequalities:

....I suppose I'd almost define [eating disorders] at times as something that can be self-harming. Yeah, so it might come out in a self-harm type way, particularly if you're working

around [sexual] abuse issues...[.]...you know, sort of like a punishment behaviour. Often you hear women talking about it in terms of maintaining control, so what they do or don't eat, or how they do it [.] which might be linked more broadly to other issues rather than necessarily just a focus on eating...[.]... it might be actually more about control issues....[.]...and then there's probably others [for whom] it's not self-[harm], it is a form of control or discipline, like it comes into that whole discipline [thing].....undeserving generally of life, taking up space, that sort of stuff. So women wanting to be small and ...[.]...not sexualized in any way.....

(Elizabeth, Social worker)

The idea that eating disordered women are re-enacting on themselves the abusive treatment associated with sexual abuse, or self-disciplining themselves because sexual abuse has taught them they are “undeserving”, is again based only on a negative understanding of power. In response to a question about why sexual abuse might lead to negative practices of self-harm, Elizabeth explains further:

Nicole: Why do you think [women who've been sexually abused] are trying to harm themselves?

Elizabeth:....well I think it probably fits into a few things.....lack of self-worth, lack of esteem, it probably feeds in to that, you know, the ideal woman stuff around “If I can present a particular image then people won't know how bad I am”, that sort of stuff...[.].....I reckon that [.] really broad societal stuff is linked to....it's sort of reaffirmed by abuse of any sort, 'cos you've got all those messages about that you're not OK as you are, or that you don't deserve anything other than abuse and so they're really linked with societal messages about the ideal body anyway, or the ideal woman and, you know, what her body should look like....

(Elizabeth, Social worker)

Socio-cultural messages about female thinness are seen to resonate with the messages of sexual abuse because both are underpinned by an assumption of women as inherently unworthy. Elizabeth is not arguing that all eating disordered women are sexually abused, though, because she emphasises

elsewhere that in the particular client group she sees in a women's health centre there is a strong link between sexual abuse and eating disorders (the centre where Elizabeth works is widely recognised for its work with women who have experienced sexual abuse). Nevertheless, the construction of eating disorders as continuing self-abuse produces women as victims within a meta-narrative of gender abuse, based on a negative formulation of power. Furthermore, the effects of abuse become internalised as a totalising experience with globally negative effects on individual women. Again, I do not wish to undermine the idea that sexual abuse involves a relatively unambiguous form of gender power, and that its effects are often extremely negative and problematic for individuals (see Scott, 2001). However, it is possible to also look to its *productive* effects, just as it is possible to look at the productive aspects of eating disorder practices, and this may help produce additional conceptualisations of women other than as victims. I must point out, though, that through my experiences as a practitioner in the women's health centre in which Elizabeth is based, I am aware that there is also a focus on ideas such as 'surviving' sexual abuse and the productive ways women use these experiences in their lives, which is common to feminist approaches to sexual abuse (Scott, 2001), and these ideas are actively translated into therapeutic encounters.

There were five other health workers, all closely associated with eating disorder support groups, who shared aspects of the de-pathologising approach described above. Melissa, Sarah, Patricia, Christina and Jennifer also present eating disorders and body image as linked experiences, emphasising shared their socio-cultural roots and the importance of de-pathologising them. However, each of these workers also situates eating disorders within a wider multi-causal framework, identifying pre-existing psychological or biological vulnerability as triggered by socio-cultural processes. Thus, these health workers all provide reductionist accounts of eating disorders based on essentialist notions of the individual and the body. In contrast, the accounts of Elizabeth, Andrew and Irene are distinctive because they do not draw on humanist or biological discourse, with its essentialist and reductionist tendencies.¹

¹ It is notable that none of the health workers participating in this study drew directly on the early feminist theorisations of eating disorders, with their humanist assumptions of selfhood and emphasis on the mother-daughter relationship (that is, Orbach, 1986; Lawrence, 1984; McLeod, 1981; Chernin, 1985). Within feminist and other more alternative therapeutic settings, narrative therapy, with its post-structuralist assumptions, appears to have superseded these earlier theorisations. Where support group workers drew on psychodynamics in addition to feminism and post-structuralism, they did not incorporate a feminist theorisation of the relationship between mother and daughter which was so central within early feminist theories of eating disorders.

The Problem of Power and Agency in Counter Explanations

The accounts of Elizabeth, Andrew and Irene offer understandings of both eating disorders and body image dissatisfaction that are counter to dominant multi-causal frameworks structured around the inherent individualism of humanist and biological theory. Instead, these accounts situate eating disorders and body image in a socio-cultural context that avoids universalising about the subjectivity of women, and places value on their subjective and potentially diverse experiences. However, a focus on the idea of eating disorders as products of negative gender power involves a number of dilemmas. Firstly, it fails to explain why many women do not develop eating disorders in western cultures, a point also noted by Hepworth and Griffin (1990) in relation to early feminist theories of anorexia. Secondly, the conceptualisation of power as having only negative and repressive effects locates women as non-agentic, their actions no more than power effects resulting from complete "body dis-empowerment" (Andrew). This results in a 'victim discourse' not uncommon in certain types of structural feminism (McNay, 1992), with its deterministic conceptualisation of the relation between individuals and society. A dualistic focus on either the individual or the social as the origin of eating disorders therefore extends individual-society dualism across the explanatory discourses, where dominant multi-causal models centre one, and counter discourses the other. In both, women are understood to be essentially devoid of agency within the practices of eating disorders themselves. While the latter avoids transposing cultural processes onto individual women, an emphasis on the idea of eating disorders as effects of repressive gender power, and a lack of attention to the productive aspects of power, nevertheless produces a meta-narrative that is associated with a series of particular power/knowledge effects. The following section examines how the conceptualisation of power as negative becomes manifest in counter practice.

Counter Therapies: Truth, Determinism and Diversity in Practice

Alternative approaches to therapy were distinctive from dominant psychiatric treatment paradigms and sought to challenge their pathologising effects in a number of specific ways. These included an emphasis on client centred-ness and empowerment, a situating of individual experience within a wider social context within therapy, and use of a range of narrative therapy techniques such as "externalising" and attending to "anti-information", "resistance" and "contradiction". A central way in which health workers presented their therapeutic practice as counter to dominant treatment paradigms was through the use of techniques which aim to reduce the power/knowledge effects within intervention. While Andrew argues that acknowledging

the power relation between workers and clients does not mean he is not "influential", he suggests that it is possible for practitioners to be "de-centred" in the therapeutic relationship:

I'm always acutely aware of the fact that I'm male in this context and [...] I would be very concerned that I couldn't come to the centre of this work. So just in these sort of explorations I get increasingly decentred in these conversations... [...] It doesn't mean that I'm not influential but I'm decentred.... [...]....there's always a power relation and that doesn't go away. I think we can do lots of things to try and check that power relation. We can monitor it and we can find ways of reducing the differential and we can also become more accountable to the possible toxic effects or hazardous effects of that power relation.

(Andrew, Social worker)

To acknowledge and attempt to reduce the potential power effects associated with the authoritative position of the health professional, and its peculiarly gendered nature in the case of male professional and female client, contrasts sharply with the way male psychiatrists in this study underscored their authority through the idea of the father/psychiatrist. Instead, Andrew attempts to place women and their knowledge, rather than himself, at the centre of the therapeutic process and in control to some extent. Elizabeth seeks to reduce power/knowledge effects by starting with women's perspectives, rather than her own:

Well I guess.....from the start it would be not me placing a definition of what I think the problem is on the person. So that's very much that feminist approach I suppose, exploring with the person, the woman, what's going on, getting as much information as possible...

(Elizabeth, Social worker)

Elizabeth goes on to describe a process where she is trying to "reduce power all the time":

I say to them [...] "If I say things to you that really resonate with you, follow those up, but if other things aren't useful then that's fine too. I'm not suggesting that what I say you should take on"... [...]....and I suppose in some ways what you're trying to do is reduce the power all the time, knowing that there will always be a power differential anyway. So even if you

reduce it you've still got power 'cos you're the worker and you don't [offer] any disclosures, or not major disclosures because I'm sure they'd find that really boring. But I think it's also that thing about trying to be real, trying to be a real person so that I'm not an expert, you know, I'm not objective, that's actually not possible but I have some expertise that I can share with them, and I would actually be really clear about what models would inform me.....

(Elizabeth, Social worker)

There is a repudiation of the idea of the health worker as "expert" and, instead, deference to the client's sense of what is important. The worker also attempts to behave like "a real person", rather than setting herself up as an "objective" and distant authority figure. This carries to potential to produce a quite different relationship between practitioner and client, and is obviously counter to dominant psychiatric practices where professional knowledge is authoritative and patients are encouraged to accept the expert's view of their disorder, while their own knowledge is distrusted as a function of illness.

Another technique commonly used by workers drawing on feminist ideas involves drawing attention to the commonality of women's problems. For example, Irene tries to connect women to each other, and to the "politics" of "body image", as part of a "non-pathologising" approach:

.....I would describe my approach as sort of non-pathologising wherever possible....[.]....and as non-individualizing, so wanting to sort of step women into or step people into connection with other people's experience and into the sort of politics of what I think [.] the ideas around body image are about.....

(Irene, Social worker)

The assumption that women's experiences are similar and share common roots is counter to the psychiatric emphasis on the intrapsychic and the distinctly individual nature of eating disorder psychopathology (although, somewhat contradictorily, there is a universal conceptualisation of the nature

of this pathology within psychiatric discourse). Elizabeth also emphasises the importance of placing individual experience in a social context and linking women's experiences:

.....It's a bit like the language that narrative [therapy] uses... [.]... it's co-authored or "There's a whole range of people involved in this problem in your life"... [.]... so you'd be looking at not just the individual, looking at structural stuff... [.]... so they're not just some individual who's got this problem. It's making the broader links about demeaning images in society or the expectations of women in society.....[I get responses] like "Oh, so its not just me?" and it's like "No, I've spoken to a lot of women that have had similar [experiences]", ... [.]... [it's] totally re-affirming.. [.]... it's unique for that woman, however, there may be similarities with other women and [.] we all live in a certain type of society..... [.]..... certainly it's useful to see the linkages among women... [.]... to develop [an] understanding that there's a lot of similarities rather than the difference that they might perceive.....

(Elizabeth, Social worker)

Elizabeth emphasises "similarities" rather than "difference", in line with a feminist emphasis on the commonality of women's gendered experiences. This approach is reflective of feminist-style consciousness-raising and, while there is acknowledgement of "unique" experience, women are nevertheless bound by shared experiences of gender oppression. While making links between women's experiences is clearly counter to psychiatric practices that individualise eating disorders, this account nevertheless continues to centre one view of power as negative and repressive.

Using post-structural ideas more explicitly, Andrew suggests that therapy involves "conversations" that "unpack" anorexia nervosa so it becomes "an emblem for ways of living":

.....I think that whole notion of body disempowerment [.] as an effect of modern power can be very helpful as sort of like a back drop, but I'm not prepared to tell stories about that or impose that idea. I'm interested in having conversations [.] that characterize the experience of anorexia nervosa or whatever it is, and to um unpack it, you know, conversations that are

unpacking of it so that it becomes an emblem for ways of living, ways of thinking or body practice or constructions of gender and identity.....

(Andrew, Social worker)

The process of therapy is presented as one in which the socio-cultural, rather than the individual, meanings of eating disorders are revealed. Andrew then explains the effects of this approach:

.....many of the people who have consulted me, mostly women, some young men, have begun to experience some degree of alienation in relation to what they have been embracing. And I think [they] had the opportunity to experience themselves as more of an instrument of self-discipline rather than the originator of it, you know, they're the instrument of disciplinary practices [...] rather than the originators of it or the authors of it.....

(Andrew, Social worker)

Making links between individual behaviour and social processes is described as leading to "a degree of alienation" from the idea of the individual as the "originator" of disciplinary practices. While helping individuals gain a sense of themselves as "instruments" of disciplinary power is clearly counter to dominant psychiatric approaches that locate eating disorders deeply within the self, in both approaches individuals are relatively passive: within the former, individual behaviour is determined by social processes that operate only in one direction, while in the latter it is a product of illness. While the individual is granted agency and power within the therapeutic process in Andrew's account, this does not extend to the pursuit of body management practices in themselves.

The notion of individuals experiencing "alienation" from the idea that an eating disorder originates within them is linked to the narrative idea of 'externalising'. With this technique, the eating disorder is named, for example as 'anorexia' or 'bulimia', and placed outside the person as an external entity to challenge the pathologising effects of psychiatric discourse (White and Epston, 1989). In other examples of this, Irene describes "anorexia" and "bulimia" as taking "control" of a person, while Andrew talks about "anorexia nervosa and how it speaks and what it requires of young women". The technique of speaking about eating disorders as if they are external entities is carried over into actual therapeutic conversations to challenge

the idea of the person as the problem (see White and Epston, 1989; White, 1992). Health workers associated with eating disorder support groups also describe using the narrative technique of externalisation as part of their therapeutic approach. For example, Patricia uses externalisation when facilitating a support group:

Patricia: The support group is not structured, they're open membership, so people drop in and drop out all of the time. We're really, really conscious of some [...] of the [tactics] of eating disorders that come into the room with people around comparison, around pedagogy, "I'm not as bad as her, I'm too big, I don't fit here 'cos there's a few more people who have eating disorders around here". So we find that some narrative ideas really help us in gate keeping safety and [placing] boundaries around the group.

Nicole: How do you use those ideas to do that?

Patricia: Well, I guess we name some of the tactics that the eating disorders can have people doing....

Nicole: Externalizing?

Patricia: Yeah, we externalize that stuff, you know, externalize just some of those tactics, and how they have [...] an impact on the group, how they may have an impact on us, how they impact on society and how that impacts on the group, so we name some of that stuff and we encourage the group to name it eventually.

(Patricia, Community worker)

Within this approach, the "tactics" of "eating disorders" become associated with an external entity, rather than the individual herself. In the following extract another health worker, Melissa, gives an example of client externalizing an eating disorder:

I was reading through a file recently...[...] I was giving a talk and I wanted to compare someone who can externalize the eating disorder...[...]...and someone who can't, and it was the same client and she used to write me letters...[...]...it was [...] a therapeutic thing for her, when she needed to she'd just write stuff down...[...]...and I found a letter from around the time that I was first seeing her and then one a year later, and the first letter was saying

things like "I am so gross, oh, my thighs they're disgusting and I ate this today and I'm going to start a diet tomorrow. Why can't I get the will power to lose weight?" And then there was another letter (laughs) a year down the track and it was so angry...[.].....she was very angry, full of "F" words but she was talking to the eating disorder.....

(Melissa, Counsellor)

While there is potential for the individual to wrest back control from the eating disorder in this account, power nevertheless lies with a reified external entity to which the individual is completely subject when in the grip of an eating disorder. The following account from Jennifer also demonstrates this idea:

I externalise the problem. I talk about the kinds of invitations...[.].....I try and reframe [.] the notion of anorexia and bulimia...[.].....often young women will say to you they do feel really good, they do feel like they're in charge of it, and they don't particularly want anyone to take it away, or they've got war in their head going on about that. So I talk about anorexia nervosa being a bit of a con merchant coming into a young woman's life and it masquerades as having something to offer her....

(Jennifer, Social worker)

Young women are tricked by "anorexia nervosa", and their sense that "they do feel really good, they do feel like they're in charge of it" is revealed to them to be false and promulgated by a "con merchant". Young women's versions of their experiences are consequently dismissed in a not dissimilar way to the psychiatric assumption that their claims are only a function of illness, and young women are once again dupes of an entity more powerful than themselves.

Christina takes the technique of externalisation a step further through the drawing of an analogy between an eating disorder and a "violent partner":

...what I often do is interview somebody [who has an eating disorder] as though they were a woman or a person who's in a relationship with a violent partner, and I actually have a person who comes and does this with me when I do a talk...[.].....and I interview her around

all of those [...] tactics she used and the difficulties in applying those tactics against this perpetrator and why she was paralysed for so many years and how it was unhelpful when people came up to say [...] "Well, where's your self respect? Just leave", you know, but he's got a gun at her head. Well, people with anorexia nervosa and bulimia nervosa have an invisible gun at their head, "If you eat that this most terrible thing is going to happen".....

(Christina, Counsellor)

In this account, the eating disordered woman is positioned as a victim of abuse, a prisoner of "anorexia nervosa and bulimia nervosa". Once again, the eating disorder is located externally, which counters to some extent the pathologising effects of dominant psychiatric approaches. However, women are instead located in another extremely powerless position as hostages of a violent external entity. The following extract demonstrates further the way in which women become victims in this account:

....I would say that anorexia, you know, externalizing it, if it had a voice [it would be] like a big scary monster sort of thing. All it did when I was anorexic was say "There you are, that's a good girl, you've done it again". And if I stepped out of line "Don't you dare step out of line, don't you dare, you'll get fat. You won't be the right kind of person". And it wasn't just a way a way of looking, I mean the skeletal body is a language, a powerful, powerful language that like cutting and scratching, which is commonly associated with sexual abuse. Seven out of the ten women I see have been sexually abused. That's my finding over seventeen years... [...]....I interview a lot of my women who cut and scratch and burn and self-mutilate, and what else [but self-abuse] is taking a box of laxatives, or bingeing to the point that you're so much in pain, and then vomiting, which is a very, very painful experience... [...]...they're all forms of denigration and abuse of the body, self-abuse of the body.....

(Christina, Counsellor)

Anorexia is a metaphor for abuse in this account - a "language" which is tied to experiences of sexual abuse - where 'the self' abuses 'the body' in a dualistic way as a canvass for self-loathing. Self-abuse is therefore driven by negative emotions associated with sexual abuse, where the individual becomes not only a victim of her abuser but also of herself. Unlike Elizabeth, however, Christina does not draw on a

feminist analysis of gender power relations as the context within which the related experiences of sexual abuse and eating disorders occur. Furthermore, while Christina shares the concern of other non-psychiatric therapists to de-pathologise eating disorders, her dramatic portrayal of the intra-psychic dynamics of an eating disorder paints a fairly totalising, pathological picture of a damaged and desperate victim. Somewhat paradoxically, in attempting to subvert the pathologising effects of psychiatric discourse, here, externalisation reproduces some of the de-powering aspects of the illness narrative.

Another technique associated with a narrative approach, and linked to the strategy of externalisation, involves identifying “anti-information” and “resistance” within women’s accounts of their experiences. For example, Irene’s anti-pathologising approach includes looking for opportunities to provide “alternative information” that maximizes the individual’s sense of “agency” and challenges the fatalism of psychiatric approaches:

..... some of the [...] ideas around anorexia are almost like addiction ideas, you know, like you're either addicted to food or [...] there's ways that really pathologise it, "Lets look at genes for anorexia or eating" or whatever, and I think they're really problematic because [...] they're very.....fatalistic in that there's no possibility for change and personal agency, personal choice is really sort of minimized in those views..[...]... it's actually [...] a sickness or something that you don't have very much power about. So I think on a smaller scale I'd look for opportunities to provide anti-information or alternative information to the pathologising information I don't think is helpful. I would look for [...] times when they might be critical of some of the body image stuff....

(Irene, Social worker)

Irene presents anti-pathologising information as empowering because it enhances agency. However, while the individual is granted agency in analysing eating disorders in the context of therapy, and in resisting them to some extent in their day-to-day lives, they are not granted agency in having adopted body management practices in the first place. Again, this is based on the idea of eating disorders as

products of oppressive cultural processes in which women exercise no agency. In the next extract, Irene explains further the way she works with the concept of 'resistance' in therapy:

.....[with] people that have been struggling with [eating disorders] for a while you also have a realm of information about times when bulimia wasn't in her life or wasn't as strong. So that's really useful therapeutically because what that is [is] a whole realm of information about when she's been able to exclude bulimia and anorexia from her life. So that I would use, you know, in therapy....

(Irene, Social worker)

Irene argues that this approach is based on "Foucauldian" thinking:

....[it's] quite a Foucauldian idea actually, in terms of, you know, where there's power there's resistance. So I guess that I would identify more closely with the those sorts of post-structural ideas than [narrative] therapy [in particular]...[.]... and so that resistance is really important in the work and really important as a feminist. I guess feminist ideas about women and a belief in women and so [.] there's opportunities to look at questions of, you know, how she's resisted anorexia or bulimia and that's then useful in terms of her experience....

(Irene, Social worker)

In this account, eating disorders are a product of "power", and the notion of looking for "how she's resisted anorexia or bulimia" is based on the Foucauldian idea that power produces both compliance and resistance. However, because eating disorders are described only as effects of the operation of repressive power on women, they become defined only as compliance. Irene goes on to elaborate further, through a specific case illustration, the way in which the idea of eating disorders as effects of repressive power is carried over into practice:

....you [.] have to be able to say "What happened recently that made bulimia come back when it had been away?". [And that] was really useful and it was to do with and abusive relationship with a boyfriend. And that was the opportunity to step into a more political view

of what happened so that [...] anorexia or bulimia [...] in this case is very much sort of partnered the boyfriend in his denigration of her and was very opportunistic. Anorexia and bulimia are very opportunistic to get in and then take control. And I guess that's a kind of narrative way of talking about it which is to externalize it in that kind of way, and so... [...]...her recognition of the abuse meant that [...] given that she'd left this relationship [...] through the conversation, through the therapy [she] was able to talk about it as abusive [and that] really gave her a sense of her own desire to not have that relationship nor bulimia in her life and sort of set her on that path.....

(Irene, Social worker)

In a similar way to Christina, an analogy is drawn between the controlling effects of "bulimia" and the experience of relationship abuse. While an emphasis on a "political view" of eating disorders is clearly counter to psychiatric approaches, the individual is a victim of dual forms of repressive power to which she is beholden, and agency comes only in choosing "to not have that relationship nor bulimia in her life". Again, the eating disorder is reified as an active and powerful entity with a will outside the woman's own to which she is completely subject within the practices of the eating disorder, while agency is to be found only in acts that resist eating disorders.

In the next extract, Andrew provides further insight into the way he externalises "anorexia nervosa" through the process of therapy, and his emphasis on identifying instances in the individual's life that "contradict" it:

Andrew: I think anorexia nervosa becomes 'other' in the course of these conversations. So I think that's a big change and as I've said they would have the opportunity to express other expressions of life, you know [...] that come from outside but they're present in the person's life and to try and figure what these other expressions speak to, you know, they're expressions that often, often contradict so much of [what] these emblems, anorexia and so on, [are about].....I guess, you know, [...]people have the opportunity to engage in the prefabrication of their life, and that's an active process.....[.]....

Nicole: OK, that hints at something I wanted to ask you because I have a sense that a lot of traditional therapies almost encourage the person, facilitate the person in writing a new truth about themselves. So that doesn't sound too like what you're saying.

Andrew: Yeah. Well, I'm sure that's a little bit more of the same really. I'm a little bit wary of actually reproducing in the name of therapy the very same the same sorts of understandings of life that I think are the context for so-called eating disorders. So I'm a [.] lot more interested in conversations and practices that open up the possibility to explore other knowledges and skills of life and to have the opportunity to monitor the effects of those other knowledges and skills of life, you know, to be able to have some conversations that contribute some consciousness of the extent to which people are involved in the production of their own production, even if it's in terms of other ways of living that open up more opportunities out there in the world...[.]...And I think it's more to do with the abandoning of truths than [.] the subscribing to a new one, in the name of humanism or whatever, because I think humanism is part of a context of this anyway, part of the context of eating disorders.....

(Andrew, Social worker)

Therapy is presented as an opportunity to identify "other expressions of life" that contradict eating disorders, where individuals are actively involved in the "production of their own production". In response to a clarifying question, Andrew argues that therapy should be about "the abandoning of truth" rather than the establishment of alternative truths about the person, because this would be part of the humanist project which he sees as implicated in eating disorders in the first place. This account outlines an approach to therapy that is counter to humanistic therapy because it advocates the development of awareness of the socially constructed nature of subjectivity, and the extent to which individuals are active in this process. However, while there is a dismissal of notions of truth, there are also places in Andrew's account where the therapeutic process is described as if it contributes to the development of new truths

about the self. For example, in the next extract Andrew's describes young women as making "new identity claims":

.....in this work [it is] the young woman that's consulting me... [...]... they come up with new identity claims and words that I would never have arrived at. And I guess I'm there to ask the questions and I think about you know providing the scaffolding through therapeutic conversations... [...].....it's not my role to come in with the identity conclusions or or even for that matter to be imposing knowledges about ways of living.

(Andrew, Social worker)

While the process of arriving at different identity claims challenges pathological 'truths' about the self, the notion of "identity conclusions" implies a fixing of subjectivity that sits uncomfortably with Andrew's earlier emphasis on the complete abandonment of truth. It is not clear from these accounts the extent to which the identification of contradictory or alternative identities functions simply to challenge dominant truth claims and garner a sense of the multiple self-production of subjectivity, or to provide the individual with a new, more empowering identity. The latter runs the risk of falling into the humanist trap of constructing a new 'real' self, rather than forestalling closure and leaving room for the constant production of identity.

As noted earlier, while there is an emphasis in Andrew's account on the idea that the individual is actively involved in the production of subjectivity, his account also centres a structuralist conceptualisation of power with its inherent determinism. In the next extract, Andrew gives some insight into the way in which he approaches the development of subjectivity through the description of a specific therapeutic interchange:

..... when we get to understand a little bit about [...] anorexia nervosa and how it speaks, and [...] what it requires of a young woman in various ways, it seems [to me] that [this young woman's action of telephoning] an old school friend is a bit of a contradiction [to the social isolation required by anorexia]. So I get interested in that. I mean this doesn't fit with this other overall plan, what does it fit with? I mean, what would be a name for this? So there's some effort to name it, you know, like "It doesn't really fit with this other agenda of your life

[.] which is a more isolating agenda, so I'm just wondering what it fits?". So there's an opportunity for some naming of it. It might be "Well I guess it's having my life", I don't know, or it might be might be something like "making an appearance [.] in the social world".....

(Andrew, Social worker)

Andrew looks out for contradictions to "anorexia nervosa", and then encourages the young woman to give such actions a name as a way of bringing them into the light and contrasting them against the practices of anorexia. This is reflective of the Foucauldian concept of 'difference', which is based on the idea that individual experience is determined by multiple social relationships that produce differential effects and different subject positions for individuals, as well as the idea of resistance (McNay, 1992). Andrew continues describing how he worked with contradiction in this particular case:

.....then I say "Well I'd like to ask you a few more questions about how you managed to take this step in terms of the forces that you're arraigned against". But I've got an idea that maybe someone else played a hand in [encouraging the young woman to phone her friend], you know, and I actually I suspect that the mother's played a part because I figure "Well this young woman would have to find a number or this school friend would have moved probably because this is like five years down the track and she'd be twenty-three, so how did.....?" So I figure that maybe the mother's played a part in this so I can say "Look, I've got a bit of an idea that someone else might have played a part in this." And the mother starts apologizing and saying "I know I shouldn't have done this and [.] this is exactly what [the psychiatrists] were telling me. This is something that I just can't let go and [.] I've got to reform but it's so hard when your daughter's [.] just so sad and isolated". And I say "Wait, wait, wait, wait". I turn back to the daughter and say "Look I'm just wondering, you said this was to do with having a life or making an appearance or whatever it is. Are you saying this was a development that [.] you think to be positive or negative in your life? Where do you stand on that?" "Well I suppose it's kind of positive". "So you're telling me that your Mum joined with you in taking the step that was for your life?" [.] and the daughter looks at her Mum and said "Well, yes".

(Andrew, Social worker)

Andrew continues by outlining his response to the information that the mother and daughter joined together against anorexia nervosa:

So I say, "Wow, I'm just wondering if I can hear more about the history of your connection with each other? I know there've been ups and downs and I don't want to put a gloss on this, but I'm wondering if I can ask you some questions about the positive aspects of your connection with each other and how those served both of you. I'd like to get to know what that's made possible". So this [...] contributes to the mother totally breaking from this pathologising because she's involved in a conversation in which she's also talking about how her daughter's contributed to her life as a woman and this undoes that.....

(Andrew, Social worker)

This example demonstrates the way pathologising truths about "anorexia" and the mother-daughter relationship can be challenged in the therapeutic conversation. While the young woman's mother assumes encouraging her daughter to telephone a friend is part of the problem in line with psychiatric conceptualisations of the controlling mother, the therapist helps to re-frame this act as one of positive connection between women that challenges the tactics of "anorexia". A new meaning is therefore given to actions that were obscured by pathological understandings of eating disorders and of women. This is not as fixed as drawing a new identity conclusion, and succeeds in finding diversity and complexity in individuals' lives in a way that has the potential to challenge and unsettle pathologising constructions. However, in common with Irene's account, resistance and contradiction are found only in actions that can be interpreted as 'anti-anorexia', and not in the practices of the eating disorder itself. While individuals are understood as involved in the production of themselves in theory and within actual therapeutic processes, anorexic practices themselves are conceptualised only in a deterministic way as an effect of oppressive power.

This contradiction is also present in the 'official' account of narrative therapy. Thus, while White and Epston (1989) state that they draw on the Foucauldian concept of power as productive, there is an emphasis on the idea of the normalising judgement of modern power to engage individuals in their own

subjugation (White and Epston, 1989). Descriptions of work with individuals experiencing anorexia similarly involve an emphasis on identifying "anorexia" as the source of practices such as self-monitoring, and on the idea of resistance as actions that are "anti-anorectic", and which become the "preferred version" of self (White, 1992: 114). This leans toward the idea of a "new" identity conclusion, and runs the risk of fixing subjectivity, more than the accounts given by health workers in their interviews.

Contradictory Therapies

The diversity characterising the explanatory accounts of health workers involved in eating disorder support groups is also reflected in their approaches to practice. More specifically, while Patricia, Melissa and Christina use narrative techniques such as externalisation in their therapeutic interventions, they also draw on other approaches that lead to a number of practice contradictions. For example, Patricia simultaneously uses a psychodynamic approach, focusing on the individual's need to "build better boundaries" around herself. This is clearly tied to her earlier explanation of eating disorders as a function of identity confusion and weak boundaries around the self. Individuals are therefore positioned in two contradictory ways in practice: through narrative techniques, the disorder is placed beyond them and into a culturally produced entity, while within psycho-dynamics, the disorder is a function of internal psycho-emotional deficiencies that require an intra-psycho resolution. In one formulation, the individual is in the grip of an entity external to herself, in the other she is in the grip of repressed emotions that arise from deep within her.

Melissa draws on "Jungian theory" in addition to narrative techniques, placing an emphasis on "the reality of feelings" and the ways in which individuals "disown aspects of [them]selves". While this is understood as a cultural process, it nevertheless posits an *a priori* self that pre-exists culture, where therapy involves 'evoking' repressed feelings as part of a process of self-discovery. Like Patricia, this results in a contradictory positioning of individuals in relation to the eating disorder in practice, where it is at once outside and separate from them, *and* deeply internal.

Lastly, Christina uses other therapeutic approaches that contradict the narrative principle of reducing power/knowledge effects in therapy and client centred-ness. For example, Christina had recovered from an eating disorder herself and positions herself as "miles ahead" in terms of her knowledge and

experience in this regard, often taking an educative approach in therapy. Christina's account is therefore distinguished by a simultaneous deference to client experience *and* a positioning of herself as an authoritative expert on that experience based on survivor pedagogy.

In addition to one-to-one and group therapy, Christina has also established and continues to run an inpatient treatment program that is counter to the bed rest programs used in major public hospital eating disorder units. She describes her approach in the following extract:

Christina: [Clients] have beds that they can stay in but they can come and go and they can decide to crash in their bed if they want to, they're up and about they're mobile.....[.]....

Nicole: They're not restricted to the bed like they are [in other programs]?

Christina: No, no. I mean there are basic rights, we're looking at client rights, and I don't even call them a client, but people who are keen to learn something about themselves, so then they're interested. I'll present them with a whole range of ideas that are from the spiritual context, the physiological context, the dietary context, political, social and invite them in to add their own case notes to also help to draw their own program. I've got a basic sort of skeleton key program which includes the dietary side where I offer them....[.]....they usually jump at this one, "Oh goody, if I come into your [program] you're not going to make me gain weight."

Nicole: Oh OK.....that's important?

Christina: It's very important for them

Nicole: Because they so much don't want to gain weight?

Christina: No they don't want to gain weight, and the deal is that we're going to try and keep you stable. We'll teach you how much food you can really eat 'cos that's something you don't know, you don't know how to maintain your weight, you know how to lose, you know how to gain, but you have no idea of how to maintain.....

(Christina, Counsellor)

This program is clearly counter to bed rest programs in psychiatric units, with its emphasis on weight maintenance rather than weight gain, patient involvement in designing programs and freedom to be

mobile. However, it also sits within Christina's wider intervention that simultaneously centres both client and worker experience. Christina is an ex-patient of a traditional eating disorder unit and describes her program, in part, as a response to negative experiences of paternalising psychiatric treatment. The survivor pedagogy that characterises her approach is particularly interesting in this context because, like paternalising psychiatric approaches, both rely on an expert discourse. In a complete contrast to psychiatric approaches, though, Christina valorises the individual's struggle through the idea of eating disorders as a "rite of passage", and offers a positive perspective on the prospects for recovery. This program therefore provides an important alternative to the paternalistic aspects of bed rest programs, but because it is available only on a private basis, access is restricted to those who can afford to meet the associated costs or who have private health insurance.

In addition to the fact that each of the workers using diverse explanatory discourses and practices has strong associations with eating disorder support groups, other than Jennifer, each of these workers also revealed that they had experienced an eating disorder themselves. These two factors may in part explain the complex nature of their accounts, and the way they attempt to incorporate high levels of diversity into their practice approaches. Firstly, the eating disorder support groups place an emphasis on client choice about treatment, and refrain from taking a fixed position on a preferred treatment approach. They also place a premium on ensuring that scarce inpatient and outpatient resources remain viable, further reinforcing a reticence to be aligned with any one particular treatment paradigm. Secondly, they are critical of the pathologisation of eating disorders and pursue a patients' rights agenda, resulting in an open-ness to anti-pathologising approaches such as narrative therapy and feminism. Lastly, their own experiences of eating disorders, and of treatment, brings a further layer of understanding that is likely to influence their approaches, most overtly in the case of Christina. While drawing on diverse techniques in therapy may sometimes be beneficial, when they derive from approaches with fundamentally contradictory assumptions about personhood and subjectivity, the opportunities for resisting dominant pathologising paradigms and practices may become unintentionally compromised by the individualism and gendered contradictions underpinning humanist conceptualisations of self.

Tensions in Counter Practice: The Problem of Power and Agency

Counter discourses and practices involve a problematisation of agency in eating disorders that seems similar to the problematisation of autonomy and control in humanist accounts. However, humanist discourse, with its ideology of gender neutrality and contradictory assumptions about femininity, is replaced in alternative accounts by the idea that lack of agency derives entirely from reduced access to power, rather than from within individual women themselves. Alternative approaches also succeed to some extent in challenging the dualistic and contradictory approach to femininity that characterises dominant psychiatric paradigms by valorising, rather than pathologising, female connected-ness through the practices of linking women and celebrating connections such as those between mothers and daughters. Through externalisation and searching for contradiction and resistance, narrative therapy is an important counter-practice that resists dominant psycho-pathologising paradigms, involving a more genuine attempt to maximise women's agency in therapy that contrasts with duplicitous efforts to control it within psychiatric intervention. However, because agency is narrowly conceptualised as actions that are 'anti-anorexia/bulimia', this nevertheless results in an attempt to influence behaviour in a particular direction. Furthermore, while post-structuralism treats subjectivity as multiple and diverse, and power as productive and diffuse, the explanatory accounts of health workers drawing on these ideas tend to centre a negative conceptualisation of the operation of power in eating disorders. This derives from the emphasis on a feminist meta-narrative about the oppressive effects of "patriarchy" and "structural" gender inequality at the expense of other post-structural ideas of 'difference', and the notion that individuals are also actively engaged to some extent in their own production (McNay, 1992). This parallels the one-sided nature of Foucault's earlier examinations of power relations from the perspective of power, rather than from "the view of those subject to power" (McNay, 1992: 39). Thus, while there is a theoretical acknowledgement of ideas of 'uniqueness' and the 'self-production of self' by health workers using post-structural and feminist ideas, a negative view of power over-determines similarity at the expense of difference.

The very structure of a research interview that seeks to draw out truth claims, definitions, and theories of causation to some extent sets research participants up to explain eating disorders in a more definitive, over-arching way than they might approach them in practice. However, a centring of the idea of power as negative and repressive also imbues constructions of counter-practice. While health workers using alternative ideas made significant efforts to minimize power/knowledge effects within the therapeutic

relationship, and make therapy responsive to multiple subjectivities, resistance and contradiction, the narrative technique of externalisation reproduces a positioning of eating disordered women as non-agentive victims of repressive power, generating only one version of subjectivity. Again, this underscores similarity at the cost of difference, potentially obscuring other contradictory meanings and experiences. The way Jennifer dismisses young women's empowered experiences of eating disorders as products only of the 'false consciousness' of "anorexia" is an example of this. The conceptualisation of counter-intervention exclusively in terms of 'anti-anorexia' might therefore run the risk of producing resistance as an unintended power/knowledge effect.

The tendency to centre the idea of women as victims of repressive gender power reduces the potentially complex and diverse understandings of the meaning of female body management practices in the context of health care intervention. In contrast, Foucault's later work on the ethics of the self has the potential to counter this negative approach to subjectification through greater sensitivity to difference and individual agency within social constraints (McNay, 1992). Foucault's concepts of 'difference' and 'ethics of the self' therefore have the potential to act as a corrective to totalising, universalising discourses (McNay, 1992), and provide a redefinition of experience from the perspectives of those who are usually simply the objects of theory (Sawicki, 1991). In line with these ideas, some post-structural feminist analyses provide more complex insights that go beyond the one-directional idea of eating disorders as products of gender oppression, without eschewing acknowledgement that unequal gender power relations are nevertheless important. For example, Malson (1998) draws attention to women's experiences of anorexia as productive of multiple, contradictory subjectivities and femininities, while Bordo (1990) demonstrates a range of meanings associated with gendered body praxis, including the idea that anorexia can be understood as a form of resistance *in and of itself* to a traditional, passive femininity and a reproductive destiny. While these insights are made in the context of academic research rather than the provision of health care, they nevertheless show how a focus on eating disorders as negative gender power effects diminishes the complexity of women's behaviour and its cultural meanings. I am not suggesting that eating disorders represent a positive lifestyle choice. Women's testimonies attest to the difficult struggle of eating disorders, and the punitive character of many of the practices (Malson, 1998). However, this analysis demonstrates that a more dynamic understanding of the way in which women might also be understood as discourse *users* (Parker, 1992), as well as discourse instruments, within the practices of eating

disorders themselves is required to develop more diverse understandings of their often contradictory meanings in the context of health care intervention. The concluding chapter of this thesis will examine these ideas further as part of identifying directions for feminist-informed health care practice.

Finally, the health workers involved in narrative and feminist approaches also typically present their practice as a fundamentally rationalistic enterprise where intervention takes place only at an intellectual level, while the body remains noticeably absent from accounts. In contrast, Melissa and Christina talk about using ritual and the emotions in therapy, and Melissa mentions the use of dance, art, music and massage. An exclusion of the body in feminist and narrative approaches is particularly significant when the focus of intervention involves practices that very much centre on the physical body. Furthermore, women's accounts of eating disorders often emphasise the emotions, drawing links between their management and control of the female body (Malson, 1998). Therapies based on feminist and post-structural ideas as they are presented here somewhat paradoxically follow the humanist tradition of engaging the mind and excluding the body, running the risk of failing to take account of the extent to which eating disorders involve 'body praxis' (Bordo, 1990), and potentially bypassing opportunities for forging new meanings around the historically pathologised female body and the feminised emotions.

Promoting Critical Thinking and Social Action

In this section, health workers' accounts of alternative approaches to the prevention of eating disorders are examined, with particular attention to the ways in which subjectivity and power are construed. Preventive counter-practices took a number of forms, including: promoting notions of size diversity; the promotion of critical media analysis skills; feminist social action, and; the fostering of "anti-anorexia" and "anti-bulimia" in the wider community.

The promotion of diversity of size was emphasised as a key approach to prevention by a number of health workers. For example, Jennifer argues that it is important to "tackle society's prescription for women" through activities such as "No Diet Day". Elizabeth and Christina describe a network of health workers and women from the community who focus on the promotion of "size acceptance". This network has been active in the annual "No Diet Day" and other size acceptance media promotions in a challenge to the promotion of dieting and the thin female body image. As was pointed out in discussion of the BID

program's activities in this area, it is difficult to market less 'sexy' ideas such as 'size acceptance', while products that can be associated with idealized notions of beauty and social success are much more amenable. Seeking diverse portrayals of women and an anti-diet philosophy are obviously important counter-points to the relentless promotion of a thin ideal for women, but it is extremely difficult to compete with the vested interests of global consumer capital and its embrace of aesthetic healthism using the very marketing techniques it has developed for these purposes.

Two health workers using alternative explanations and practices propose an approach to prevention that is similar to the marketing of self-care within the BID program. For example, Patricia argues for a focus on promoting "healthy body image" through "educating the health professionals" and "gym instructors". Like in the BID program, there is an emphasis on the idea of promoting 'nurturing' self-care rather than negative, non-nurturing practices associated with the pursuit of thinness. Melissa places an emphasis on the idea of individuals "making informed choices about dieting" that are "not attacking the [weight loss] industry", and the promotion of "self-esteem" through acceptance of feelings. In a way not dissimilar to the BID program approach to self-care, self-acceptance is seen as leading to "resilience" to eating disorders based on the assumption that if you look after yourself properly, you won't fall prey to loss of control. These approaches reproduce the dilemmas identified in the previous chapter in terms of the reproduction of a self-disciplinary ethic and a gendered valorisation of humanist notions of autonomy and self-control.

Some health workers also suggest the idea of promoting critical thinking as another method of preventive counter-practice. For example, Patricia emphasises the importance of eating disorder support groups providing space for young women to critically discuss "eating and having body configurations of one size", while Sarah argues that there needs to be an emphasis on teaching young girls skills so they can "critically assess the media". Robyn talks about promoting critical media skills among young people so they can "challenge the advertising mentality and [...] challenge society" through the realization that images are fuelled by a profit motive. Elizabeth describes undertaking critical media analysis with young women who are "assaulted " by images of thinness and weight loss. She argues that such work could lead to "social revolution" in relation to cultural expectations around weight and body image. The goal of promoting critical thinking, as health workers present it, is therefore to foster resistance to consumer culture and its prescription for women, premised on the idea that media prescriptions will lose some of

their power when their manipulative techniques, contradictions and profit motives are revealed. While encouraging critical analysis could be illuminating and empowering for young people, if it is undertaken in the spirit of persuasion that certain behaviours are risk-filled, which characterises much contemporary health promotion (Petersen, 1997), its transformative potential may be undermined. An approach that centres a participatory ethic, with mutual interpretation and analysis, is therefore most likely to avoid unintended power/knowledge effects and would offer an alternative to the more paternalistic, non-participatory approach of the BID program.

In a more direct challenge to the marketing of thinness, some health workers emphasise the idea of feminist social action. Elizabeth describes a feminist group that monitors and responds to “demeaning images” of women in the media. In some Australian states, these groups deface billboards that they consider to be offensive, and register official complaints about advertising that objectifies women as bodies. There have been instances where these actions have resulted in advertising being removed, and the state government in Victoria has actually drafted guidelines around sexist advertising in response. In a similar vein, Helen, a psychiatrist, argues that more could be done in “legislating against promoting certain images for women and [in] promoting weight loss regimes and diets”, suggesting that this needs to come from “consumer groups and women [taking] more control”. These more confrontational approaches to change contrast sharply with the BID program’s consensus-oriented marketing style, resisting rather than accommodating the objectification of women and the promotion of practices considered harmful.

Finally, Irene talks about connecting women to “the [Anti-] Anorexia League” as a way of taking “politicised conversations” about eating disorders into the community. The “Anti-Anorexia League”, now known as the ‘Anti-Anorexia, Anti-Bulimia Archive’, was established ten years ago by narrative therapist, David Epston. It now operates as a web-based archive providing access to women’s autobiographical accounts of resistance to eating disorders and, through this, promoting “anti-anorexia” and “anti-bulimia” in the broader community (Epston, 2000).

The Anti-Anorexia, Anti-Bulimia Archive extends into the public realm the narrative technique of externalisation. The aim of this project is described on the web site as fostering resistance to eating disorders based on the idea that the person is not the problem, and celebrating the overcoming of

'anorexia' and 'bulimia' (Epston, 2000). The introductory texts are steeped in the language of military-style resistance that is envisaged as leading to "a movement that will operate both under- and above-ground to conscientiously object to, resist and repudiate anorexia/bulimia" (Epston, 2000). As in therapeutic uses of externalisation, eating disorders are reified, sometimes even demonised, in the introductory web site text as external entities with active wills to which women are subject. Epston is clearly passionate about the struggles of the clients he has worked with, and the site has an almost evangelical zeal, for example, through the description of women as having "defied evil and reclaimed their innocence" (Epston, 2000). In common with therapeutic uses of externalisation, power is only conceived of as acting in a one-directional fashion within eating disorders themselves, and resistance is conceptualised only as actions deemed "anti-anorexia" or "anti-bulimia". While the archive nevertheless provides an important source of different ideas about eating disorders in the public domain, their demonisation inadvertently produces a victim discourse similar to that identified within therapeutic uses of the technique which, again, is paradoxically similar to that associated with illness narratives. The missionary zeal with which the site is introduced also betrays a very particular view about what does and does not constitute resistance, potentially obscuring other meanings and experiences of body management practices. However, only an examination of women's autobiographies could reveal the different ways the idea of "anti-anorexia" is actually used, potentially representing a useful direction for future research inquiry in this area.

Reconciling Feminist Social Action and the Concept of Difference

Feminist forms of social action that challenge the objectification of women's bodies, and the associated promotion of thin female body images, are predicated on the idea that these practices represent one aspect of wider gender oppression. They are also underpinned by an assumption of shared experience and interest, as well as a social justice ethic in demanding redress. However, as was demonstrated earlier in examination of health workers' explanatory accounts, a centring of a meta-narrative of gender oppression tends to position women as victims of repressive power. While a feminist emancipatory politics needs to be able to situate women within an understanding of the more over-arching structures of power, it also needs to be sensitive to difference in order to avoid the tendency of some feminism to "regard women as powerless and innocent victims of patriarchal social structures" (McNay, 1992: 63). It is important, then, that narratives explaining gender power relations in eating disorders, and actions that seek to challenge their operation in practice, leave room for multiple interpretations of experience and

action. For example, a Canadian eating disorder prevention program mentioned in Chapter 3 was based on feminist principles of empowerment and collective action, and post-structural ideas of the mutual production of knowledge, sought to guide the change process in a ballet school (see Piran, 1998). While the individual level of change was over-emphasised in this program, it nevertheless leaned towards an interactive process “where institutions and communities become transformed as people who participate in changing them become transformed” (Wallerstein and Bernstein, 1994; 142). Individual and social change can therefore become tied together as one dynamic process based on the idea that “the outer is reproduced in the inner”, and that “social structures become mental ones” (Gottlieb, 1984, p.107, cited in MacSween, 1993, p.81). While such an approach goes some way towards finding a balance between a feminist emancipatory agenda and post-structural ideas of multiplicity and difference, it also succeeds to some extent in breaking down the historical divisions so graphically illustrated in this study between health care practices considered “therapeutic” and those considered “preventive”. Indeed, it is only in the accounts of health workers using feminist and post-structural ideas that there is a linking of the therapeutic and preventive through ideas like the Anti-Anorexia, Anti-Bulimia Archive and women’s involvement in social action, where ‘therapy’ is seen as having a political function, and social action a ‘therapeutic’ one.

Dilemmas in Counter Practice

Finally, interviews with health care workers using counter discourses and practices also explored the nature of dilemmas encountered in practice from the point of view of the practitioners themselves. The main practice dilemma emphasised by health workers was their positioning in relation to psychiatry. In particular, Christina says she has been accused of “conspiring with anorexia” and branded “unprofessional” by senior psychiatrists based in the unit in which she was once a patient. Elizabeth says she is dismissed by psychiatric staff as a “pseudo-professional”, and is seen as “over-involved” and “emotional” in her advocacy role for clients receiving treatment in the eating disorder unit. Melissa describes being highly strategic in putting a non-pathologising view when dealing with clients in common with practitioners using more traditional psycho-medical discourses. Jennifer describes a level of discomfort with the controlling nature of bed rest programs in the psychiatric unit in which she works. While her own work under the auspices of this unit appears to occur in parallel with paternalistic psychiatric treatment, her approach actually involves many practices that run counter to the dominant pathologising paradigm. The different approaches used in the treatment and prevention of eating

disorders therefore appear to operate in relative isolation from each other, and some of those working with alternative models describe resistance to their involvement from health professionals operating within psychiatric settings. While this study demonstrates a level of reflection and change *within* psychiatry itself, it seems there is a level of resistance to ideas and practices perceived as arising from outside the discipline, and outside medical institutions in community settings that lack power and authority.

Inter-subjectivity in the Research Process

As was noted in Chapter 4, I shared many of the assumptions of health workers employing post-structural and feminist approaches to practice. This had two interesting corollaries. The first is that health workers using post-structural ideas were reticent to make generalisations about eating disorders. This presented a research dilemma for me because my purpose was, in part, to uncover concepts in order to critically analyse them for their truth claims. Because the research participants were also wary of producing absolutism and closure, and shared my concerns over the power effects of knowledge, they avoided participating in the creation of truth, thereby 'sabotaging' this aspect of my project to some extent. This represents a tautological dilemma in that research questions that are based on a post-structural epistemology which seeks to deconstruct 'truth' become inherently problematic when participants are informed by similar principles themselves. In anticipation of this dilemma, I had reframed my questions prior to interviews with these workers so that it would be more possible for them to 'speak' without necessarily making universalist, realist claims. For example, I asked how they "conceptualise" or "understand" eating disorders rather than how they "define" them, and what they believe their "origins" to be rather than their "causes". However, it is clear that each of these workers, particularly Irene and Andrew who most consistently use post-structural theory, found themselves called upon to universalise, to some extent, by the nature and structure of the questions asked. A more overt positioning of research participants as actively involved in constructing *and* interpreting social realities, and a more inter-subjective approach to analysis *within* the research process, may have overcome this tension to some extent (see, for example, Stanley, 1990). While this research study acknowledged inter-subjectivity and the idea of the mutual production of knowledge, my analysis occurred outside interview processes and, so far, has not involved the participants.

The second consequence of the fact that I shared many assumptions with health workers using alternative discourses and practices is that I found the process of critically analysing these health care workers' responses worked to transform and extend my own understandings of post-structuralism and feminism, and the implications of this are examined in the following concluding chapter.

Summary

This chapter outlined important innovations in the development of health care practices that are counter to dominant psychiatric treatment paradigms and humanistic health promotion prevention programs. These primarily draw on feminism and post-structuralism, and centre the idea of eating disorders as effects of repressive gender power, rather than as forms of psychopathology, both theoretically and in practice. While there is also attention to post-structural ideas of difference, resistance and contradiction in health workers' accounts, an emphasis on a negative conceptualisation of power at the expense of its productive effects results in a tendency to position eating disordered women as de-powered victims, obscuring other understandings of their experiences. In line with more recent developments in feminist thinking, it is imperative that ways are found to situate women within overarching structures of power that are also sensitive to difference. In this way, then, more empowering approaches to both therapy and social action might be forged. The concluding chapter examines the contributions of selected feminist theorists that seek to re-conceptualise questions of women and agency, briefly discussing examples of feminist research into eating disorders which aim to elaborate their productive aspects, and examining the implications of these ideas for feminist-informed health care practice.

Chapter 13

Conclusion

Feminism, Power and Agency: The Positive Paradigm and Feminist Praxis

This thesis has critically examined the wide diversity of theoretical explanations and health care interventions used in the treatment and prevention of eating disorders. This has included the main psycho-medical theories and psychiatric treatments, the approach to health promotion within a major body image dissatisfaction program, and alternative explanations and approaches to therapeutic and preventive intervention informed by feminism and post-structuralism. In this final concluding chapter, I summarise the main points arising from this analysis, and signal future directions for overcoming some of the dilemmas associated with current approaches to health care intervention in this area. I also describe the transformative effects that involvement in this research study has had for me in terms of extending my understandings of the implications of feminism for post-structuralism, and of post-structuralism for feminism, and the consequences of these insights for feminist-informed health care.

Psycho-Medicine and the Reproduction of Gender

The critical literature review of psycho-medical approaches to eating disorders undertaken at the beginning of the thesis initially identified the operation of gendered assumptions about individual autonomy and self-control within dominant discourses of eating disorders in the psycho-medical literature, particularly psychodynamic and psychobiological explanations. Analysis of health workers' explanations of eating disorders and their approaches to practice confirmed that psychodynamic and psychobiological theories remain dominant, and provided insights into the specific ways gendered assumptions operate within the context of current contemporary intervention. I demonstrated that a focus on the internally located and supposedly gender-neutral construct of identity obscures the profoundly gendered and contradictory nature of the discourses used to construct the subjectivities of women with eating disorders. I showed how the supposedly gender neutral construct of identity renders eating disordered women deficient in the masculinized ideal of selfhood, reproducing an ascendancy of masculinized autonomy over feminised deficiency, which ironically reproduces the discursive double bind that has been widely implicated as structuring eating disorders themselves (for example, Bordo, 1990; MacSween, 1993).

Next, the gendered assumptions underpinning health workers' ideas of the related construct of 'self-control' in eating disorders were examined. I showed that health workers' accounts of sexuality in anorexia and bulimia draw on gendered notions of female sexuality as simultaneously passive and out of control, resulting in a re-inscription of a dichotomous sexuality. The second way that self-control became central within explanations of eating disorders was through the construct of 'emotion'. Here, health workers drew on supposedly non-gendered psychological theories that rely on masculinized notions of rationality that equate emotionality with dysfunctionality and psychopathology. In common with theories of identity, health workers constructed 'self-control' through supposedly gender-neutral discourses that pathologise the feminine and serve both to obscure the gendered meanings of eating disorders, as well as re-inscribe gendered dualisms that have been implicated in causing eating disorders in the first place.

Following on from the analysis of the ways in which health workers' understandings of subjectivity in eating disordered women are gendered, the thesis turned to an examination of the wider aetiological framework within which these ideas are situated. I demonstrated that a 'multidimensional' model of the causes of eating disorders remains dominant at the current time and that, despite its claim to multiplicity, biological and psychological reductionism results in cause returning to the individual. I also argued that multidimensional models reduce the social from an interpretive perspective to a 'risk factor', rendering gender invisible because it is only relevant as the risk factor of 'sex'. In common with psychological theories of identity and control, multidimensional models of causation assume a pre-social, 'gender-neutral' individual, and therefore cannot account for the specifically gendered nature of subjectivity and how this might influence health. Thus, multidimensional models only explain why particular women develop eating disorders, rather than why women in particular develop them. Furthermore, psychodynamic and psychobiological theories work in concert with multidimensional frameworks so that the feminine is pathologised in covert ways under cover of an ideology of gender neutrality.

The thesis then turned to an examination of the ways in which gendered ideas about eating disordered women operate within psychiatric intervention. I demonstrated that a contradictory positioning of the anorexic individual as simultaneously autonomous *and* externally controlled, and active *and* passive, underpins health workers' constructions of bed rest intervention, and that this reproduces, in practice, the gendered approach to autonomy and control that distinguishes explanations of eating disorders. Next, I showed that while psychiatrists' accounts of psychotherapy emphasise the development of authentic

autonomy and self-control, this is augmented by peculiarly gendered, controlling practices that seek to de-power women within a father/psychiatrist-daughter/patient dynamic, with a particular focus on controlling sexuality. In a similar way to constructions of bed rest intervention, controlling psychotherapeutic practices result in a conflicted approach to individual autonomy and control in the therapeutic setting, reproducing once again the discursive 'double-bind' of femininity. I also argued that the more overtly controlling nature of bed rest intervention conflicts with the stated aims of psychotherapy, reflecting a multidimensional approach to treatment where interventions primarily targeting the body are relatively separate from those targeting the mind. I also pointed out that while some psychiatrists demonstrate awareness of the contradictory nature of different aspects of psychiatric intervention, there was little awareness of its gendered flavour.

To summarise, psycho-medical explanations of eating disorders privilege the individual as the source of disorder, and employ gendered conceptualisations of selfhood that idealise masculinised autonomy and self-control, and pathologise feminine connected-ness and emotionality. Treatment interventions essentially reproduce a dualistic approach to autonomy and control, employing peculiarly gendered forms of paternalism that undermine the psychotherapeutic aims of self-development, and reproduce the gendered dualisms implicated in causing eating disorders in the first place.

Health Promotion and the Dissipation of Resistance

Moving on from a focus on treatment, I next examined health workers' approaches to the prevention of eating disorders. I demonstrated that clinical practitioners' focus on early detection and intervention as the central approach to the prevention of eating disorders reproduces dilemmas associated with dominant psychiatric treatment paradigms. In particular, screening and case detection reproduces the position of women as objects of surveillance; extends techniques of surveillance and control to a wider section of the female population; and, fails to challenge the de-powering effects of conventional therapy. I also demonstrated that because psychiatrists' and other clinical practitioners' conceptualisations of primary prevention focused almost exclusively on health education, eating disorders were marginalised as an inappropriate target for intervention based on the idea of 'doing more harm than good'. Instead, 'body image dissatisfaction' became the focus of primary prevention.

I also examined the approach to health promotion within a body image dissatisfaction program, based on the premise that health promotion principles, such as a social view of health and the encouragement of community participation and empowerment, might offer an alternative to the gendered contradictions and controlling paternalism of psycho-medicine. In a similar way to psychopathological constructions of anorexia and bulimia, supposedly gender-neutral psychological theories were used by BID workers to construct body image dissatisfaction as a 'women's problem' through gendered assumptions about emotionality as equivalent to irrationality and lack of self-control, and an idealization of masculinized autonomy and self-control. At the same time, socio-cultural explanations were used to characterise body image dissatisfaction as an essentially culturally situated problem with individual elements.

The BID program is distinctive from the health promotion programs examined in the literature review of approaches to prevention for its focus on social as well as individual change. However, rather than challenge the socio-cultural processes that produce eating disorders and body image dissatisfaction among women, the program actually reproduces the dualistic gender-double bind structuring female body management practices in the first place, and dissipates the possibilities for resistance. This occurs through its reliance on social marketing and an uncritical perspective on the extent to which health promotion is complicit in wider cultural processes. It is significant to note that while I have critiqued the BID program for its uncritical use of a mainstream marketing approach, the program has been de-funded since the interviews with BID workers took place. During interviews, BID workers cited resistance to their program from more traditional, disease-oriented health promotion. It seems that a program positioning itself as 'positive' and 'health promoting' could not survive in a field that is primarily concerned with the prevention of disease.

Narrative Therapy, Feminist Praxis and the Focus on Repressive Power

Lastly, the thesis examined the potential of alternative intervention paradigms, based on post-structural and feminist principles, to challenge the gendered contradictions and individualised focus of other practice paradigms. In this aspect of the analysis, I argued that these approaches are distinctive from psycho-medical and health promotion approaches in a number of critical ways, challenging many of their assumptions. In particular, they centre on the idea of eating disorders as effects of repressive gender power, rather than as forms of psychopathology, both theoretically and in practice, and attempt to minimise power differentials in the therapeutic relationship. They also avoid reproducing the gendered

contradictions and hierarchical dualisms associated with psycho-medical and health promotion approaches because they completely eschew psychological theories based on humanism. However, these accounts are distinguished by a conceptualisation of power as repressive, and on the idea of negative subjectification, at the expense of other post-structural ideas of difference and the productive effects of power. This results in a tendency to position eating disordered women as de-powered victims of gender power, and potentially obscures other understandings of their experiences. In effect, what is refused in each of the explanatory and practice discourses used by health workers in this study is the idea that eating disordered women might be exercising a degree of *agency* within the practices of an eating disorder.

As was noted in the previous chapter, the fact that I shared many of the assumptions of health workers employing post-structural and feminist approaches to practice transformed and extended my own understandings. Like these health workers, while I subscribed in principle to Foucault's dual focus on the idea of the disciplinary effects of power and its productive nature, my conceptualisation also tended to emphasise the negative at the expense of the productive. Indeed, it was this emphasis that led me to frame this research study as an analysis 'from the perspective of power'. However, through the process of discourse analysis, I came to see that I shared a somewhat one-sided perspective on power with the health workers I was critiquing. This realisation led me to re-think the effects of health care intervention, and alerted me to the fact that while many traditional interventions undoubtedly seek to co-opt women into de-powered positions, they are not necessarily successful in doing so. As was pointed out earlier, the idea of resistance has long been integrally associated with anorexia nervosa, and the continued dilemmas experienced by psychiatry in treating eating disorders might be better understood as the failure of power, rather than the mark of its success. However, I believe that the idea of power as productive extends beyond the idea of resistance, so that "a more precise and varied account of agency is required" to explain how individuals and groups "struggle over, appropriate and transform cultural meanings and resources" within social constraints (McNay, 2000: 4).

Feminism, Power and Agency: The Positive Paradigm and Feminist Praxis

Over the past decade, post-structural feminists have given particular attention to the questions of power, individual agency and social change. In this final section of my conclusion, I want to briefly outline selected examples of selected feminist analysis that offer scope for re-thinking the question of agency in

eating disorders, and their implications for feminist praxis. As was noted in the introductory chapter, feminist theorists have utilised the later ideas of Foucault to analyse how dominant constructions of gender are oppressive, but do not completely determine women's experiences and actions (for example, McNay, 1992; Probyn, 1993). The feminist notion of 'embodiment' leaves room for agency because it there is "a moment of indeterminacy where the embodied subject is constituted through dominant norms but is not reducible to them" (McNay, 2000: 32). Butler's (1993) notion of the 'performative' has also provided a way of thinking about gender identity as not entirely determined or constructed. As was noted in the introduction, the performative reiteration of sexual norms is seen as indicative of their instability, and of the possibility for change through the "re-signification of the symbolic domain" (Butler, 1993: 22), leaving space for the exercise of individual agency.

McNay (2000) argues, though, that much feminist work on identity, while providing an important and powerful critique, nevertheless "remains within an essentially negative understanding of subject formation" because of its Foucauldian emphasis on the subject as a "discursive effect" (McNay, 2000: 2). She argues that this does not offer a sufficiently dynamic understanding because within this formulation agency comes to be constructed only as resistance (McNay, 2000: 2). McNay (2000) goes on to examine the potential of other post-structural theorists, specifically Bourdieu, Ricoeur and Castoriadis, for a "generative" theory of agency. To give one example, McNay (2000) argues that Bourdieu's ideas, while sharing Foucault's idea of the body as culturally inscribed, also focus on "the moment of praxis or living through of these norms by the individual" (McNay, 2000: 36). Bourdieu develops the notion of 'habitus' as "a system of durable, transposable dispositions that mediates the actions of an individual and [...] of production" (Bourdieu, 1990: 53, cited in McNay, 2000: 36). Thus, unlike the notion of disciplinary power, habitus is not determining, but is understood as a "generative structure" that is *temporal* (McNay, 2000: 38). Like Foucault, there is the idea that social inequalities are produced through the subtle inscription of power upon individuals, however, habitus is understood to generate "a potentially infinite number of patterns of behaviour, thought and expression that are both 'relatively unpredictable' but also 'limited in their diversity'", producing "an active and creative relation [...] between the subject and the world" (McNay, 2000: 38).

In addition to the discursively situated work of Bordo (1990; 1993) and Malson (1998) noted in the previous chapter, there are other feminist analyses that explore the productive aspects of the body management practices characterising eating disorders, and the place of individual agency within them.

For example, Lester (1997) continues to draw on Foucault through Probyn's (1993) appropriation of his notion of 'technologies of the self' as "an ensemble of meaningful practices" which "constitute and transform the self" (Probyn, 1993, cited in Lester, 1997). Lester (1997) employs Probyn's idea of the "doubleness" of the body as discursively produced and corporeal, which is "constituted in the doubleness of the body and self" (Probyn, 1991: 119, cited in Lester, 1997: 483). Through reconfiguring the relationship between 'inside' (self) and 'outside' (body), changes in subjectification become possible (Probyn, 1993, cited in Lester, 1997). Subjectification is described as a process where "the line of the outside is folded, and refolded against the inside along a series of 'optional' practices involved in the relation of self to self and to selves" (Probyn, 1993: 129, cited in Lester, 1997: 483). Like the concept of embodiment, this allows for "an individualised construction of the 'inside' and 'outside' without reifying the individual as a privileged site, and without cementing the boundaries between mind and body, and individual and culture, so they remain "fluid" and "flexible" (Lester, 1997: 484).

Through these ideas, Lester (1997) theorises an embodied self in anorexia, attending to both individual experience and cultural context, and thereby attempts to overcome the individual-society divide that separates the medical model of anorexia and some feminist critiques. Her research with anorexic women demonstrates that anorexia involves the *deliberate* "transformation of self" through specific bodily practices (Lester, 1997). Bordo (1993) was the first to articulate the idea that women's pursuit of thinness and rejection of fat symbolises a rejection of the feminine, that is, of emotion, and sexuality. Lester (1997) takes this idea further in arguing that the thin female body communicates the 'attitude' of the self (Lester, 1997). She argues that the anorexic woman's control over the boundaries of her body is meaningful in a context where individualism is "bound up with deep-seated, gendered categories of representation and analysis", and that the anorexic woman redefines the relationship between 'inside' and 'outside' in her "project of self-tailoring", illuminating the dynamic relation between individual and culture (Lester, 1997: 486). Lester (1997) therefore argues that agency is exercised by the anorexic woman in maintaining a "closed system" which no substances may penetrate, thereby redefining her boundaries (Lester, 1997: 486-487). While she goes on to elaborate the paradox of anorexia, in that thinness as the path to liberation becomes enslaving, what is most important in Lester's (1997) analysis is the emphasis on self-production and agency within the practices of anorexia itself and, at the same time, acknowledgement of the way outside (culture) is brought inside.

In her ethnographic research into anorexia, Warin shows how relatedness operates between individuals in a live-in treatment centre, arguing that the sense of belonging that individuals display involves “playing with agency” (Warin, forthcoming, 6). Warin shows that relatedness is reconfigured through desiring to become anorexic and desiring to be ‘the best’ anorexic, that is, the thinnest and the sickest, thereby demonstrating a high level of competition between individuals. She argues that individuals experienced anorexia as a “productive and empowering state of distinction” which, in Bourdieu’s (1984) terms, is “the distinction of symbolic power” because anorexics’ bodies publicly demonstrate “that they had not given in to ‘sins of the flesh’” (Warin, forthcoming: 11-12). Furthermore, Warin argues that, for some individuals, treatment hindered recovery because it “provided a forum for competition” (Warin, forthcoming: 13). Thus, by failing to account for the relational aspects of anorexia and the agency of anorexic individuals, treatment inadvertently undermined the possibilities for recovery.

In common with the analysis undertaken in this thesis, Gremillion (2001) demonstrates that psycho-medicine participates in a reproduction of processes that are implicated in causing anorexia in the first place, specifically through the reproduction of notions of female fitness. Through an ethnographic study in an inpatient treatment centre, Gremillion (2001) shows that patients help create and negotiate “culturally dominant understandings of subjectivity, embodiment and health” within treatment, demonstrating that “discourses of feminine fitness are not pre-given but achieved” (Gremillion, 2001: 395). Gremillion (2001) acknowledges and documents the paternalistic and manipulative nature of the treatment program, the differentials of power between staff and patients and the pressure applied to patients to comply with medical dictates, and shows that patients experience confusion and distress in response. However, she also demonstrates that ideas of feminine fitness are not simply imposed on women in treatment but, as patients, they *actively* author and destabilise notions of female fitness and control within treatment processes (Gremillion, 2001: 395). Thus, women are far from passive recipients of treatment interventions, nor merely “sites of resistance” to them (Gremillion, 2001: 395), but are active participants in cultural processes, just like the practitioners who treat them. Drawing on Butler (1993), Gremillion (2001) argues that the creation of normalised bodies “does not, therefore, occur in a top-down fashion, operating on a material reality we can assume to exist a priori” (Gremillion, 2001: 410). Thus, while there are “top-

down effects”, the processes of health care are shown to be a more dynamic form of “cultural work” (Gremillion, 2001: 410).¹

The works of Lester (1997), Warin (forthcoming) and Gremillion (2001) demonstrate in different ways the active involvement of eating disordered women in the pursuit of identities and relationships within the practices of eating disorders and, in Gremillion's (2001) research, within health care processes as well. These works therefore demonstrate the productive, generative operation of power in eating disorders, providing a balance to research, such as my own, which demonstrates the ways in which power seeks to discipline and repress. I argued earlier that alternative approaches to health care informed by post-structural and feminist ideas succeed in challenging many of the gendered dilemmas associated with psycho-medical treatment and mainstream health promotion practice through their acknowledgement of the discursive production of subjectivity. They also grant women agency in the therapeutic context through the processes of uncovering 'subjugated knowledges' about their lives. However, the emphasis on repressive power in health workers' accounts indicates that there is scope for a more balanced engagement with both the negative and productive effects of power within alternative practice paradigms. Thus, while gaining insight into the disciplinary effects of 'eating disorders' is undoubtedly powerful for individuals and challenging of pathologising discourses, it is equally important to develop approaches to intervention that overcome the individual-society divide separating current practice paradigms so that more empowering approaches to both therapy and social action might be forged.

¹ In writing this concluding chapter, it came to my attention that Helen Gremillion has just published a new book, 'Feeding Anorexia: Gender and Power at a Treatment Centre'. While this work includes presentation of the ethnographic research cited above, it also includes other analyses that share features with some of the arguments made in this thesis. For example, Gremillion (2003) draws attention to the 'maternal caretaking' that characterises in-patient treatment programs for anorexia. She also conducts a critical analysis of the scope of narrative therapy as an alternative to mainstream psychiatric treatments, and explores the question of whether 'externalising' techniques create a totalising entity that reproduces traditional ideas of power and resistance.

APPENDIX 1

DEFINITIONS, PREVALENCE AND OUTCOMES OF EATING DISORDERS

Diagnostic Criteria for Eating Disorders

Anorexia Nervosa	
<p>a) Refusal to maintain body weight over a minimally normal body weight for age and height, eg. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during the period of growth leading to body weight less than 85% of that expected;</p> <p>b) Intense fear of gaining weight or becoming fat, even though underweight;</p> <p>c) Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape of self-evaluation, or denial of the seriousness of the current low weight;</p> <p>d) In post menarchal females, amenorrhoea i.e. absence of at least three consecutive menstrual cycles</p>	<p><i>Restricting Type:</i> During the current episode of anorexia nervosa, the individual has not regularly engaged in binge-eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics or enemas).</p> <p><i>Binge Eating/Purging Type:</i> During the current episode of anorexia nervosa, the individual has regularly engaged in binge-eating or purging behaviour.</p>
Bulimia Nervosa	
<p>a) Recurrent episodes of binge eating, which is characterised by both of the following: (i) eating, in a discrete period of time (eg. 2 hours) an amount of food that is larger than most individuals would eat, and (ii) sense of a lack of control over eating during the episode</p> <p>b) Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas or other medications, fasting, or excessive exercise.</p> <p>c) The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.</p> <p>d) Self-evaluation is unduly influenced by body shape and weight.</p>	<p>e) The disturbance does not occur exclusively during episodes of anorexia nervosa.</p> <p><i>Purging Type:</i> During the current episode of bulimia nervosa, the individual has regularly engaged in self-induced vomiting or the use of laxatives, diuretics or enemas.</p> <p><i>Nonpurging Type:</i> During the current episode of bulimia nervosa, the individual has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.</p>
Eating Disorder Not Otherwise Specified	
<p>This category is for eating disorders that do not meet the criteria for any of the above and include:</p> <p>a) For females, all the criteria for anorexia nervosa are met except that the individual has regular menses.</p> <p>b) All of the criteria for anorexia nervosa are met except that, despite significant weight loss, the individual's weight is in the normal range.</p> <p>c) All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency</p>	<p>of less than twice a week or for a duration of less than 3 months.</p> <p>d) The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (eg. self-induced vomiting after the consumption of two cookies).</p> <p>e) Repeatedly chewing and spitting out, but not swallowing, large amounts of food.</p> <p>f) Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of bulimia nervosa.</p>

Source: Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, 2000)

Prevalence of Eating Disorders and Treatment Outcomes

The prevalence of anorexia nervosa in Australia has been estimated in the population as a whole at 0.4 per cent, and at between 1.6 per cent and 1.8 per cent for bulimia nervosa (Wade et al, 1996), and the prevalence of anorexia and bulimia among young women is estimated at 3 percent (Patton, Coffey and Sawyer, 2003). While these figures appear to be relatively low, prevalence estimates vary according to the strictness of operational definitions used, and the diagnostic criteria for anorexia and bulimia have become progressively more restrictive over time, resulting in progressively lower estimations. For example, the prevalence of bulimia is up to seven times higher using the APA's original definition outlined in the DSM III (APA, 1980) than that derived by using the later DSM III-R, published in 1987 (Wade et al, 1996). Clearly, prevalence rates associated with the even more restrictive DSM IV used by Wade et al (1996) are lower again. Nevertheless, it has been suggested that the incidence of eating disorders has increased over the last three decades (Killen et al, 1996; Hoek et al, 1995), and official estimations exclude what are presumed to be large number of cases that never present for treatment (Hoek et al, 1995). In addition to increasing incidence, anorexia is associated with a high mortality rate of over 10 per cent for individuals admitted to hospital in the United States (American Psychiatric Association, 1994). Both anorexia and bulimia are associated with a wide range of serious physical health problems, mainly related to starvation and the effects of bingeing and purging (American Psychiatric Association, 1994). While eating disorders were once associated with white, middle and upper class families, research now suggests they are now diagnosed more widely in all socio-economic groups (Miotto et al, 2003) and ethnic groups (Dolan, Lacey and Evans, 1990), as well as in developing nations that are taking on western values and lifestyles (Nasser, 1994; Lee, 1996). Because of their association with western-type cultures, eating disorders have been called 'culture-bound' syndromes (Lee, 1996).

The wide variation in estimates of the prevalence of eating disorders is suggestive of the difficulties involved in trying to draw a definitive distinction between those aspects of women's behaviour that are considered 'normal' and those defined as 'psychopathological', particularly when they share many similarities and are widespread. For example, it has been estimated that approximately 15 per cent of young women in the United States have 'sub-clinical eating disorders', involving practices such as dieting and purging (Abraham and Llewellyn-Jones, 1992), while Wade et al (1996) estimate that one-third of Australian women have used binge-dieting, vomiting and diet pills. It has been argued that the category of

EDNOS has been created in an attempt to recognise the variety of eating and weight control problems that exist in the community which do not necessarily fulfil the criteria for clinical eating disorders (Wade et al, 1996).

It is estimated that only 50 per cent of individuals with anorexia nervosa recover in the intermediate-term (Hsu, Crisp and Callender, 1992), and that those with chronic forms later return to anorexic behaviour (Ratnasuriya et al, 1989). The reported outcomes for bulimia nervosa are similar, with only 50 per cent of women recovering within five to ten years (Keel and Mitchell, 1997), and one third later returning to bulimic behaviour (Keel et al, 1999).

APPENDIX 2
INTERVIEW GUIDES

INTERVIEW QUESTIONS FOR PSYCHIATRISTS

1. How would you explain the causes of eating disorders?
2. How would you explain the causes of body image problems? What is the relationship between these problems and eating disorders?
3. How do you distinguish between individuals with eating disorders and individuals who are concerned about their body size and shape and who diet or purge to lose weight?
4. How would you explain the causes of eating disorders in males?
5. Why do you think eating disorders and dissatisfaction with body size are more common among women than men?
6. How would you define prevention, and how should the prevention of eating disorders be approached? What about the prevention of body image problems – how should this be approached?
7. Are there aspects of your practice that you see as having a preventive goal? If so, could you describe them?
8. How do you decide on a treatment approach for an individual patient who has an eating disorder? What is the goal of prescribing antidepressants for eating disorders? What treatment effects/outcomes have you observed? Have side effects been a problem?
9. Have you been involved in cases that have presented dilemmas or difficulties? If so, could you describe the ways in which you attempted to resolve these problems?

10. Has your practice involved any ethical dilemmas? If so, how would you describe these, and how were these resolved?

11. How would you describe health promotion, and do you see this concept as having relevance for psychiatric practice?

INTERVIEW QUESTIONS FOR HEALTH PROMOTION WORKERS

1. How would you explain the causes of eating disorders?
2. How would you explain the causes of body image problems? What is the relationship between these problems and eating disorders?
3. How do you distinguish between individuals with eating disorders and individuals who are concerned about their body size and shape and who diet or purge to lose weight?
4. How would you explain the causes of eating disorders in males?
5. How would you explain the causes of body image problems in males?
6. Why do you think eating disorders and dissatisfaction with body size are more common among women than men?
7. How would you define prevention, and how should the prevention of eating disorders be approached? What about the prevention of body image problems – how should this be approached?
8. How would you describe “health promotion”?
9. Can you describe the aims and objectives of the program you are working on?
10. Have you experienced any difficulties or dilemmas in implementing the program? Have you experienced any ethical dilemmas in working with this program? If so, could you describe these? How do you attempt to resolve these?

INTERVIEW QUESTIONS FOR COUNSELLORS AND THERAPISTS

1. How do you understand the origins of eating disorders?
2. Why do you think eating disorders are more common in women?
3. How do you understand eating disorders in males?
4. How do you approach therapy with individuals experiencing eating disorders?
5. Have you experienced any difficulties and dilemmas in therapy in this area? Could you explain these?
6. How do you understand the ideas of prevention and health promotion?
7. How might the prevention of eating disorders be approached?

APPENDIX 3

LETTER OF INVITATION

Dear

I am currently undertaking doctoral research into approaches to the prevention of eating disorders with the Departments of Public Health and General Practice at the University of Adelaide. The prevention of eating disorders has been a relatively under-explored area in terms of theory, practice and research. My thesis involves an examination of approaches to preventive health care within psychiatry and health promotion, as the key health disciplines involved in this area.

I am approaching psychiatrists such as yourself, who have specialist experience and interest in eating disorders, to invite you to participate in the study. This would involve participation in a one hour, semi-structured interview with myself, conducted at a time and location convenient to you. The interviews would be tape-recorded and later transcribed for the purposes of data analysis, and the identity of research participants will remain confidential.

Please find attached an information sheet for participants providing further details about the study. If you are willing to participate in this study and would like to arrange an interview time, or would like further information about the research, I can be contacted at the Department of General Practice, University of Adelaide, on: Tel: (08) 8303 6266, Fax: (08) 8303 3511, or by email on: nicole.moulding@adelaide.edu.au.

Yours sincerely,

Nicole Moulding

APPENDIX 4

PARTICIPANT INFORMATION SHEET

Information Sheet for Participants in the Research Study "Approaches to the Prevention of Eating Disorders in Two Health Care Settings"

This study will examine different approaches to the prevention of eating disorders and related body image problems used in psychiatric and health promotion settings. The prevention of eating disorders and related problems has been an under-explored area of health care theory and practice, with most attention to date devoted to treatment. While prevention has gained increasing attention in the eating disorder literature more recently, there has been little examination of the ways in which health care professionals involved in the area approach prevention in practice. The study is being conducted as doctoral research.

It is hoped that the findings of the study may provide further insight into the ways in which the prevention of eating disorders and body image problems are currently conceptualised and approached by health care professionals working in this area. This will provide an important basis from which to consider the further development of appropriate frameworks for preventive practice.

Practitioners involved in the study will participate in a one-hour, semi-structured interview that will be tape-recorded and later transcribed for the purposes of data analysis. The identity of participating practitioners will remain confidential, and the information provided during interviews will be used only for the purposes of the study.

If you require further information on the study, contact details of the investigators are provided below:

Ms Nicole Moulding,
Department of General Practice,
University of Adelaide, SA, 5005.
Telephone: (08) 8303 6266
Fax: (08) 8303 3511
Email: nicole.moulding@adelaide.edu.au

Dr Julie Hepworth,
Department of General Practice,
University of Adelaide, SA, 5005.
Telephone: (08) 8303 6276
Fax: (08) 8303 3511
Email: julie.hepworth@adelaide.edu.au

APPENDIX 5

CONSENT FORM

FOR PARTICIPATION IN THE UNIVERSITY OF ADELAIDE STUDY ENTITLED
"APPROACHES TO THE PREVENTION OF EATING DISORDERS IN
TWO HEALTH CARE SETTINGS"

1. I, (please print name)
consent to take part in the research project entitled:
....."APPROACHES TO EATING DISORDERS IN TWO HEALTH CARE SETTINGS"...

2. I acknowledge that I have read the attached Information Sheet entitled:
Information Sheet for Participants in the Research Study "Approaches to Eating Disorders in
Two Health Care Settings"

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research
worker. My consent is given freely.

4. It has also been explained that my involvement may not be of any benefit to me.

5. It has been explained to me that I will be given the opportunity to respond to the analysis
generated from the interview data.

6. I have been informed that, while information gained during the study may be published, I will not
be identified and my interview responses will not be divulged.

7. I understand that I am free to withdraw from the project at any time.

8. I am aware that I should retain a copy of this Consent Form, when completed, and the attached
Information Sheet.

.....
(signature) (date)

WITNESS

I have described to (name of
participant)
the nature of the project. In my opinion she/he understood the explanation.

Status in Project:

Name:

.....
(signature) (date)

APPENDIX 6

HEALTH CARE WORKERS' PSEUDONYM AND PROFESSIONAL BACKGROUND

1. William: Psychiatrist
2. Robyn: Psychiatrist
3. John: Psychiatrist
4. Eric: Psychiatrist
5. Paul: Psychiatrist
6. Rebecca: Psychiatrist
7. Robert: Psychiatrist
8. Vivien: Psychiatrist
9. Philip: Psychiatrist
10. Helen: Psychiatrist
11. Ruth: Nurse
12. Penny: Nurse
13. Melissa: Counsellor
14. Christina: Counsellor
15. Patricia: Community worker
16. Sarah: Community worker
17. Stacey: General practitioner
18. Elizabeth: Social worker

19. Irene: Social worker
20. Jennifer: Social worker
21. Andrew: Social worker
22. Pamela: Dietician – BID Program
23. Joanne: Dietician – BID Program
24. Rosemary: Fashion design lecturer - BID Program
25. Steven: General practitioner - BID Program
26. Julie: Health promotion worker - BID Program
27. Adam: Market researcher - BID Program
28. Gillian: Psychologist - BID Program
29. Clare: Psychologist - BID Program
30. Georgia: Psychologist - BID Program
31. Matthew: Psychologist - BID Program

APPENDIX 7
PUBLICATIONS

REFERENCES

- Abraham, S., & Llewellyn-Jones, D. (1992). *Eating Disorders: The Facts*. Oxford: Oxford University Press.
- American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders (Third Edition)*. Washington, DC.: American Psychiatric Association.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorder (Fourth Edition)*: American Psychiatric Association.
- American Psychiatric Association (2000). *Diagnostic Criteria from DSM-IV-TR*. Washington, D.C.: American Psychiatric Association.
- Anderluh, M. B., Tchanturia, K., Rabe-Hesketh, S., & Treasure, J. (2003). Childhood obsessive-compulsive personality traits in adult women with eating disorders: defining a broader eating disorder phenotype. *American Journal of Psychiatry*, 160, 242-247.
- Andersen, A. E. (1984). Anorexia nervosa and bulimia in adolescent males. *Pediatric Annual*, 13, 901-904.
- Auchus, M., Kose, G., & Allen, R. (1993). Body image distortion and mental imagery. *Perceptual and Motor Skills*, 77, 719-728.
- Bacaltchuk, J., Trefiglio, R. P., Oliveira, I. R., Hay, P., Lima, M. S., & Mari, J. J. (2000). Combination of antidepressants and psychological treatments for bulimia nervosa: A systematic review. *Acta Psychiatrica Scandinavica*, 101, 256-267.
- Barbarich, N. (2002). Is there a common mechanism of serotonin dysregulation in anorexia nervosa and obsessive compulsive disorder? *Eating and Weight Disorders*, 7, 221-231.
- Barbarich, N. C., Kaye, W. H., & Jimerson, D. (2003). Neurotransmitter and imaging studies in anorexia nervosa: new targets for treatment. *Current Drug Target CNS Neurological Disorders*, 2, 61-72.
- Barrett, R. J. (1987). *Schizophrenia and personhood*, Unpublished manuscript.
- Barrett, R. J. (1988). Clinical writing and the documentary construction of schizophrenia. *Culture, Medicine and Psychiatry*, 12, 265-299.
- Basseches, H. I., & Karp, S. A. (1984). Field dependence in young anorectic and obese women. *Psychotherapeutic Psychosomatics*, 41, 33-37.
- Bemis, K. (1978). Current approaches to the etiology and treatment of anorexia nervosa. *Psychological Bulletin*, 85, 593-617.
- Ben-Tovim, D. I., Whitehead, J., & Crisp, A. H. (1979). A controlled study of the perception of body width in anorexia nervosa. *Journal of Psychosomatic Research*, 23, 267-272.
- Ben-Tovim, D. I., & Walker, M. K. (1991). Women's body attitudes: a review of measurement techniques. *International Journal of Eating Disorders*, 10, 155-167.
- Ben-Tovim, D. I., Walker, K., Gilchrist, P., Freeman, R., Kalucy, R., & Esterman, A. (2001). Outcome in patients with eating disorders: A 5-year study. *The Lancet*, 357, 1254-1257.
- Beumont, P. J. V., George, G. C. N., & Smart, P. E. (1976). 'Dieters' and 'vomitters and purgers': an ominous variant of anorexia nervosa. *Psychological Medicine*, 6, 617-622.
- Black, M., & Coward, R. (1981). *Man-made language: linguistic, social and sexual relations*. Screen Education, 39.

- Black, C. M. D., & Wilson, G. T. (1996). Assessment of eating disorders: interview versus questionnaire. *International Journal of Eating Disorders*, 20, 43-50.
- Bordo, S. (1988). Anorexia nervosa: psychopathology as the crystallization of culture. In I. Diamond & L. Quinby (Eds.), *Feminism and Foucault: Reflections on Resistance*. Boston: Northeastern University Press.
- Bordo, S. (1989). The body and the reproduction of femininity: a feminist appropriation of Foucault. In A. M. Jaggar & S. R. Bordo (Eds.), *Gender/Body/Knowledge: Feminist Reconstructions of Being and Knowing*. New Brunswick: Rutgers University Press.
- Bordo, S. (1990). Reading the slender body. In M. Jacobus, E. F. Keller & S. Shuttleworth (Eds.), *Body/Politics: Women and the Discourses of Science* (pp. 83-112). New York: Routledge.
- Bordo, S. (1993). *Unbearable Weight: Feminism, Western Culture and the Body*. Berkeley: University of California Press.
- Bourdieu, P. (1984). *Distinction: A Social Critique of the Judgement of Taste*. London: Routledge.
- Bourdieu, P. (1990). *The Logic of Practice*. Cambridge: Polity Press.
- Braidotti, R. (1994). *Nomadic Subjects: Embodiment and Sexual Difference in Contemporary Feminist Theory*. New York: Columbia University Press.
- Breggin, P. R. (1979). *Electroshock: Its Brain-Disabling Effects*. New York: Springer Publishing Company.
- Bremner, J. D., Vythilingam, M., Vermetten, E., Southwick, S. M., McGlashan, T., Nazeer, A., Khan, S., Vaccarino, L. V., Soufer, R., Garg, P. K., Ng, C. K., Staib, L. H., Duncan, J. S., & Charney, D. S. (2003). MRI and PET study of deficits in hippocampal structure and function in women with childhood sexual abuse and posttraumatic stress disorder. *American Journal of Psychiatry*, 160, 924-932.
- Britt, E., & Del-Gobbo, S. (1990). Changing patterns of referral to an eating disorders clinic. *New Zealand Medical Journal*, 103, 564-565.
- Brooks, A., Le Couteur, A., & Hepworth, J. (1998). Accounts of experiences of bulimia: a discourse analytic study. *International Journal of Eating Disorders*, 24, 193-205.
- Broom, D. H. (1991). *Damned If We Do: Contradictions in Women's Health Care*. Sydney: Allen and Unwin.
- Broverman, I. K., Vogel, S. R., Broverman, D. M., Clarkson, F. E., & Rosenkrantz, P. S. (1972). Sex-role stereotypes: a critical appraisal. *Journal of Social Issues*, 28, 59-78.
- Bruch, H. (1974a). *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*. London: Routledge and Kegan Paul Ltd.
- Bruch, H. (1974b). Perils of behaviour modification in the treatment of anorexia nervosa. *Journal of the American Medical Association*, 230, 1419-1422.
- Bruch, H. (1978). *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge, Massachusetts: Harvard University Press.
- Brumberg, J. J. (1988). *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease*. Cambridge: Harvard University Press.
- Buddeberg-Fischer, B., Klaghofer, R., Gnam, G., & Buddeberg, C. (1998). Prevention of disturbed eating behaviour: a prospective intervention study in 14- to 19-year old Swiss students. *Acta Psychiatrica Scandinavica*, 98, 146-155.
- Bunton, R., & Burrows, R. (1995). Consumption and health in the 'epidemiological' clinic of late modern medicine. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.

- Burman, E. (1991). What discourse is not. *Philosophical Psychology*, 4, 325-342.
- Burman, E., & Parker, I. (1993). Introduction - discourse analysis: the turn to text. In E. Burman & I. Parker (Eds.), *Discourse Analytic Research: Readings and Repertoires of Texts in Action* (pp. 1-13). London: Routledge.
- Burman, E., Alldred, P., Bewley, C., Goldberg, B., Heenan, C., Marks, D., Marshall, J., Taylor, K., Ullah, R., & Warner, S. (1996). *Challenging Women: Psychology's Exclusions, Feminist Possibilities*. Buckingham: Open University Press.
- Burman, E. (1996a). Introduction: contexts, contests and interventions. In E. Burman, P. Alldred, C. Bewley, B. Goldberg, C. Heenan, D. Marks, J. Marshall, K. Taylor, R. Ullah & S. Warner (Eds.), *Challenging Women: Psychology's Exclusions, Feminist Possibilities*. Buckingham: Open University Press.
- (1996b). The spec(tac)ular economy of difference. In S. Wilkinson & C. Kitzinger (Eds.), *Representing the Other* (pp. 138-140). London: Sage Publications.
- Burrows, R., Nettleton, S., & Bunton, R. (1995). Sociology and health promotion: health, risk and consumption under late modernism. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Bush, D. M. (1987). Changing definitions of self for young women: the implications for rates of violence. In T. Honess & K. Yardley (Eds.), *Self and Identity: Perspectives Across the Lifespan*. London: Routledge and Kegan Paul.
- Butler, J. (1993). *Bodies That Matter: On the Discursive Limits of Sex*. New York: Routledge.
- Button, E. J., Fransella, F., & Slade, P. D. (1977). A reappraisal of body perception disturbance in anorexia nervosa. *Psychological Medicine*, 7, 235-243.
- Button, E. J., & Whitehouse, A. (1981). Subclinical anorexia nervosa. *Psychological Medicine*, 11, 509-516.
- Cachelin, F. M., Striegel-Moore, R., & Paget, W. B. (1997). Comparison of women with various levels of dietary restraint on body image, personality, and family environment. *Eating Disorders: The Journal of Treatment and Prevention*, 5, 205-215.
- Carrington, K. (1997). Governing sexual violence: Criminalization and citizenship. In S. Cook & J. Bessant (Eds.), *Women's Encounters with Violence: Australian Experiences* (pp. 219-229). Thousand Oaks: Sage Publications Inc.
- Carter, J. C., Stewart, A., Dunn, V. J., & Fairburn, C. G. (1997). Primary prevention of eating disorders: might it do more harm than good? *International Journal of Eating Disorders*, 22, 167-172.
- Cash, T. F., & Deagle, E. A. (1997). The nature and extent of body-image disturbances in anorexia nervosa and bulimia nervosa: a meta-analysis. *International Journal of Eating Disorders*, 22, 107-125.
- Casper, R. C., Halmi, K. A., Goldberg, S. C., Eckert, E. D., & Davis, J. M. (1979). Disturbances in body image estimation as related to other characteristics and outcome in anorexia nervosa. *British Journal of Psychiatry*, 134, 60-66.
- Castel, R. (1991). From dangerousness to risk. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality*. Chicago: The University of Chicago Press.
- Chernin, K. (1985). *The Hungry Self: Women, Eating and Identity*. London: Virago Press.
- Chesler, P. (1974). *Women and Madness*. New York: Avon Books.
- Chesters, L. (1994). Women's talk: food, weight and body image. *Feminism and Psychology*, 4, 449-457.

- Clearihan, C. (1999). Could depression and anxiety be a looming epidemic? *Australian Family Physician*, 29, 301.
- Cook, J. A., & Fonow, M. M. (1990). Knowledge and women's interests: issues of epistemology and methodology in feminist sociological research. In J. M. Nielsen (Ed.), *Feminist Research Methods: Exemplary Readings in the Social Sciences*. Boulder: Westview Press.
- Cooper, T. (1987). Anorexia and bulimia: the political and the personal. In M. Lawrence (Ed.), *Fed Up and Hungry: Women, Oppression and Food* (pp. 175-192). London: The Women's Press.
- Crawford, R. (1977). You are dangerous to your health: the politics and ideology of victim blaming. *International Journal of Health Services*, 7, 663-680.
- Crawford, R. (1985). A cultural account of 'health': self-control, release and the social body. In J. McKinlay (Ed.), *Issues in the Political Economy of Health Care*. New York: Methuen.
- Crawford, R. (1994). The boundaries of the self and the unhealthy other: reflections on health, culture and AIDS. *Social Science and Medicine*, 38, 1347-1365.
- Crawford, J., Kippax, S., Onyx, J., Gault, U., & Benton, P. (1992). *Emotion and Gender: Constructing Meaning from Memory*. London: Sage Publications Ltd.
- Crisp, A. H. (1970). Premorbid factors in adult disorders of weight, with particular reference to primary anorexia nervosa (weight phobia): A literature review. *Journal of Psychosomatic Research*, 14, 1-22.
- Crisp, A. H., & Fransella, F. (1972). Conceptual changes during recovery from anorexia nervosa. *British Journal of Medical Psychology*, 45, 395-405.
- Crisp, A. H., & Kalucy, R. S. (1974). Aspects of the perceptual disorder in anorexia nervosa. *British Journal of Medical Psychology*, 47, 349-361.
- Crisp, A. H. (1979). Early recognition and prevention of anorexia nervosa. *Developmental Medicine and Child Neurology*, 21, 393-395.
- Crisp, A. H. (1980). *Anorexia Nervosa: Let Me Be*. London: Academic Press.
- Crisp, A. H., & Bhat, A. V. (1982). 'Personality' and anorexia nervosa: The phobic avoidance stance. *Psychotherapy and Psychosomatics*, 38, 178-200.
- Crow, S. J., & Mitchell, J. E. (1994). Rational therapy of eating disorders. *Drugs*, 48, 372-379.
- Dally, P. (1969). *Anorexia Nervosa*. New York: Grune and Stratton.
- Davies, B. (1991). The concept of agency: a feminist poststructuralist analysis. *Social Analysis*, 30, 42-53.
- Delphy, C. (1987). Protofeminism and antifeminism. In T. Moi (Ed.), *French Feminist Thought: A Reader*. Oxford: Basil Blackwell.
- Denzin, N. (1978). *The Research Act: A Theoretical Introduction to Sociological Methods*. New York: McGraw-Hill Book Company.
- Derrida, J. (1976). *Of Grammatology*. Baltimore: John Hopkins University Press.
- De Vault, M. L. (1999). *Liberating Method: Feminism and Social Research*. Philadelphia: Temple University Press.
- Devlin, B., Bacanu, S., Klump, K. L., Bulik, C. M., Fichter, M. M., Halmi, K. A., Kaplan, A. S., Strober, M., Treasure, J., Woodside, D. B., Berrettini, W. H., & Kaye, W. H. (2002). Linkage analysis of anorexia nervosa incorporating behavioural covariates. *Human Molecular Genetics*, 11, 689-696.

- Dolan, B., Lacey, J. H., & Evans, C. (1990). Eating behaviour and attitudes to weight and shape in British women from three ethnic groups. *British Journal of Psychiatry*, 157, 523-528.
- Dresser, R. (1984). Feeding the hungry artists: legal issues in treating anorexia nervosa. *Wisconsin Law Review*, 2, 297-374.
- Epston, D., & White, M. (1992). *Experience, Contradiction, Narrative and Imagination: Selected Papers of David Epston and Michael White, 1989-1991*. Adelaide: Dulwich Centre Publications.
- Epston, D. (2000). *Anti-Anorexia, Anti-Bulimia Archive*, <http://narrativeapproaches.com>.
- Erikson, E. (1968). *Identity: Youth and Crisis*. London: Faber.
- Erikson, E. H. (1980). *Identity and the Life Cycle*. New York: Norton and Company Inc.
- Evidence-Based Medicine Working Group (1992). Evidence-based medicine: a new approach to teaching the practice of medicine. *Journal of the American Medical Association*, 268, 2420-2425.
- Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioural therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge Eating: Nature, Assessment, and Treatment*. New York: The Guilford Press.
- Fairburn, C. G., Norman, P. A., Welch, S. L., O'Connor, M. E., Doll, H. A., & Peveler, R. C. (1995). A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. *Archives of General Psychiatry*, 52, 304-312.
- Fairburn, C. G., Shafran, R., & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy*, 37, 1-13.
- Felker, K. R., & Stivers, C. (1994). The relationship of gender and family environment to eating disorder risk in adolescents. *Adolescence*, 29, 821-34.
- Ferguson, J. M. (1993). The use of electroconvulsive therapy in patients with intractable anorexia nervosa. *International Journal of Eating Disorders*, 13, 195-201.
- Foucault, M. (1972). *The Archaeology of Knowledge*. London: Tavistock Publications Limited.
- Foucault, M. (1975). *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage Books.
- Foucault, M. (1977a). *Discipline and Punish: The Birth of the Prison*. London: Penguin Books.
- Foucault, M. (1977b). Nietzsche, genealogy, history. In D. F. Bouchard (Ed.), *Language, Counter-Memory, Practice: Selected Essays and Interviews* (pp. 139-164). New York: Cornell University Press.
- Foucault, M. (1978). *The History of Sexuality Volume 1: An Introduction*. London: Penguin Books.
- Foucault, M. (1980a). *Howison Lectures*. Berkeley.
- Foucault, M. (1980b). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. Brighton: Harvester.
- Foucault, M. (1982). The Subject and Power. In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond Structuralism and Hermeneutics*. Chicago: University of Chicago Press.
- Foucault, M. (1984). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. Brighton, Sussex: Harvester Press.
- Foucault, M. (1988). *The History of Sexuality Volume 3: The Care of the Self*. New York: Vintage Books.

- Fransella, F., & Crisp, A. (1979). Comparisons of weight concepts in groups of neurotic, normal and anorexic females. *British Journal of Psychiatry*, 134, 79-81.
- Franzen, U., Florin, I., Schneider, S., & Meier, M. (1988). Distorted body image in bulimic women. *Journal of Psychosomatic Research*, 32, 445-450.
- Freud, S. (1973). *Introductory Lectures on Psychoanalysis*. Harmondsworth: Penguin Books Ltd.
- Freund, K. M., Graham, S. M., Lesky, L. G., & Moskowitz, M. A. (1993). Detection of bulimia in a primary care setting. *Journal of General Internal Medicine*, 8, 236-242.
- Ganesan, V. (1986). Electroconvulsive therapy under fire. *Indian Journal of Clinical Psychology*, 13, 145-147.
- Gardiner, J. K. (1995). Can Ms Prozac talk back? feminism, drugs and social constructionism. *Feminist Studies*, 21, 501-517.
- Gardner, H. (1995). *The Politics of Health: The Australian Experience*. Melbourne: Churchill Livingstone.
- Gardner, R. M., & Bokencamp, E. D. (1996). The role of sensory and nonsensory factors in body size estimations of eating disorders subjects. *Journal of Clinical Psychology*, 52, 3-15.
- Garfinkel, P. E., & Garner, D. M. (1982). *Anorexia Nervosa: A Multidimensional Perspective*. New York: Bruner Mazel.
- Garner, D. M., & Garfinkel, P. E. (1979). The eating attitudes test: An index of the symptoms of anorexia nervosa. *Psychological Medicine*, 9, 273-279.
- Garner, D. M., & Garfinkel, P. E. (1980). Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine*, 10, 647-656.
- Garner, D. M., Garfinkel, P. E., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. *Psychological Reports*, 47, 483-491.
- Garner, D. M., & Garfinkel, P. E. (1981). Body image in anorexia nervosa: measurement, theory and clinical implications. *International Journal of Psychiatry in Medicine*, 11, 263-284.
- Garner, D. M., Garfinkel, P. E., & Olmstead, M. P. (1983). An overview of socio-cultural factors in the development of anorexia nervosa. In P. Darby, P. E. Garfinkel, D. M. Garner & M. Olmstead (Eds.), *Anorexia Nervosa: Recent Developments in Research* (pp. 65-82). New York: Alan Liss.
- Garner, D. M., Olmstead, M. P., & Garfinkel, P. E. (1983). Does anorexia nervosa exist on a continuum? Subgroups of weight-preoccupied women and their relationship to anorexia nervosa. *International Journal of Eating Disorders*, 2, 11-20.
- Garner, D. M., Olmstead, M. P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders*, 2, 15-34.
- Garner, D. M., & Olmstead, M. P. (1984). *The Eating Disorder Inventory Manual*. Odessa: Psychological Assessment Resources.
- Garner, D. M., Garfinkel, P. E., Rockert, W., & Olmstead, M. P. (1987). A prospective study of eating disturbances in the ballet. *Psychotherapeutic Psychosomatics*, 48, 170-175.
- Garrett, C. (1994). The eating disorders smorgasbord. *Australian Journal of Communication*, 21, 14-31.
- Garrett, C. (1995) *Beyond Anorexia Nervosa: Narrative, Spirituality and Recovery*. Cambridge: Cambridge University Press.

- Gilchrist, P. N., Phillips, P. J., Odgers, C. L., & Hoogendorf, J. (1985). The psychological aspects of artificial nutritional support. *Australian and New Zealand Journal of Psychiatry*, 19, 54-59.
- Gilchrist, P. N., Ben-Tovim, D. I., Hay, P. J., Kalucy, R. S., & Walker, M. K. (1998). Eating disorders revisited. I: anorexia nervosa. *Medical Journal of Australia*, 169, 438-441.
- Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, Mass.: Harvard University Press.
- Glassner, B. (1995). In the name of health. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Goltz, K., & Bruni, N. (1995). Health promotion discourse: language of change? In H. Gardner (Ed.), *The Politics of Health: The Australian Experience*. Melbourne: Churchill Livingstone.
- Gordon, C. (1991). Governmental rationality: an introduction. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality*. Chicago: The University of Chicago Press.
- Gottlieb, R. S. (1984). Mothering and the reproduction of power: Chodorow, Dinnerstein and social theory. *Socialist Review*, 14, 93-119.
- Grace, V. M. (1991). The marketing of empowerment and the construction of the health consumer: a critique of health promotion. *International Journal of Health Services*, 21, 329-343.
- Graham, H. (1979). Prevention and health: every mother's business: a comment on child health policies in the 1970s. In C. Harris (Ed.), *Sociology of the family: New Directions for British Sociology*: University of Keele.
- Grbich, C. (1999). *Qualitative Research in Health: An Introduction*. St Leonards: Allen and Unwin.
- Green, L. W., & Raeburn, J. (1990). Contemporary developments in health promotion: definitions and challenges. In N. Bracht (Ed.), *Health Promotion at the Community Level* (pp. 29-44). Newbury Park: Sage Publications.
- Green, L. W., & Kreuter, M. W. (1991). *Health Education Planning: An Education and Environmental Approach*. Mountain View: Mayfield Press.
- Gremillion, H. (1992). Psychiatry as social ordering: Anorexia nervosa, a paradigm. *Social Science and Medicine*, 35, 57-71.
- Gremillion, H. (2001). In fitness and in health: crafting bodies in the treatment of anorexia nervosa. *Journal of Women in Culture and Society*, 27, 381-414.
- Gremillion, H. (2003). *Feeding Anorexia: Gender and Power at a Treatment Centre*. London: University of Chicago Press.
- Gresko, R. B., & Rosenvinge, J. H. (1998). The Norwegian School-based prevention model: development and evaluation (pp. 75-98). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Griffin, S. (1971). Rape: the all-American crime. *Ramparts*, 10.
- Grosz, E. (1994). *Volatile Bodies: Toward a Corporeal Feminism*. St. Leonards, N.S.W.: Allen & Unwin.
- Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105-117). Thousand Oaks: Sage.
- Gull, W.W. (1874) Anorexia Nervosa (Apepsia Hysterica, Anorexia Hysterica). *Transactions of the Clinical Society*, 7, 22-27.

- Halmi, K. A., Powers, P., & Cunningham, S. (1975). Treatment of anorexia nervosa with behaviour modification. *Archives of General Psychiatry*, 32, 93-96.
- Halmi, K. A. (1983). Anorexia nervosa and bulimia. *Psychosomatics*, 24, 111-129.
- Harper, D. J. (1994). The professional construction of 'paranoia' and the discursive use of diagnostic criteria. *British Journal of Medical Psychology*, 67, 131-143.
- Harper, D. J. (1995). Discourse analysis and 'mental health'. *Journal of Mental Health*, 4, 347-357.
- Hartman, D. (1996). Anorexia nervosa: diagnosis, aetiology and treatment. *Postgraduate Medical Journal*, 71, 712-716.
- Hay, P. J., Gilchrist, P. N., Ben-Tovim, D. I., Kalucy, R. S., & Walker, M. K. (1998). Eating disorders revisited. II: bulimia nervosa and related syndromes. *Medical Journal of Australia*, 169, 488-491.
- Heenan, C. (1996). Women, food and fat: too many cooks in the kitchen? In E. Burman, P. Alldred, C. Bewley, B. Goldberg, C. Heenan, D. Marks, J. Marshall, K. Taylor, R. Ullah & S. Warner (Eds.), *Challenging Women: Psychology's Exclusions, Feminist Possibilities* (pp. 19-35). Buckingham: Open University Press.
- Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the Subject: Psychology, Social Regulation and Subjectivity*. London: Methuen and Co. Ltd.
- Hepworth, J., & Griffin, C. (1990). The discovery of anorexia nervosa: discourses of the late 19th Century. *Text*, 10, 321-338.
- Hepworth, J. (1999). *The Social Construction of Anorexia Nervosa*. London: Sage.
- Herzog, D. B., Keller, M. B., Sacks, N. R., Yeh, C. J., & Lavori, P. W. (1992). Psychiatric comorbidity in treatment-seeking anorexics and bulimics. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 810-818.
- Hirst, P., & Woolley, P. (1982). *Social Relations and Human Attributes*. London: Tavistock Publications Ltd.
- Hoek, H. W. (1993). Review of the epidemiological studies of eating disorders. *International Journal of Eating Disorders*, 5, 61-74.
- Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn & V. Walkerdine (Eds.), *Changing the Subject: Psychology, Social Regulation and Subjectivity*. London: Methuen and Co. Ltd.
- Hollway, W. (1989). *Subjectivity and Method in Psychology: Gender, Meaning and Science*. London: Sage Publications Ltd.
- Horeh, N., Zalsman, G., & Apler, A. (2000). Internalised anger, self-control and mastery experience in inpatient anorexic adolescents. *Journal of Psychosomatic Research*, 49, 247-253.
- Home, R. L., Van Vactor, J. C., & Emerson, S. (1991). Disturbed body image in patients with eating disorders. *American Journal of Psychiatry*, 148, 211-215.
- Horsfall, J. (1991) The silent participant: Bryan Turner on anorexia nervosa. *Australian and New Zealand Journal of Sociology*, 27, 232-234.
- Hsu, L. K. G., Crisp, A. H., & Callender, J. S. (1992). Recovery in anorexia nervosa: the patient's perspective. *International Journal of Eating Disorders*, 11, 341-350.
- Hsu, L. K. (1996). Epidemiology of eating disorders. *Psychiatric Clinician North America*, 19, 681-700.

- Hsu, L. K. G., Rand, W., Sullivan, S., Liu, D. W., Mulliken, B., McDonagh, B., & Kaye, W. H. (2001). Cognitive therapy, nutritional therapy and their combination in the treatment of bulimia nervosa. *Psychological Medicine*, 31, 871-879.
- Huon, G. F. (1994). Towards the prevention of dieting-induced disorders: modifying negative food- and body-related attitudes. *International Journal of Eating Disorders*, 16, 395-399.
- Huon, G. F., Braganza, C., Brown, L. B., Ritchie, J. E., & Roncolato, W. G. (1998). Reflections on prevention in dieting-induced disorders. *International Journal of Eating Disorders*, 23, 445-458.
- Jacobovits, C., Halstead, P., Kelly, L., Roe, D. A., & Young, C. M. (1977). Eating habits and nutrient intakes of college women over a thirty year period. *Journal of the American Dietetic Association*, 71, 405-411.
- Jaggar, A. M. (1989). Love and knowledge: emotion in feminist epistemology. In A. Garry & M. Pearsall (Eds.), *Women, Knowledge and Reality: Explorations in Feminist Philosophy*. (pp. 129-155). London: Unwin Hyman.
- Kaltiala-Heino, R., Rissanen, A., Rimpela, M., & Rantanen, P. (2003). Bulimia nervosa and impulsive behaviour in middle adolescence. *Psychotherapeutic Psychosomatics*, 72, 26-33.
- Karwautz, A., Volkl-Kernstock, S., Nobis, G., Kalchmayr, G., Hafferl-Gattermayer, A., Wober-Bingol, C. C., & Friedrich, M. H. (2001). Characteristics of self-regulation in adolescent patients with anorexia nervosa. *British Journal of Medical Psychology*, 74, 101-114.
- Katz, J. L. (1985). Some reflections on the nature of the eating disorders: on the need for humility. *International Journal of Eating Disorders*, 4, 617-626.
- Keel, P. K., & Mitchell, J. E. (1997). Outcome in bulimia nervosa. *American Journal of Psychiatry*, 154, 313-321.
- Keel, P. K., Mitchell, J. E., Miller, K. B., Davis, T. L., & Crow, S. J. (1999). Long-term outcome of bulimia nervosa. *Archives of General Psychiatry*, 56, 63-69.
- Kellehear, A. (1993). *The Unobtrusive Researcher*. St. Leonards: Allen and Unwin.
- Kelly, M. P., & Charlton, B. (1995). The modern and the post-modern in health promotion. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Kelly, L. (1996). 'It's everywhere': sexual violence as a continuum. In S. Jackson & S. Scott (Eds.), *Feminism and Sexuality: A Reader* (pp. 191-206). Edinburgh: Edinburgh University Press.
- Killen, J. D., Taylor, C. B., Hammer, L. D., Litt, I., Wilson, D. M., Rich, T., Hayward, C., Simmonds, B., & Varady, A. (1993). An attempt to modify unhealthful eating attitudes and weight regulation practices of young adolescent girls. *International Journal of Eating Disorders*, 13, 369-384.
- Killen, J. D., Taylor, C. B., Hayward, C., Haydel, K. F., Wilson, D. M., Hammer, L., Kraemer, H., Blair-Greiner, A., & Strachowski, D. (1996). Weight concerns influence the development of eating disorders: a four-year prospective study. *Journal of Consulting and Clinical Psychology*, 64, 936-940.
- Kitzinger, C. (1992). The individuated self concept: a critical analysis of social-constructionist writing on individualism. In G. M. Breakwell (Ed.), *Social Psychology of Identity and the Self Concept* (pp. 221-250). London: Surrey University Press.
- Kitzinger, C., & Wilkinson, S. (1996). Theorizing representing the other. In S. Wilkinson & C. Kitzinger (Eds.), *Representing the Other* (pp. 1-32). London: Sage Publications.
- Krieger, N. (1994). Epidemiology and the web of causation: has anyone seen the spider? *Social Science and Medicine*, 39, 887-993.

- Kuzel, A. J. (1992). Sampling in qualitative inquiry. In B. F. Crabtree & W. L. Miller (Eds.), *Doing Qualitative Research*. Newbury Park: Sage.
- Laessle, R. G., Schweiger, U., & Pirke, K. M. (1988). Depression as a correlate of a starvation in patients with eating disorders. *Biological Psychiatry*, 23, 719-725.
- Laessle, R. G., Krieg, J. C., Fichter, M. M., & Pirke, K. M. (1989). Cerebral atrophy and vigilance performance in patients with anorexia nervosa and bulimia nervosa. *Neuropsychobiology*, 21, 187-191.
- Larocca, F. E., & Goodner, S. A. (1986). Tube feeding? Is it ever necessary? *New Directions for Mental Health Services*, 3, 87-98.
- Latzer, Y., & Shatz, S. (1999). Comprehensive community prevention of disturbed attitudes to weight control: a three-level intervention program. *Eating Disorders*, 7, 3-31.
- Lautenbacher, S., Roscher, F., Strian, F., Pirke, K. M., & Krieg, J. C. (1993). Theoretical and empirical considerations on the relation between 'body image, body scheme and somatosensation. *Journal of Psychosomatic Research*, 17, 447-454.
- Lawrence, M. (1984). *The Anorexic Experience*. London: The Women's Press.
- Lazarus, R. (1991). *Emotion and Adaptation*. New York: Oxford University Press.
- Lee, S. (1996). Reconsidering the status of anorexia nervosa as a western culture-bound syndrome. *Social Science and Medicine*, 42, 21-34.
- Lees, S. (1986). *Losing Out: Sexuality and Adolescent Girls*. London: Century Hutchinson.
- Lefebvre, C. (1992). Consumer trends in the 1990s: implications for health promotion. *American Journal of Health Promotion*, 6, 165-166.
- Lefebvre, C. (1995). Social marketing and health promotion. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Le Grange, P., Lock, J., & Dymek, M. (2003). Family-based therapy for adolescents with bulimia nervosa. *American Journal of Psychotherapy*, 57, 237-251.
- Leon, G. R., Keel, P. K., Klump, K. L., & Fulkerson, J. A. (1997). The future of risk factor research in understanding the etiology of eating disorders. *Psychopharmacology Bulletin*, 33, 405-411.
- Leonard, S., Steiger, H., & Kao, A. (2002). Childhood and adulthood abuse in bulimic and non-bulimic women: prevalences and psychological correlates. *International Journal of Eating Disorders*, 33, 397-405.
- Lester, R. J. (1997). The (dis)embodied self in anorexia nervosa. *Social Science and Medicine*, 44, 479-489.
- Leung, F., Geller, J., & Katzman, M. (1996). Issues and concerns associated with different risk models for eating disorders. *International Journal of Eating Disorders*, 19, 249-256.
- Levine, M. P., & Smolak, L. (1998). The mass media and disordered eating: Implications for primary prevention (pp. 23-56). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Lewis, P. (1999). Feeding anorexic patients who refuse food. *Medical Law Review*, 7, 21-37.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills: Sage Publications.
- Lloyd, G. (1989). The man of reason. In A. Garry & M. Pearsall (Eds.), *Women, Knowledge and Reality: Explorations in Feminist Philosophy*. (pp. 111-128). London: Unwin Hyman.

- MacLeod, S. (1981). *The Art of Starvation*. London: Virago.
- MacSween, M. (1993). *Anorexic Bodies*. London: Routledge.
- Malson, H. (1991). Hidden a-genders: the place of multiplicity and gender in theorisations of anorexia nervosa. *POWS Newsletter*, 8, 31-42.
- Malson, H. (1998). *The Thin Woman: Feminism, Post-structuralism and the Social Psychology of Anorexia Nervosa*. London: Routledge.
- Mann, T., Nolen-Hoeksema, S., Huang, K. and Burgard, D. (1997). Are two interventions worse than none? Joint primary and secondary prevention of eating disorders in college females. *Health Psychology*, 16, 215-225.
- Marcia, J. E. (1987). The identity status approach to the study of ego identity development. In T. Honess & K. Yardley (Eds.), *Self and Identity: Perspectives Across the Lifespan*. London: Routledge and Kegan Paul.
- McClelland, L., & Crisp, A. (2001). Anorexia nervosa and social class. *International Journal of Eating Disorders*, 29, 150-156.
- McLeod, S. (1981). *The Art of Starvation*. London: Virago.
- McNay, L. (1992). *Foucault and Feminism: Power, Gender and the Self*. Oxford: Polity Press.
- McNay, L. (2000). *Gender and Agency: Reconfiguring the Subject in Feminist and Social Theory*. Oxford: Polity Press.
- Melve, K. K., & Baerheim, A. (1994). Signs of subclinical eating disorders in teenage girls. *Scandinavian Journal of Primary Health Care*, 12, 197-203.
- Mims Australia (2003). *Mims*, 6, 85-90.
- Mintz, L. B., & Betz, N. E. (1988). Prevalence and correlates of eating disordered behaviour among undergraduate women. *Journal of Counselling Psychology*, 35, 463-471.
- Miotto, P., De Coppi, M., Frezza, M., & Preti, A. (2003). The spectrum of eating disorders: prevalence in an area of Northeast Italy. *Psychiatry Research*, 119 (1-2), 145-154.
- Mizes, J. S. (1988). Personality characteristics of bulimic and non-eating disordered female controls: a cognitive-behavioural perspective. *International Journal of Eating Disorders*, 7, 541-550.
- Moreno, A. B., & Thelen, M. H. (1993). A primary prevention programme for eating disorders in a junior high school population. *Journal of Youth and Adolescence*, 22, 109-124.
- Moriarty, D., Shore, R. & Maxim, N. (1990). Evaluation of an eating disorder curriculum. *Evaluation and Programme Planning*, 13, 407-413.
- Moulding, N. (2003). Constructing the self in mental health practice: identity, individualism and the feminization of deficiency. *Feminist Review*, 75, 57-74.
- Moulding, N. & Hepworth, J. (2001). Understanding body image disturbance in the promotion of mental health: a discourse analytic study. *International Journal of Community and Applied Social Psychology*, 11, 305-317.
- Muscari, M. E. (1998). Screening for anorexia and bulimia. *American Journal of Nursing*, 98, 22-24.
- Nasser, M. (1994). Screening for abnormal eating attitudes in a population of Egyptian secondary school girls. *Social Psychiatry and Psychiatric Epidemiology*, 29, 25-30.
- Nasser, M. (1994) Screening for abnormal eating attitudes in a population of Egyptian secondary school girls. *Social Psychiatry and Psychiatric Epidemiology*, 29, 25-30.

- Neale, J. M., Davison, G. C., & Haaga, D. A. F. (1996). *Exploring Abnormal Psychology*. New York: John Wiley and Sons, Inc.
- Nettleton, S., & Bunton, R. (1995). Sociological critiques of health promotion. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Neuman, W. L. (1997). *Social Research Methods: Qualitative and Quantitative Methods*. Needham Heights: Allyn and Bacon.
- Neumark-Sztainer, D. (1996). School-based programs for preventing eating disturbances. *Journal of School Health*, 66, 64-71.
- Newby, J. (2003). Anorexia Gene. <http://www.abc.net.au/catalyst/stories/s914473.htm>.
- Noordenbos, G. (1998). Eating disorders in primary care: early identification and intervention by general practitioners (pp. 214-229). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Nylander, J. (1971). The feeling of being fat and dieting in a school population: epidemiologic interview investigation. *Acta Sociomedica Scandinavica*, 3, 17-26.
- O'Connor, M. L., & Parker, E. (1995). *Health Promotion: Principles and Practice in the Australian Context*. St Leonards: Allen and Unwin.
- O'Dea, J. A. (1995). Body image and nutritional status among adolescents and adults: a review of the literature. *Australian Journal of Nutrition and Dietetics*, 52, 56-67.
- Oakley, A. (1981). Interviewing women: a contradiction in terms. In H. Roberts (Ed.), *Doing Feminist Research*. London: Routledge and Kegan Paul.
- Olesen, V. (1994). Feminisms and models of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.
- Orbach, S. (1986). *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age*. London: Faber and Faber.
- Palazzoli, M. S. (1974). *Self-Starvation: From the Intrapsychic to the Transpersonal Approach to Anorexia Nervosa*. London: Human Context Books.
- Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.
- Parker, I., & Burman, E. (1993). Against discursive imperialism, empiricism and constructionism: thirty-two problems with discourse analysis. In E. Burman & I. Parker (Eds.), *Discourse Analytic Research: Readings and Repertoires of Texts in Action*. London: Routledge.
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing Psychopathology*. London: Sage Publications.
- Parker, I. E. (1999). *Deconstructing Psychotherapy*. London: Sage Publications.
- Patton, G. C., Johnson-Sabine, E., & Wood, K. (1990). Abnormal eating attitudes in London schoolgirls : a prospective study: outcome at twelve month follow-up. *Psychological Medicine*, 20, 383-394.
- Patton, G. C., Coffey, C., & Sawyer, S. M. (2003). The outcome of adolescent eating disorders: findings from the Victorian Adolescent Health Cohort Study. *European Child and Adolescent Psychiatry*, 12 Supplement, I25-9.

- Paxton, S. J., Wertheim, E. H., Gibbons, K., Szmukler, G. I., Hillier, L., & Petrovich, J. C. (1991). Body image satisfaction, dieting beliefs and weight loss behaviours in adolescent girls and boys. *Journal of Youth and Adolescence*, 20, 361-379.
- Paxton, S. J. (1993). A prevention program for disturbed eating and body dissatisfaction in adolescent girls: a 1 year follow-up. *Health Education Research*, 8, 43-51.
- Payne, M. (1997). *Modern Social Work Theory*. London: Macmillan Press.
- Penas-Lledo, E. M., Vaz, F. J., Ramos, F. J., & Waller, G. (2002). Impulsive behaviour in bulimics: relation to general psychopathology. *International Journal of Eating Disorders*, 32, 98-102.
- Petersen, A. (1997). Risk, governance and the new public health. In A. Petersen & R. Bunton (Eds.), *Foucault, Health and Medicine*. London: Routledge.
- Piran, N. (1998). A participatory approach to the prevention of eating disorders in a school (pp. 173-186). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Polivy, J., & Herman, C. P. (1987). Diagnosis and treatment of normal eating: Special issue: eating disorders. *Journal of Consulting and Clinical Psychology*, 55, 635-644.
- Polivy, J., & Herman, C. P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213.
- Potter, J., & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London; Newbury Park, Calif.: Sage Publications.
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage.
- Powers, P., & Erickson, M. (1986). Body image in women and its relationship to self image and body satisfaction. *Journal of Obesity and Weight Reduction*, 5, 37-50.
- Probst, M., Van Coppenolle, H., Vandereycken, W., & Goris, M. (1992). Body image assessment in anorexia nervosa patients and university students by means of video distortion: a reliability study. *Journal of Psychosomatic Research*, 36, 89-97.
- Probyn, E. (1991) This body which is not one: technologizing an embodied self. *Hypatia*, 6, 11-124.
- Probyn, E. (1993). *Sexing the Self: Gendered Positions in Cultural Studies*. London: Routledge.
- Prudic, J., Olsson, M., & Sackheim, H. A. (2001). Electro-convulsive therapy practices in the community. *Psychological Medicine*, 31, 929-934.
- Rabinow, P. (1984). *The Foucault Reader: An Introduction to Foucault's Thought*. London: Penguin Books.
- Rathner, G. (1992). Aspects of the natural history of normal and disordered eating and some methodological considerations. In W. Herzog, H. C. Deter & W. Vandereycken (Eds.), *The Course of Eating Disorders: Long-Term Follow-up Studies of Anorexia and Bulimia Nervosa* (pp. 273-303). Berlin: Springer-Verlag.
- Ratnasuriya, R. H., Eisler, I., Szmukler, G. I., & Russell, G. F. M. (1989). Outcome and prognostic factors after 20 years of anorexia nervosa. *Annals of the New York Academy of Science*, 575, 567-568.
- Rawlings, E., & Carter, D. (1977). *Psychotherapy for Women*. Springfield, Ill: Charles and Thomas.
- Rose, N. (1993). Government, authority and expertise in advanced liberalism. *Economy and Society*, 22, 283-299.
- Rosen, J. C. (1989). Prevention of eating disorders. *National Anorexic Aide Society Newsletter*, 12, 1-3.

- Rosen, D. S., & Neumark Sztainer, D. (1998). Review of options for primary prevention of eating disturbances among adolescents. *Journal of Adolescent Health*, 23, 354-363.
- Rosenau, P. M. (1992). *Post-modernism and the Social Sciences: Insights, Inroads and Intrusions*. Princeton: Princeton University Press.
- Russell, G. F. M. (1977). The present status of anorexia nervosa. *Psychological Medicine*, 7, 363-367.
- Russell, G. (1979). Bulimia nervosa: an ominous variant of anorexia nervosa. *Psychological Medicine*, 9, 429-448.
- Russell, D. (1995). Female bodies and food: a case of ethics. In P. A. Komesaroff (Ed.), *Troubled Bodies: Critical Perspectives on Postmodernism, Medical Ethics, and the Body*. Durham and London: Duke University Press.
- Russell, C. J., & Keel, P. K. (2002). Homosexuality as a specific risk factor for eating disorders in males. *International Journal of Eating Disorders*, 31, 300-306.
- Sarantakos, S. (1998). *Social Research*. South Yarra: Macmillan Education Australia Pty Ltd.
- Sawicki, J. (1991). *Disciplining Foucault: Feminism, Power and the Body*. New York: Routledge.
- Sayers, J. (1982). *Biological Politics: Feminist and Anti-Feminist Perspectives*. London: Tavistock.
- Schlemmer, J. K., & Barnett, P. A. (1977). Management of manipulative behaviour of anorexia nervosa patients. *Journal of Psychiatric Nursing and Mental Health Services*, 35-41.
- Schmidt, U. (2003). Aetiology of eating disorders in the 21(st) century: new answers to old questions. *European Child and Adolescent Psychiatry*, 12, 130-137.
- Schoemaker, C. (1997). Does early intervention improve the prognosis in anorexia nervosa? A systematic review of the treatment-outcome literature. *International Journal of Eating Disorders*, 21, 1-15.
- Schoemaker, C. (1998). The principles of screening for eating disorders (pp. 187-213). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Scott, S. (2001). Surviving selves: feminist and contemporary discourses of child sexual abuse. *Feminist Theory*, 2, 349-361.
- Shisslak, C. M., Crago, M. Neal, M.E. and Swain, B. (1987). Primary prevention of eating disorders. *Journal of Consulting and Clinical Psychology*, 55, 660-667.
- Shisslak, C. M., Crago, M. and Neal, M.E. (1990). Prevention of eating disorders among adolescents. *American Journal of Health Promotion*, 5, 100-106.
- Showalter, E. (1985). *The Female Malady: Women, Madness, and English Culture, 1830-1980*. New York: Pantheon Books.
- Silverstein, B., & Perdue, L. (1986). The role of the mass media in promoting a thin standard of bodily attractiveness for women. *Sex Roles*, 14, 519-532.
- Silverstein, B., Peterson, B., & Perdue, L. (1986). Some correlates of the thin standard of bodily attractiveness for women. *International Journal of Eating Disorders*, 5, 895-905.
- Slade, P. D., & Russell, G. F. M. (1973). Awareness of body dimensions in anorexia nervosa: cross-sectional and longitudinal studies. *Psychological Medicine*, 3, 188-199.
- Smolak, L., & Levine, M. P. (1993). Separation-individuation difficulties and the distinction between bulimia nervosa and anorexia nervosa in college women. *International Journal of Eating Disorders*, 14, 33-41.

- Smolak, L., Levine, M.P. and Schermer, F. (1998). A controlled evaluation of an elementary school primary prevention program for eating problems. *Journal of Psychosomatic Research*, 44, 339-353.
- Sohlberg, S., & Strober, M. (1994). Personality in anorexia nervosa: an update and a theoretical integration. *Acta Psychiatrica Scandinavica*, 378 supplement.
- Solomon, R. (1983). *The Passions*. Notre Dame, Ind.: University of Notre Dame Press.
- Spelman, E. V. (1989). Anger and subordination. In A. Garry & M. Pearsall (Eds.), *Women, Knowledge and Reality: Explorations in Feminist Philosophy*. (pp. 263-273). London: Unwin Hyman.
- Spitzak, C. (1990). *Confessing Excess: Women and the Politics of Body Reduction*. Albany: State University of New York Press.
- Stanley, L. (1990). Feminist praxis and the academic mode of production: an editorial introduction. In L. Stanley (Ed.), *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology*. London: Routledge.
- Stanley, L., & Wise, S. (1990). Method, methodology and epistemology in feminist research processes. In L. Stanley (Ed.), *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology* (pp. 20-60). London: Routledge.
- Steiger, H., Stotland, S., Ghadirian, A. M., & Whitehead, V. (1995). Controlled study of eating concerns and psychopathological traits in relatives of eating-disordered probands: Do familial traits exist? *International Journal of Eating Disorders*, 18, 107-118.
- Steiger, H., Jabalpurwala, S., Champagne, J., & Stotland, S. (1997). A controlled study of trait narcissism in anorexia and bulimia nervosa. *International Journal of Eating Disorders*, 22, 173-178.
- Steiner, H., Kwan, W., Shaffer, T. G., Walker, S., Miller, S., Sagar, A., & Lock, J. (2003). Risk and protective factors for juvenile eating disorders. *European Child and Adolescent Psychiatry*, 12, 138-146.
- Steiner-Adair, C. (1994). The politics of prevention. In P. Fallon, M. A. Katzman & S. C. Wooley (Eds.), *Feminist Perspectives on Eating Disorders*. New York: The Guilford Press.
- Steinhausen, H. (2002). The outcome of anorexia nervosa in the 20th century. *The American Journal of Psychiatry*, 159, 1284-1293.
- Stenner, P. (1993). Discoursing jealousy. In E. Burman & I. Parker (Eds.), *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge.
- Stewart, A. (1998). Experience with a school-based eating disorders prevention programme (pp. 99-136). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Stokes, P. E., & Holtz, A. (1997). Fluoxetine tenth anniversary update: the progress continues. *Clinical-Therapeutics*, 19, 1135-1250.
- Stokols, D. (1992). Establishing and maintaining health environments: toward a social ecology of health promotion. *American Psychologist*, 47, 6-22.
- Striegel-Moore, R. H., & Steiner-Adair, C. (1998). Primary prevention of eating disorders: further considerations from a feminist perspective (pp. 1-22). In W. Vandereycken & G. Noordenbos (Eds.), *The Prevention of Eating Disorders*. London: The Athelone Press.
- Strober, M., Freeman, R., & Morrell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study. *International Journal of Eating Disorders*, 22, 339-360.

- Sullivan, B. (1997). Mapping Contract. In G. Davis, B. Sullivan & A. Yeatman (Eds.), *The New Contractualism?* Melbourne: MacMillan Education Australia.
- Sundot, B. J. (1994). Risk and trigger factors for the development of eating disorders in elite female athletes. *Medicine, Science and Sports Exercise*, 26, 414-419.
- Tang, N. (2002). Interviewer/interviewee relationships between women. *Sociology*, 36, 703-721.
- Taylor, R. (1979). The four phases of prevention. *New Doctor*, 12, 41-46.
- Taylor, S. J., & Bogden, R. (1998). *Introduction to Qualitative Research Methods: A Guidebook and Resource*. New York: John Wiley and Sons.
- Tesh, S. (1988). *Hidden Arguments: Political Ideology and Disease Prevention Policy*. New Brunswick: Rutgers University Press.
- Thompson, J. K. (1990). *Body Image Disturbance: Assessment and Treatment*. New York: Pergamon Press.
- Thompson, J. K. (1992). Body image: extent of disturbance, associated features, theoretical models, assessment methodologies, intervention strategies, and a proposal for a new DSM IV diagnostic category - body image disorder. *Progress in Behaviour Modification*, 28, 3-54.
- Tice, L., Hall, R. C., Beresford, T. P., Quinones, J., & Hall, A. K. (1989). Sexual abuse in patients with eating disorders. *Psychiatric Medicine*, 7, 257-267.
- Tiggeman, M., & Pennington, B. (1990). The development of gender differences in body size dissatisfaction. *Australian Psychologist*, 25, 306-313.
- Touyz, S. W., Beumont, P. J. V., & Dunn, S. M. (1987). Behaviour therapy in the management of patients with anorexia nervosa. *Psychotherapy and Psychosomatics*, 48, 151-156.
- Turnbull, S., Ward, A., Treasure, J., Jick, H., & Derby, L. (1996). The demand for eating disorder care. an epidemiological study using the general practice research database. *British Journal of Psychiatry*, 169, 705-712.
- Turner, B. S. (1984). *The Body and Society : Explorations in Social Theory*. Oxford; New York, NY: Blackwell.
- Turner, B. (1992). *Regulating Bodies: Essays in Medical Sociology*. London: Routledge.
- Ussher, J. (1991). *Women's Madness: Misogyny or Mental Illness?* Harlow: Prentice Hall.
- Van Dijk, T. A. (1990). Discourse & society: a new journal for a new research focus. *Discourse and Society*, 1, 5-16.
- Van Dijk, T. A. (1994). Discourse as social analysis. *Discourse and Society*, 5, 163-164.
- Vandereycken, W., & Meerman, R. (1984). Anorexia nervosa: is prevention possible? *International Journal of Psychiatry in Medicine*, 14, 191-205.
- Vandereycken, W. (1992). Validity and reliability of the Anorectic Behaviour Observation Scale for parents. *Acta Psychiatrica Scandinavia*, 85, 163-166.
- Vaz, F. J., Guisedo, J. A., & Penas-Lledo, E. M. (2003). History of anorexia nervosa in bulimia nervosa patients: its influence on body composition. *International Journal of Eating Disorders*, 34, 148-155.
- Venn, C. (1984). The subject of psychology. In J. Henriques, Hollway, W., Urwin, C., Venn, C. and Walkerdine, V. (Ed.), *Changing the Subject: Psychology, Social Regulation and Subjectivity*. New York: Routledge.

- Vitousek, K., Watson, S., & Wilson, G. T. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review*, 18, 391-420.
- Wade, T., Tiggeman, M., Heath, A. C., Abraham, S., Treloar, S. A., & Martin, N. G. (1996). Structure of disordered eating in a twin community sample. *International Journal of Eating Disorders*, 19, 63-71.
- Wade, T., Tiggeman, M., Martin, N., & Heath, A. (1997). A comparison of the Eating Disorder Examination and a general psychiatric schedule. *Australia and New Zealand Journal of Psychiatry*, 31, 852-857.
- Wade, T. D., Bulik, C. M., Neale, M., & Kendler, K. S. (2000). Anorexia nervosa and major depression: shared genetic and environmental risk factors. *The American Journal of Psychiatry*, 157, 469-471.
- Walkerdine, V. (1986). Post-structuralist theory and everyday social practices: the family and the school. In S. Wilkinson (Ed.), *Feminist Social Psychology* (pp. 57-76). Milton Keynes: Open University Press.
- Waller, D., Fairburn, C. G., McPherson, A., Kay, R., Lee, A., & Nowell, T. (1996). Treating bulimia nervosa in primary care: a pilot study. *International Journal of Eating Disorders*, 19, 99-103.
- Wallerstein, N., & Bernstein, E. (1994). Introduction to community empowerment, participatory education and health. *Health Education Quarterly*, 21, 141-147.
- Warin, M. (Forthcoming). Re-configuring relatedness in anorexia. *European Association of Anthropologists*.
- Weedon, C. (1987). *Feminist Practice and Poststructuralist Theory*. Oxford: Basil Blackwell.
- White, M., & Epston, D. (1989). *Literate Means to Therapeutic Ends*. Adelaide: Dulwich Centre Publications.
- White, M. (1992). Deconstruction and Therapy. In D. Epston & M. White (Eds.), *Experience, Contradiction, Narrative and Imagination: Selected Papers of David Epston and Michael White, 1989-1991*. Adelaide: Dulwich Centre Publications.
- Whitehouse, A. M., Cooper, P. J., Vize, V., Hill, C., & Vogel, L. (1992). Prevalence of eating disorders in three Cambridge general practices: hidden and conspicuous morbidity. *British Journal of General Practice*, 42, 57-60.
- Wikler, D. (1978). Persuasion and coercion for health. *Millbank Memorial Fund Quarterly, Health and Society*, 56, 303-338.
- Wikler, D., & Beauchamp, D. E. (1995). Health promotion and health education. In W. Reich (Ed.), *Encyclopedia of Bioethics* (pp. 1126-1129). New York: Prentice-Hall International.
- Wilhelm, K. A., & Clarke, S. D. (1998). Eating disorders from a primary care perspective. *Medical Journal of Australia*, 168, 458-463.
- Williams, G. J., Chamove, A. S., & Millar, H. R. (1990). Eating disorders, perceived control, assertiveness and hostility. *British Journal of Clinical Psychology*, 29 (pt 3), 327-335.
- Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Buckingham: Open University Press.
- Willis, E. (2002). Public health and the 'new' genetics: balancing individual and collective outcomes. *Critical Public Health*, 12, 139-151.
- Witt, D. (1994). What (n)ever happened to Aunt Jemima: eating disorders, fetal rights, and black female appetite in contemporary American culture. *Discourse*, 17, 98-122.
- World Health Organisation (1986). *Ottawa Charter for Health Promotion*. Health Promotion, 1.
- Yager, J. (1994). Psychosocial treatments for eating disorders. *Psychiatry*, 57, 153-164.

Moulding, N., (2003) Constructing the self in mental health practice: identity, individualism and the feminization of deficiency.
Feminist Review, v. 75 (1), pp. 57-74.

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Moulding, N., and Hepworth, J., (2001) Understanding body image disturbance in the promotion of mental health: a discourse analytic study.
Journal of Community and Applied Social Psychology, v. 11 (4), pp. 305-317.

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