



**BECOMING AND UNBECOMING:  
ABJECT RELATIONS IN ANOREXIA**

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Thesis submitted for the degree of  
Doctor of Philosophy  
in the  
Departments of Anthropology and Social Inquiry  
Adelaide University  
January 2002

## Declaration

This dissertation contains no material which has been submitted or accepted for the award of any other degree or diploma in a university or other tertiary institution. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person, except where due reference has been made in the text. I consent to this document being made available for loan and photocopying when deposited in the university library.

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## SYNOPSIS

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This dissertation is concerned with a group of people's everyday experiences of anorexia. Rather than focus on anorexia as a fixed point of illness, this ethnography takes the processual and sentient nature of experiences as a point of analytic and ethnographic departure. It is primarily concerned with the processes that propelled people towards and away from this phenomenon: the desires, connections, disconnections, practices, contested performances and struggles of becoming and unbecoming 'anorexic'.

It is through the concepts of relatedness and abjection that I explore experiences of anorexia. Anorexia, I argue, is fundamentally concerned with issues of relatedness; of relationships with oneself, people and objects in the world. Participants disconnected themselves from what was constitutive of social relationships: food, relationships, emotions, bodily processes, and at times, attempted to sever a connection with life itself. Moreover, in people's experiences, these types of relatedness were described as simultaneously horrifying yet desired. It was the tension created by holding these seemingly contradictory experiences together that I analyse in terms of abjection. Through negating potential linkages to others (such as refusing commensality, avoiding social spaces, withdrawing from certain relationships and purging what was considered to be dirty away from bodies), participants removed the horror associated with abjection. Rather than leave people in a void of disconnection, I argue that these practices transformed and created entirely new avenues of relatedness.

Exploring anorexia in terms of relatedness and abjection is at odds with much of the literature on this topic that characterises anorexia as the epitome of the 'western' obsession with individualism, of self-control and autonomy. The ethnography presented in this thesis clearly challenges this view, for experiences of anorexia are relational, not singular, autonomous or static. Central to people's experiences were dynamic and dialectical relationships of belonging and disconnection, of contamination and purity, of desire and horror.

As much as the concepts of relatedness and abjection provide an analytical focus for understanding anorexia, the reverse also applies. This thesis establishes anorexia as a vehicle to ethnographically constitute relatedness and abjection and in doing so, extends and critiques these theoretical concepts beyond their traditional domains of kinship and psychoanalysis. By drawing together the dynamics of anorexia, abjection and relatedness this thesis thus represents not only a significant contribution to the medical domain, but also a valuable contribution to the anthropology of relatedness.

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## ACKNOWLEDGMENTS

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This thesis is indebted to those participants who so generously shared their time and experiences with me. It is their interest, warmth and incredible generosity that have created and sustained this project and I *sincerely* thank them for allowing me to share a part of their worlds.

As with any research, the ideas presented here have developed in engagement with a number of other people. In particular, it is with deep gratitude that I thank those who have supervised this work: Margie Ripper, Rod Lucas and Deane Fergie. All three provided exemplary supervision through their fine scholarship, unwavering support, and friendship.

Deane and Rod, as former teachers and work colleagues, introduced me to the values of ethnography; to the discovery of new relationships and processes embedded in the world. It is their superb tutelage that prepared me for postgraduate work. Deane, as always, was able to bring fresh eyes to this ethnography and suggest themes that were hidden from my view. Margie similarly had the astute ability to ask incisive questions of my work, encouraging me to link ideas to wider analyses of gender relations. Rod, through his brilliant critiques of key points, encouraged me to push theoretical arguments in directions that have served to strengthen this analysis. Although any of these three would deny working any magic, it is their keen intellect and inspiration that I pay tribute to.

Perhaps the most extraordinary aspect of this supervisory 'team' was the circumstances in which they operated. Throughout this research Deane was embroiled (and vindicated) in the protracted Hindmarsh Island Bridge Federal Court Case. Despite the enormous pressures that this case (and the previous Royal Commission) brought to bear on Deane and Rod, they continued (at different times) to supervise this work. I will always admire and respect their professional (and personal) abilities and integrity. During this uncertain time Margie continued to be my 'anchor', and I am enormously thankful for her 'mooring'.

A great number of people assisted in making this research possible. Many health professionals welcomed me into their workplaces and gave me encouragement of all kinds. I am especially grateful to Elliot Goldner, Margaret Norman, Rolf Breyer, May McNicol, Peter Gilchrist, Charlotte Procter, Chris Freeman, Maggie Gray, Vonnie Coopman and Cina Mastrantone.

Karen Turner and Jon Telfer read earlier drafts of this work and I have benefited enormously from their meticulous attention to detail, insightful comments and encouragement at crucial moments.

I am grateful to all the postgraduate students and staff in the Departments of Anthropology and Social Inquiry at the University of Adelaide who have engaged with this work and offered intellectual stimulus at various seminars, postgraduate meetings and over informal conversations (most notably the weekly morning tea in Social Inquiry). In particular, I would like to thank Nicole Moulding, Catherine Palmer, Debbi Long, Arthur Saniotis, Simone Dennis, Erez Cohen, Melissa Iocco, Lara Palombo, Pam Papadelos, Ingrid Hofmann, Emily Potter, Damon Parker, Ali Ben Kahn, Susan Oakley, Amanda Nettelbeck, Thalia Palmer, Sharon Lewis and Colleen Solly – all of whom have skills and knowledges that have, in a myriad of ways, informed this work. I also wish to acknowledge the intellectual stimulation I gained from the “Eat me! An anthropological examination of food” session at the Australian Anthropological Society’s Annual Conference at La Trobe University 2001. Many thanks to the wonderful Kalissa Alexeyeff and Roberta James, and all the other panel contributors and audience members who offered critiques and suggestions.

Financial support for this project was provided by the Catherine Helen Spence Travelling Scholarship, the Karen Halley Trust and an Australian Postgraduate Award. I thank each of these bodies and their administrators for such vital support.

And lastly, I wish to thank my family. To my parents Joan and Jack, thank you for believing in the value of education and fostering a love of learning. To my partner Cameron, for whom words are completely inadequate, thank you for your unstinting encouragement and confidence in me to achieve on so many levels. Your support has enabled me to pursue goals and opportunities beyond all my expectations. It is to Cameron and our daughter Freya, who was by far the greatest birth in the midst of this ethnographic production, that I dedicate this thesis.



# INTRODUCTION

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*The introduction announces a project, and a project is nothing until it is realised.*  
*(Derrida 1976: x)*

There was an air of anticipation amongst the young women in the community house. The anticipation had been building all week, simmering amongst conversations on the verandah, then spilling over into therapy sessions with staff. As a group, the women told me about the nameless ‘underweight woman’ who was coming to stay with them for a brief period. Her emaciated state was their central concern, for all the women in this program had gained weight through a recovery program and were still adjusting to their new embodied presence. A few days later this anonymous person found a name. “Josie will sabotage all our hard work just by being here”, Sophie complained to the nurses.<sup>1</sup>

Although she was expected to arrive in time for dinner, Josie had been held up at the hospital by appointments with doctors. This delay only added to the suspense. She must be “*really sick*” they said. Josie arrived just as the eight women on the recovery program were sitting down to de-brief *after* their shared evening meal (her timing could not have been better). By the time everyone had gathered in the lounge and taken up their usual seats, Josie was already sitting perched in the middle of a large sofa, the centre of attention. Her presence was palpable and I saw the downcast eyes of the eight women as they sneaked glances to assess her diminutive frame, the large water bottle placed between her knees, the prominent veins in her arms and legs, her waxy skin and protruding cheek bones. Despite her ‘cadaver-like’ appearance, Josie’s demeanour was

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<sup>1</sup> Following customary ethnographic practice pseudonyms have been used for participants throughout this thesis except in the case of one woman who requested that her name not be changed, as she felt that this was an important part of her recovery, and who she is.

not one of sickness, weakness or fatigue. She sat upright, her head held high, her strong voice and direct eye contact reflecting the power of unease she had created. She held centre stage and the other women (including me) were silenced, yet drawn to her presence.

I start with this recollection as it captures the central ethnographic and analytic themes that underpin this thesis, of relatedness and abjection. Josie knew that she held a position of distinction in the group. She embodied what many longed to return to — ‘pure anorexia’ — the ‘clean’ state of being that was untainted by the polluting aspects of food, her body and relationships. She firmly belonged to what some referred to as ‘the anorexia club’: an elite and secretive group that strategically mobilised the term ‘anorexia’ for their own purposes. Josie was not disempowered by the label of disorder. On the contrary, it afforded her a level of symbolic power that the others had relinquished. Her level of ‘sickness’ only served to heighten her position of power within the room. By entering a contract of recovery, the eight women no longer belonged to anorexia, they had “cut the cord” and sullied themselves by imbibing food. Several told me afterwards that returning to ‘normal health’ disgusted them, and the desire to move back to anorexia — to be clean, empty and pure — was something with which they constantly struggled.

The struggles and strategies described in this thesis are concerned with the shifting forces of desire and power. These forces do not unfold along a linear trajectory but are in constant motion, reflecting the back and forth strategies of making and re-making, and of connecting and disconnecting within and across different fields. This motion is primarily concerned with relatedness, of relating to oneself, to others and to the world. This thesis is thus concerned with the interconnected processes and tensions of agency, intersubjectivity and being.

In anthropology relatedness has traditionally been associated with kinship studies, of family connections, arrangements and obligations that were initially assumed to be grounded in the ‘natural’, biological facts of sexual procreation. A key figure in shifting these formalist traditions was Schneider (1968/1980, 1984), who, in his first work argued that American kinship was a *cultural system* that operated through symbolic logic. Schneider suggested that sexual reproduction was a core symbol of a kinship system that comprised two distinct models of “relationship as natural substance [symbolised in idioms of blood] and relationship as code for conduct [what people do and say they do]” (Schneider 1980: 29). In his second book, which encompassed a commentary on *American Kinship* (1968/1980), he argued (as others including Needham (1971) had also done) that the centrality of sexual procreation to anthropological models of kinship was deeply flawed due to its focus on the cultural specificity of assumed universal, ‘natural’ facts.

While this thesis does not focus on contemporary debates about kinship studies, my point in raising Schneider’s path-breaking work is to demonstrate its importance in opening up new scopes to conceptualise relatedness.<sup>2</sup> Recent interests in kinship studies have returned to and questioned his problematic, and at times contradictory dichotomy of the social and biological (Franklin 1997). “Relatedness”, as Edwards and Strathern comment, “was never one thing, and definitely never either a matter of social or biological connection alone” (Edwards & Strathern 2000: 162). Edwards (1993, 2000) argues elsewhere that the concept of relatedness extends beyond the presence of ‘natural’ and shared substance (for example blood or genes) and can be used to include other notions of connectedness “with or without a genetic link” (1993: 45). Relatedness is thus not simply about *the separate* domains of ‘biology’ or ‘the social’, but the intersections between them and beyond them.

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<sup>2</sup> Strathern (1992) acknowledges Schneider as “the anthropological father” of *After Nature*, “since it is both with and against his ideas on kinship that [her book] is written” (1992: xviii).

It is in this wider focus of relatedness that the arguments of this thesis are situated. I argue that concepts and practices of relatedness are not only composed of ties created by procreation and familial/social obligation, but of *multiple* elements: the everyday exchange and sharing of food and substances, living together, domestic arrangements, places, memories, emotions and relationships (including sexual) — “elements which are themselves not necessarily bounded entities but may overflow or contain parts of each other or take new forms” (Carsten 2000a: 34). Relatedness “permeates all domains of social life” (Edwards 2000: 27). While Holy cautions that such a general characterisation of relatedness renders it in danger of “becoming analytically vacuous” (Holy 1996: 168), such broadening is required to prise relatedness away from the privileged and arbitrary distinctions of biology and culture, and move it towards the everyday acts that comprise relatedness.

Ernst refers to these elements or components of relatedness as “*relations of relationships*, not relations of individuals” (Ernst 1990: 111, emphasis in original). This is an important distinction to make, as the cluster of analytic and folk terms that are often used interchangeably to denote idioms of relatedness (relationships, relatives, relations and relational) are in effect differing parts of its conceptualisation. Relatedness, as I use it, is a multi-layered continuum — “comprising everything from the most formal relations of descent to the least formal relations of, say, secret friendships” (Stafford 2000: 53).

Rather than positioning eating disorders within a framework of individual pathology, I argue that relatedness, in all its forms, is central to people’s practices and experiences of anorexia. Those practices that are taken for granted as creating and sustaining relatedness — from the everyday practices of commensality to the capacity to have children — were consistently negated by participants with a diagnosis of anorexia.

Moreover, these practices were regarded as dirty and disgusting, and feared for their threatening, yet desired, potentialities.

Negating consensual avenues of relatedness did not leave these people in a void. On the contrary, it meant that new meanings and experiences of being related were created. New forms of relatedness included concealment of 'anorexic practices' (from family, medical staff and friends), secrecy and competitiveness with other in-patients, friendships forged through a sharing of common diagnosis, and the personification of anorexia as a friend, an abusive lover, a parent, a child, the devil in disguise, or an enemy. Some even gave anorexia a name like Ana or Ed (the former a shortened version of anorexia and the latter an acronym of eating disorder). Individually and collectively, people entered into a relationship with anorexia that in turn, tempered their relationship with their everyday worlds.

Central to these processual movements of relatedness were ambiguous experiences. The very term anorexia, which literally means lack of desire/a loss of appetite (Peters 1995: 63) is erroneous, for people with this diagnosis often stand in an ambiguous relationship with food: "obsessed with it, she [sic] similarly regards it as an object of desire and disgust" (Celermajer 1987: 65). Participants in this study simultaneously experienced pleasure and disgust, were empowered and disempowered, felt safe yet constantly threatened, were both pure and dirty, and when the sickest felt at their best. Anorexia was a constant process of becoming and unbecoming, of having a life by moving towards death.

In many ways, these experiences of relatedness have remarkable resonances with what Kristeva outlines in her theory of horror, which she terms abjection. Located in the physical immediacy of bodies, abjection is a psychoanalytic/literary model that Kristeva uses to explain the process of self-individuation in the early years of life. Kristeva

suggests that in order for a child to attain identity and a place within the symbolic order it must separate from the “nourishing and murderous” maternal body (1982:54) and recognise its own bodily boundaries and limits. This, Kristeva argues, is a process that occurs on the *threshold* of acquiring language, for it is when the child learns the language associated with the ‘clean and proper body’ that subjectivity is possible. By disavowing aspects of corporeality, especially that which threatens bodily boundaries — the improper, dirty and disorderly — the subject learns to mark off the self and claim the body as its own.

While the word ‘abject’ literally means to cast off, away, or out, abjection is defined in relationship to desire. It “beseeches, worries and fascinates desire” (Kristeva 1982: 1), and is endured because of this relationship (Fuery 1995: 94). Kristeva identifies three broad forms of abjection: in relation to food and bodily incorporation; toward bodily waste; and toward the signs of sexual difference. As such, substances like spit, food, faeces and vomit are abject for they “disturb identity, system, order ... [they do] not respect borders, positions and rules ... [they are] inbetween, ambiguous, [and] composite” (Kristeva 1982: 4). As “imaginary uncanniness and real threat”, what is abject must be rejected and cast out, otherwise it “ends up engulfing us” (ibid: 4). As neither subject or object, the abject is “closely bound up with questions of identity, boundary crossing, exile and displacement” (Smith 1998:29).

While this thesis does not rely on Kristeva’s psychoanalytic framework, it does extend her concept of abjection and ground it ethnographically. In arguing for a critical application of Kristeva’s theory, I demonstrate that one cannot write about abjection without considering relatedness. Relatedness is at the very core of abjection, for, in being cast out, one moves away from relationships (with people, oneself and objects), and creates a different kind of relatedness. Abjection, as I use it, moves beyond

Kristeva's location of it in the imaginary, psyche and language, to the everyday practices and terms of sociality. It is not simply about subjectivity, but also concerned with intersubjectivity. By bringing the concepts of relatedness and abjection together into the analytical arena, this thesis raises new questions and new perspectives not only concerning anorexia, but on the lives of those who are given this diagnosis.

This thesis thus 'tracks' the multiple dimensions of relatedness and abjection through people's experiences of anorexia. It explores what was considered abject (objects, spaces and bodies), the embodied, visceral responses to this (simultaneous horror and fascination), and the practices by which people desired, 'cast out' and removed the abject. Things that were considered abject, including fats, bodily processes, public spaces and relationships were distanced, negated, cleansed and purged in an attempt to remove their threat. While these practices were seen by clinicians as symptomatic of a diagnosis of anorexia nervosa, they were understood by those who practiced them as an entitlement to belong to anorexia, a process that was interwoven with the powers of revulsion and desire.

It is through this ethnography that anorexia becomes a vehicle not only for extending the analytic concept of abjection, but also the notion of relatedness. Anthropological concepts of relatedness have not been addressed in any of the writings on anorexia, despite the literature being replete with negative connotations of sociality such as withdrawal, regression, lying, hidden behaviours and toxic families (in the forms of 'obsessive mothers' and 'absent fathers'). Cross-cultural literature clearly demonstrates the usefulness of examining food in terms of relatedness. Becker (1995), for example, in exploring embodied experiences in Fiji, highlights the "relational matrix" of self, body, food, kin and community relations that underpin the Oceanic ethos of social relatedness (1995: 5). Meigs (1997) similarly notes how the Hua people of the Eastern

Highlands of Papua New Guinea understand food and eating as a continuous and dynamic process of relatedness. Relatedness is also central to people's experiences of anorexia, yet has been overlooked by discourses of individualism.<sup>3</sup> Similarly, with the exception of Reineke (1997) (who discussed abjection, anorexia and medieval women mystics within Kristeva's psychoanalytic terms), an extended and ethnographically informed theory of abjection has not been central to any explorations of contemporary anorexia.

The perpetual movement by participants in this ethnography (of their desires, connections and ruptures) highlights the ways in which relatedness and abjection move and transform across apparently divided epistemological fields. Relatedness, as argued above, is not exclusively biological or social. Nor is abjection located within, or outside the individual. In a challenge to and questioning of these concepts (the enduring anthropological endeavour) this thesis proposes that experiences of anorexia continually cross the divides that are central to abjection and relatedness, shifting from one realm to another. It is by way of these movements, and the intersections between them, that anorexia, relatedness and abjection are experienced.

\* \* \*

The fieldwork on which this thesis is based was conducted in multiple sites (Vancouver, Edinburgh and Adelaide) over fifteen months (August 1998 - October 1999). It deals with forty four women and three men ranging in ages from 14 to 55.<sup>4</sup> People's backgrounds varied: they came from struggling farming backgrounds, migrant families, and professional families. Equally, the location of their residences varied

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<sup>3</sup> In a therapeutic context, Katzman and Lee (1997) argue that a shift in clinical interventions towards contextual variables may be useful. They suggest, for example, that "thinking about eating disorders as a problem of disconnection, transition, and oppression, rather than dieting, weight and fat phobia" (Katzman & Lee 1997: 392) would be beneficial to those women with eating disorders who dwell "in a psychological diaspora" (ibid).

<sup>4</sup> The average age was 28, belying the stereotype of people with anorexia being in their early teens.



from inner city rental apartments, country homes, housing estates to opulent mansions in leafy suburbs. Although the participants were Anglo-Celtic they often spoke of connections and disconnections with related family homelands: Greece, Croatia, Estonia, the UK and Germany. Occupations similarly ranged amongst participants, some were students at high school or university (law, medicine, psychology); others worked in a variety of professions: teaching, nursing, general practice, acting, and sales assisting in retail shops (including *The Body Shop*). Several, who were too unwell to work, were surviving on financial assistance from government agencies.

While over a third of these people lived alone, a substantial percentage (52 %) lived with family (parents, partners or children). This group comprised not only those who were married (five) and had children (six) but also the youngest participants of this research (thirteen of whom were under the age of twenty three). Many of these were studying and were financially dependent on their parents. A small number (six) lived in share accommodation with friends, and again, most of these people were studying at university. The most striking aspect of people's living arrangements was the absence of sexual relationships. Over seventy percent were single at the time of my fieldwork. In terms of relatedness, this is significant, for several described the difficulty of having 'other' and intimate relationships whilst "you were having a relationship with anorexia". As Maddy, now recovered, said: "The place where anorexia is, it's a very narrow space, and there is little room for anything else".

In attempting to understand anorexia I tried to expose myself to as many of people's experiences as possible, through what Stoller calls "an assortment of ingredients — [of] dialogue, description, metaphor, metonymy, synecdoche, irony, smells, sights and sounds" (Stoller 1989: 32). This often meant accompanying people through cycles of treatment — into hospitals, visits to different treatment centres, meetings with

psychiatrists and nursing staff — and back to their own homes and everyday lives. We met in cafes, parks and pubs, went grocery and clothes shopping, and spent hours sitting in kitchens, lounge rooms and on bedroom floors. I thus engaged not only with those who had a diagnosis of anorexia, but with health professionals, community and volunteer workers, health administrators, and participants' family members, neighbours and friends. Although treatment spaces are an important part of people's experiences, these did not define participants' social worlds and are not the central focus of this thesis. It is the comprehensive nature of fieldwork that distinguishes this thesis from all other writing on anorexia, an ethnographic analysis that incorporates and extends beyond an institutional and discursive framing.

Meetings were initially arranged through clinicians and community nurses, who acted as gatekeepers to 'a psychiatric community of eating disorder patients'. The term 'community' is a misnomer, for there was no one place where people with anorexia lived together for a lengthy period of time. I did, however, have the opportunity to do limited fieldwork in a community treatment house where residents lived for up to four months. Most of the time, though, encounters were one to one, reflecting the isolated lives that many people led.

This thesis is thus an account that reflects the diversity and changing, processual nature of this 'disorder'. While I do not claim to represent the plurality of people's experiences, and their continually changing and contingent nature, I have sought to elucidate common threads of what people experience as anorexia. Although different people had different names for 'anorexia', throughout this thesis I refer to it as anorexia, as this is the diagnosis that each were given, a 'label' that profoundly affected people's lives.<sup>5</sup> I recognise the desire of many to write this term away (Malson 1998: 144;

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<sup>5</sup> Like Garrett (1998) I also use 'anorexia' somewhat as a 'blanket term', to denote the intermingling of anorexia with other eating disorders. While I use the term 'anorexia nervosa' when describing the

Pembroke 1993; Eckermann 1994), but I could not ignore the symbolic power attached to such a word, and the strategies used to mobilise its worth. This is not to suggest that the label existed independently as a clinical entity, or that it was necessarily taken as a given (it was, at certain times, denied), but rather to point to the ways in which anorexia was mobilised and transformed by participants. Anorexia was more than a medical diagnosis; it was, amongst many things, an empowering state of being, a friend, an enemy, and a way of life.

In many ways I have always had a much clearer sense of what this thesis would *not* be about, and it was this steering away that directed the course of this ethnography. It is important for me to briefly articulate my differences and dissatisfaction with taken-for-granted assumptions concerning anorexia, for they provided a springboard for my analytic and ethnographic focus.

### **The spectacle of thinness**

It is hard to disentangle the myriad of assumptions that circulate around anorexia. It has, in the words of Appadurai, its own 'social life' (1986). These assumptions have a strong hold in the public imagining of this 'disorder', and it seems as if everyone has some familiarity and hence an opinion on the topic.<sup>6</sup> Throughout this research I have listened to and read an almost endless stream of interpretations on anorexia: it is a regression to childhood; an inability to deal with adulthood; an issue of control and resistance against a universal backdrop of female subordination; a genetic

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medical framing of this category, most often I refer to it as anorexia, as this was the language used by participants.

<sup>6</sup> I found that there was an implicit assumption amongst some female audience members at seminar presentations of this research that 'being a woman' stood as an authority and authenticity for all other women's experience. Tsing (1993), citing Strathern's arguments in *The Gender of the Gift* (1988) warns against such easy assumptions:

... that women everywhere are the same; that women's speech reveals a "woman's point of view"; that women always speak from the gender identity of "woman". Strathern stresses the necessity of investigating the forms of power and discourse framed by the exclusions and oppositions of gender; these become the starting point for discussing both the "femaleness" and the "agency" of women's agency. (Tsing 1993: 33)

predisposition; a biological dysfunction; the fault of the media promulgating images of thin models as the ideal body type; a result of 'toxic' families and even, as the family friend of one participant suggested, "anorexia is the devil's work".<sup>7</sup>

Despite the differing frameworks (of feminism, medicine, history and religion) there were common taken-for-granted representations that underpinned and limited each analysis. Each viewed the person who self-starved or who had a diagnosis of anorexia as striving toward the attainment of thinness. It was the thin body that was the focus of attention, the marker of illness or succumbing to patriarchal ideals.<sup>8</sup> The thin body was the extreme body, and one that provided simultaneous horror and fascination in popular imaginings. Visual representations of these bodies play into the ways in which thin bodies inhabit limited space — Wolf's front cover of *The Beauty Myth* (1990) depicts a bandaged and silenced naked woman holding an orange and contorted underneath a small wooden table. Other media images have women standing sideways against blank walls, emphasising their jutting hips and frail postures (and are often accompanied with before and after photographs).

Focusing on thinness has a number of problems. It is firstly a privileging of the visual, of the outsider's, the coloniser's gaze. I am reminded of Kafka's short story *A Hunger Artist* (1924), a story that chronicles a form of paid entertainment that was popular in travelling carnivals around the turn of the 19<sup>th</sup> century in Europe. In a cage laden with straw, the male hunger artist publicly fasted for 40 days and nights. Permanent guards (which were usually butchers) watched the hunger artist day and night, "in case he should have some secret recourse to nourishment" (Kafka 1924/1992: 268).

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<sup>7</sup> Bray (1996) lists the many significations of anorexia, concluding that "this taxonomy demonstrates that the body of the woman who practices eating disorders presents a coding problem. As the 'dark continent of femininity', the territory of the anorexic body has been colonised by a motley group of discourses contesting the truth of anorexic lack" (1996: 413-4).

<sup>8</sup> Popular and medical literature is replete with examples of 'anorexics' looking in the mirror and 'seeing' an imaginary body, one which belies their emaciated form. Similarly, when people with anorexia are asked to draw their physical body they are said to exaggerate their size. The current emphasis on thinness is not in accordance with people's own representations or renderings.

“Children”, Kafka wrote “stood open mouthed, holding each other’s hands for greater security, marvelling at him as he sat there pallid in tights, with his ribs sticking out so prominently ... [sometimes] stretching an arm through the bars so that one might feel how thin it was ...” (ibid).

There is no doubt that thinness associated with anorexia holds a fascination. It is, as the description of Josie attests, a spectacular end product. Many media articles that I collected during my fieldwork used the same enticement of spectacle, depicting shocking colour images of young women’s emaciated bodies, often semi-naked. People dying of cancer are rarely represented in the same exhibitionist manner.<sup>9</sup> A male journalist contacted the eating disorder association I volunteered at, wanting to interview a young woman with anorexia, and requested a “really skinny one” for the story. In focusing solely on this visual spectacle of anorexia, the female body continues to be positioned and reproduced as public, as an object to be examined, beholden and always visible. Anorexia is reduced to a carnivalesque image that is represented by femaleness, thinness, illness, horror, fascination, and death. In the wake of reflexive anthropology I was acutely aware of *not* reproducing the exoticism associated with representations of anorexia.<sup>10</sup> Moreover, as I discuss in the conclusion of this thesis,

<sup>9</sup> People with HIV/AIDS though are similarly represented in a process of death. What holds fascination and horror for both anorexia and AIDS is the closeness of death in the prime of one’s life.

<sup>10</sup> One psychiatrist asked me if I was aware that it was very fashionable to study anorexia, pointing to the double exoticism of anorexia and psychiatry. Anorexia is ‘fashionable’, in the sense that it is more spectacular than other eating disorders. The media privileges anorexia through glamorisation and fetishisation of this disorder as exemplified by the Australian weeknight television program (*A Current Affair*) that ‘followed’ a young woman’s experience of anorexia and treatment over three years. Not once during my fieldwork did I see the same program hosting a special on bulimia or compulsive eating. These ‘disorders’ do not offer the horror or spectacle of the wasted ‘anorexic body’ and are therefore not considered ‘high rating’. Gordon (a professor of psychology and practicing clinical psychologist), in his book *Eating Disorders: Anatomy of a Social Epidemic* (2000) highlights the way in which the media has had a hand in popularising some psychiatric disorders:

During the late 1970s and early 1980s, anorexia nervosa was widely publicised, glamorised, and to some extent romanticised. Language such as “disorder of the 80s” reflects the fact that in the era of modern media, diseases, and particularly psychiatric disorders, can easily become fashionable and popularised, and this was indeed the case for anorexia nervosa. (Gordon 2000: 3)

Malson (a lecturer in psychology) similarly notes, “the high profile of ‘anorexia nervosa’ in both the popular and academic press suggests a cultural fascination with eating disorders” (1998: 5). The medical field is not outside this fascination or construction of anorexia as spectacle. Both Malson’s and Gordon’s books have black and white representations of emaciated, naked and contorted women on their front covers, a strategy that buys right into the spectacle of thinness and death.

these representations were too simplistic and did not allow for an understanding of the complexities of gendered, embodied experiences, of the power at work, or of the sense of distinction that came from such a posturing.

During my fieldwork I quickly learnt to discard thinness as the definitive bodily marker of anorexia. Thinness denotes a static and fixed occupation of space and time. Most participants were not 'spectacularly thin', and the few who were did not remain so. People were continually moving through different stages of anorexia each time we met, from being newly diagnosed, to weight gain programs, toward recovery and in many cases, back to hospitals (including intensive care units). Rita, who became a central informant, made light of the fact that people with anorexia are not always thin. When we arranged to meet for the first time she joked on the phone that she would be "the fat one" standing by her white car in the car park outside a public garden. I wasn't sure at the time if she was being facetious, and indeed when we met she was not the stereotypical thin 'anorexic'. Rita had experienced both anorexia and bulimia for most of her adult life, and her weight had fluctuated dramatically. My interest though was not in her weight, but rather in her experiences of anorexia, experiences that were embodied, corporeal, felt and sensed. Her body weight was not a prerequisite to sharing her memories, grief and life. Her experiences of embodiment were.

### **Discursive approaches**

The second point of departure that this research took was created by my desire not to reproduce the many discourse-orientated approaches to eating disorders. Within the vast body of literature that deals with eating disorders there is one poststructuralist thinker who stands out. Foucault's theory of discourse has been highly influential and productive in this literature because it provides a double critique of medicine and by

extension, of patriarchy.<sup>11</sup> Writers such as Turner (1984, 1987), Bordo (1988, 1989, 1990), Bartky (1988), Tait (1992), Eckermann (1994, 1997), Robertson (1992), Hepworth (1999) and Malson (1998) have all drawn on Foucault's work in some measure to throw light on "the complex network of disciplinary systems and prescriptive technologies through which power operates" (Diamond & Quinby 1988: xi). As one example, Bordo and Bartky state that the most common reason for self starvation is that constructions of femininity, and a pre-occupation with diets/exercise, have actually constituted these disorders. The critique and deconstruction of femininity within the feminist literature has suggested that powerful, patriarchal discourses construct images of femininity that are contradictory, and that anorexia is a way of resisting and simultaneously complying with these ideals.

One of these ways in which power operates, it is argued, is through the media and the dissemination of contradictory images of femininity. Even writers like Wolf (1990) who do not directly use Foucault's insights, point to the ubiquitous images of thinness, beauty and power that fill the pages of women's magazines, newspapers, films and television screens. Wolf argues that these images have created a beauty myth, one which has been 'masterfully orchestrated' to coerce and silence women. She views this myth as:

A direct solution to the dangers posed by the women's movement and economic and reproductive freedom. Dieting is the most potent political sedative in women's history; a quietly mad population is a tractable one. (Wolf 1990: 187)

Theorists with a Foucauldian perspective have offered some quite convincing explanations of anorexia itself, but like Wolf, have tend to 'read the anorexic body' as a metaphor for the social body — as Bordo's title explicitly states, a 'crystallisation of culture' (1988). In criticising this approach, Bray (1994, 1996) refers to anorexia as a

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<sup>11</sup> A brief review of Malson's recent book *The Thin Woman* (1998), for example, illustrates this alliance with Foucault's concept of discourse; seven of the eight chapter titles includes a derivative of the word discourse: discoursing, discursive or discursive productions.

'reading disorder', related to the common assumption that anorexia is a pathology brought about by women's uncritical consumption of media images of thin femininity (1996: 413; cf. Celermajer 1987).<sup>12</sup> The anorexic body of these analyses, which in many ways reproduce the docile body that Foucault articulated, is a text in which cultural values are inscribed, etched and written upon.<sup>13</sup> Power relations "have an immediate hold on it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs" (Foucault 1977: 25). The particular use of Foucault's discourse has rendered the gendered body malleable, one which "locates the generative forces outside the immediate, lived reality of the lifeworld" (Jackson 1996: 21; cf. McNay 1999).

This passivity of the body is, in part, a result of the way in which discourse and its operations of power and knowledge have been solely located by these writers in specific institutional practices – in hegemonic and dualist structures that allow little space for agency, embodiment and the everyday. This is in spite of Foucault's own theoretical shift in understanding power from institutions to the self.<sup>14</sup> Turner (1984), for example, demonstrates this hegemony at work:

Anorexia is ... a symbolic struggle against forms of authority [patriarchy, family and medicine] and an attempt to solve the contradictions of the female self, fractured by the dichotomies of reason and desire, public and private, body and self, nature and culture. (Turner 1984: 201)

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<sup>12</sup> Probyn (1987) and Eckermann (1994) similarly critique feminist writers such as Orbach and Lawrence who have embraced Bruch's (1978) leanings "towards a causal model of the media as directly responsible for all social ills, and anorexia in particular as a falling out from experiencing too much representation" (Probyn 1987: 203; Eckermann 1994: 92).

<sup>13</sup> Grosz (1994) makes a similar point concerning the close analogy between the body and the text (1994: 117). She also suggests that while Bordo's discussion of anorexia in terms of a psychology of self control is extremely useful, it risks duplicating the mind/body dualism and taking the body as a kind of natural bedrock on which psychological and sociological analyses may be added as cultural overlays (ibid: 145).

<sup>14</sup> Foucault himself recognised the overemphasis on 'techniques of domination' in institutions and shifted his later work into 'technologies of the self' (Foucault 1980, cited in Miller 1993: 321-2, cf. Foucault 1990). The overemphasis on hegemonic power is demonstrated in Barrett's (1996) ethnography, where he explicitly links Gramsci's concept of hegemonic power to Foucault's more diffuse and uncentralised nature of power (Barrett 1996: 73, cf. Frankenberg 1988).



In this formulation, women with anorexia are not only struggling against the oppression of male domination (which is located in a hegemonic discourse) but are also attempting to reconcile the embodiment of Cartesian ideology (again located in a hegemonic discourse) that is said to fracture all women. Despite the rhetoric of power acting in a diffuse manner, ‘women’ (the use of the generic itself being problematic) are fundamentally caught in a web of discursively produced hierarchical positions in which they are always dominated and disadvantaged (cf. McNay 1994; Hall 1996: 12).<sup>15</sup>

McNay argues that Foucault “steps too easily from describing disciplinary power as a *tendency* within modern forms of social control, to positing disciplinary power as a fully installed monolithic force which saturates all social relations (McNay 1994: 104). Power then, is always a form of domination, for in Foucault’s theory, discourses ‘discipline’ the body through a “multiplicity of minor processes of domination” (Foucault 1977: 138).

While not denying the use of power within medicine<sup>16</sup> or the profound influences of Foucault’s work, such an explanation cannot account for the transformative, empowering and ambiguous experiences of anorexia; in short, for the very centrality of relatedness. In my fieldwork I observed the *multiple* ways in which power was strategically deployed by those with this diagnosis.<sup>17</sup> Power was used quite differently from Turner’s Foucauldian account. It was not a force yielded to or coercive. In fact, it was a force taken and transformed into a productive embodied state. The power associated with anorexia was exemplified by Josie, whose extreme thinness was, to

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<sup>15</sup> In *The other question: difference, discrimination and the discourse of colonialism* (1990) Bhabha similarly argues that some theorists overemphasise the hegemony of colonial discourse, such as, in his view, Edward Said: “There is always, in Said, the suggestion that colonial power and discourse [are] possessed entirely by the coloniser” (1990: 77).

<sup>16</sup> Glick (1967) notes that “access to power and the ability to employ it on behalf of the sufferer is universally required if one is to be considered a healer” (Glick 1967, cited in Good 1994: 60).

<sup>17</sup> Eckermann (1994) suggests that Foucauldian formulations of power are explicitly tied to a particular construction of selfhood. As an example, she cites the work of Giddens (1991), who argues that anorexia is a search for selfhood, the production of a coherent, consonant and unitary self. His reliance on the discursive construction of the self, she argues, does not allow for multiple, embodied, and contradictory forms of power and identity (Eckermann 1994: 89-90).

those recovering from anorexia, a marker of distinction, a state of purity and a sign of belonging to an elite group.

In my fieldwork it was clear that the powers at play were not simply between doctors and patients; they were far more complex than allowed for in a static theory of domination. Within the collective of anorexia, for example, there were constant struggles for hierarchical positions of purity, to be the best anorexic. Similarly, in differing institutions, therapists and psychiatrists vied over who had the ‘authority to speak’ about anorexia, and the best way to treat anorexia was a highly contentious issue. In Bourdieu’s terms, anorexia was situated and practiced in a ‘field’, a relational social space defined by a dynamic configuration and positioning of people and structures.

In using Bourdieu’s concept of field the centrality of agency comes into play, an integral but overlooked part of social discourse. “Individuals”, as Bourdieu comments:

... exist as agents — and not as biological individuals, actors or subjects — who are socially constituted as active and acting in the field under consideration by the fact that they possess the necessary properties to be effective, to produce effects, in this field. (Bourdieu & Wacquant 1992: 107)

On a similar note, Butler in *Gender Trouble* (1990) points out that while identity is constructed, it does not follow that identity is therefore fully determined by this construction — such an argument would deny the possibility of agency.<sup>18</sup>

“Construction is not opposed to agency” Butler writes, “it is the necessary scene of agency, the very terms in which agency is articulated and becomes culturally intelligible” (1990: 147).

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<sup>18</sup> Probyn has experienced first hand the ways in which a discursive construction of identity can be limiting. In delivering a conference paper she stated in a passing comment: “I became anorexic”. It was these three words that caused consternation amongst the audience, with one person saying that “this personal mode of enunciation made him nervous” (Probyn 1993: 12). Following publication of the paper Probyn was further rebuked for absenting her own anorexic body from the text (Szekely 1988: 10) and on the other hand for writing her own ‘postmodern ethnography’ (Frank 1990: 146-8). What perplexed Probyn was that all three (different) reactions assumed an essential and static truth of her personal identity, “that I was telling, or wanting to tell, the truth, in this case about the essence of my being” (Probyn 1993: 12). Moreover, these reactions suggest a divide between objectivist and subjective knowledges and articulations, between writing too much or too little of herself into the work.

While it is clearly important, as Lupton states, “to trace the discourses and practices of medicine and to demonstrate shifts as well as continuities over time” (1997: 103), it is equally important to:

... allow for lived experience, for the *phenomenology* of the body. Bodies may be surrounded by and perceived through discourses, but they are *irreducible* to discourse. The body needs to be grasped as an actual material phenomenon which is both affected by and *affects* knowledge and society (Shilling 1991: 664, emphasis in original).

Discourses, as Weedon points out, “exist both in written and oral forms and in the social practices of everyday life” (1987: 111), yet the everyday has been remarkably absent in writings on anorexia. As the medical sociologist Eckermann points to in her discussion of eating disorders:

It could be argued that many researchers, whether writing from a feminist perspective or not, are culpable of invoking the family and the mass media as scapegoats for what might be a process more deeply embedded in our social existence than we have so far been able to fathom. It would seem that in the move from individualised and medicalised explanatory frameworks to those more socially orientated, major areas of social existence have been ignored. This process is exacerbated by insistence on distinct historical epochs with distinct sets of discourses. (1994: 92)

Ethnographic fieldwork is centrally positioned to address this lacunae. Through a range of different fieldwork methodologies, ethnographers build and sustain relationships (often long term) with participants in order to learn first hand about their everyday worlds. Surprisingly, and to the best of my knowledge, there is only one other ethnographic study of people with anorexia (see Gremillion 1996). My research therefore presents new grounds of methodology and analysis into the research of anorexia.

By attuning myself to how people with anorexia conceptualised relatedness, rather than framing them within already defined discursive positionings, the more creative and dynamic were the intersections I learned from; food was experienced as dirty and contaminating, there were practices to avoid fats saturating into the skin, and some

participants covered their noses and mouths to avoid smells sneaking into their bodies. Food had the potential to transgress boundaries, and was considered contaminating and dirty. To touch or eat food (and fats in particular) was a practice that was to be “avoided at all costs”.

Participants repeatedly told me, however, that anorexia was not simply about food. Nor was it solely concerned with the consumption of media images. The media was often said to be a red herring. “Anorexia”, one woman explained, “is way too focused on the media. People think eating disorders are solely based on body image that is warped by the media and it’s all about body size ... it has to do with that but it’s only a small piece of the pie so to speak — using a food metaphor”. For this participant, and many others, anorexia was concerned with relatedness, of “coming into family problems, coming into relationship problems, coming into big fears”. Relatedness was intensely problematic and was renegotiated through anorexic practices.

In the remainder of this introduction I outline the interconnected themes of this thesis. Although the chapters focus on different contexts of relatedness, many of the themes that emerge are connected through the ethnographically informed concept of abjection.

Even though a large proportion of my fieldwork was conducted in my home town I could never assume a shared world with those who had anorexia. I sought however, to come closer to understanding the nature of their transformative, contradictory and contingent experiences. My principal means of ‘working out’ these understandings relied on exchanges of dialogue and observations of embodied practices, what Desjarlais refers to as “a phenomenology of embodied aesthetics” (1992: 66). With participants I shared in conversations of informal knowledge, conducted open-ended

interviews, explored lyrics to songs<sup>19</sup>, delved into autobiographical writings, spoke of the meanings of art works (often their own) and examined the ways in which anorexia was represented in the media. I also observed and listened to how experiences of anorexia were represented in the medical domain, attending formal presentation of ‘cases’ at hospital ward rounds and, when given permission by participants, read their confidential hospital records.

Experiences were not only conveyed through words, they were simultaneously embodied and performed. As I detail in Chapter Two, I observed the ways in which arms and legs were held close to the body, limbs often moved as if exercising, and faces and bodies contorted at the suggestion of certain foods. Sophie quickly placed her hand over her stomach when it loudly rumbled, and apologised for her “stomach’s intrusion”. We paused to consider her response, as to why the internal sounds of the body were considered embarrassing and must be hidden. It was by way of sharing spoken and gestured language (and silences and embarrassed laughs) that I and participants were able to come to a communal plane on which to understand experiences of anorexia, however partial that connection was (cf. Clifford & Marcus 1986; Haraway 1988; Strathern 1991; Lucas 1999). As Tsing reiterates, “the knowledge of an author, like that of the people about who he or she writes, is always partial, situated, and perspectivistic” (Tsing 1993: 14-5).

It was this mixture of language and experience, rather than a separation, that I aimed for. Language, like experience, is spoken and gestured, held in memories and completely contingent. The separation between semiotics and phenomenology,

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<sup>19</sup> During my fieldwork the lead singer (Daniel Johns) of a three piece Australian band *Silverchair* wrote a song — *Ana’s song* — about his recent experiences of anorexia. One participant developed a close connection with this song, using her hospital ‘free time’ to catch a bus to the local shopping centre to buy the new CD (and showing me the album cover and reading the lyrics out to me), pinning posters of the singer and band on the walls of her single hospital room, and even writing to Daniel Johns from her hospital bed to convey empathy. Very early on in our relationship this young woman excitedly played this song to me as she considered the music and poetic lyrics to convey what she said, was unspeakable about her own experiences.

language and experience, and representation and being-in-the-world is somewhat false, for language (spoken and gestured) gives access to a world of experience and simultaneously does not wholly constitute experience (sensory experiences, for example, are not circumscribed by language).<sup>20</sup> As Jackson states, “it is difficult to draw a line between inherited cultural knowledge and personal experience” (1996: 42). He argues that the phenomenological method aims for verisimilitude, placing primary experience and secondary elaboration (in the form of language) on the same footing. Csordas similarly argues that “the notion that language is itself a modality of being-in-the-world ... is perhaps best captured in Heidegger’s notion that language not only represents or refers, but “discloses our being-in-the-world” (Csordas 1994: 11).<sup>21</sup>

In pointing to the unnecessary opposition of philosophical viewpoints (rather than the perpetual movement between them) these writers are highlighting the concept of embodiment, a concept that has been central to all of Bourdieu’s writings. It was pervasive Cartesian dichotomies, such as the one which posits representation as opposite to experience, that inspired Bourdieu to formulate his theories of habitus, capital and field, as a way of bridging the divisiveness of structuralist and objectivist arguments. What bridges these dichotomies is the body. For Bourdieu embodiment is the principle way in which structures are internalised, practiced, transformed and reproduced — this is, Bourdieu’s logic of practice, the *habitus*. Embodiment for

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<sup>20</sup> Parkin, Gell, Moeran and Weiner debated precisely this issue of “whether language calls into being the cultural worlds in which people live, or whether these worlds are given form and meaning by virtue of cognitive engagement that preceded language” (Ingold 1992: 1). I side with the two debaters who argue that language is not the essence of culture, for “culture consists of concepts rather than verbally constituted meanings, and that these concepts are established in the course of a direct, practical involvement with other persons and things in one’s surroundings, an involvement which need not (and for small children does not) entail fully fledged verbal discourse ... [it] includes all kinds of everyday non-linguistic practices as well” (ibid: 2). More importantly, one conclusion of this debate was that any attempt to draw language and culture apart would lead to the “absurdities of culturally decontextualised language and linguistically decontextualised culture” (ibid).

<sup>21</sup> A criticism levelled at phenomenology is that in describing what comes into view within immediate experience (or even in thinking about what comes into view), one necessarily draws on language, and therefore you are not studying experience at all, but the representation of experience through language. Yet phenomenology, in providing “detailed descriptions of how people immediately experience space, time and the world in which they live” (Jackson 1996: 12), arrives at not presuppositionless description of phenomena, but with a re-interpretation — as new meaning, or renewed meaning.

Bourdieu is thus not simply concerned with phenomenology<sup>22</sup> or the internalisation of structures, but with the dialectical relationship between the gendered body and space, a dialectics of structure and practice. As I discuss in Chapter One, Bourdieu's theories are thus more applicable to the arguments in this thesis than Foucault's theory of power, for they explore the relational, generative and potentially ambiguous possibilities of human action.

## OUTLINE OF THE DISSERTATION

In her ethnography of kinship, *The Heat of the Hearth* (1997), Carsten deliberates as to how she will describe the Malay houses that were central to her fieldwork in Langkawi.

She could begin, she writes, by describing the different aspects of housing:

... the appearance of the houses outside and in, their structure, design, and furnishing, the division of space within them ... These would all be legitimate 'beginnings' to a story which — like all anthropological stories — has no beginning because everything connects with everything else. (1997: 33)

The concept that 'everything connects with everything else' is similarly applicable to this thesis. To begin arbitrarily with the concept of food<sup>23</sup> one is lead into numerous, overlapping fields:

... food moves all the time ... it leads us into other areas ... it spills into every aspect of life ... it constantly shifts registers: from the sacred to the everyday, from metaphor to materiality, it is the most common and elusive of matters. (Probyn 1999: 217)

The notion that food moves, connects and disconnects links directly into a central trope of this thesis, that of movement. Movement underpins the methodology, ethnography and analysis, as evidenced below.

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<sup>22</sup> Although Bourdieu takes issue with phenomenology (for what he sees as a failure to appreciate that agents classify and construct their understandings of the social world from particular positions in a hierarchically structured social space — Swartz 1997: 57; Bourdieu 1990: 26-7), I would argue that his theory of *habitus* draws from a mixture of phenomenology and structuralism. Jackson makes exactly my point: "Despite his caveats and cavils, Bourdieu's emphasis on mundane strategising, practical taxonomies, bodily habits, social usages, and agency makes his notion of *habitus* directly comparable to the notion of lifeworld" (Jackson 1996: 20).

<sup>23</sup> Even the assumption that anorexia is primarily linked to 'food' is challenged by some of my fieldwork. Food, in its 'commonsense' meaning of nutrition, pleasure, and sustenance is disrupted by experiences of these substances as invading, polluting or even poisoning.

This thesis is divided into eight chapters. In the first, *Steering a Course Between*, I explore the places in which my fieldwork unfolded. The strategies of planning that enabled me to conduct fieldwork in a variety of sites is articulated, highlighting the ways in which I was able to move with people through a range of significations and fields. These fields were multiple and overlapping, and included differing sites of treatment, domestic homes and public spaces, as well as the public imagining and representations of this phenomenon.

The methodological planning and enactment of multi-sited fieldwork had direct implications for the theoretical underpinnings of this thesis, for the multiple sites in which my fieldwork occurred were analogous to the multiple fields (of knowledges, and representations) in which people (including health professionals and those with a diagnosis of anorexia) struggled for legitimacy and authority. Drawing on Bourdieu's notion of field and related concepts of *habitus* and symbolic capital, this chapter connects the methodology to analysis, as both seek to elucidate the underlying and invisible relations in and between social spaces.

A central question at this point might be: "how does an anthropologist do fieldwork with a group of people for whom sociality and relatedness is problematic?", considering that these are essential to any fieldwork situation (cf. Rabinow 1977: 155). Chapter Two, *Knowing Through the Body*, explores how I came to establish and maintain relationships amongst a group of people with whom I did not share common taken-for-granted assumptions and experiences. One of the ways I engaged with people was by taking their cues of sociality as a guide. We rarely ate together, some meetings were called to a halt by participants, some were awkward, and other participants allowed me to enter their 'worlds' based on the premise that I did not threaten them by asking they share commensality with me.



Part of this discussion enters into the debates concerning doing fieldwork ‘at home’, in places that are familiar to the ethnographer. The privileging of geographical space, of ‘home’ as comfortable, near and familiar, is in itself a construct that I question. One does not need to be spatially distant to experience strangeness, and strangeness and familiarity can operate simultaneously. It was, for example, through my own profound transformation in the field — pregnancy — that the seemingly disparate experiences of strangeness and distance were collapsed. It was also via these transformations that ethnographic analogy was made between my participants and myself. Through our changing and heightened embodied sensations we were able to come to some common grounds in what Jackson calls *interexperience*, an analogous space in which we explored the shifting embodied states of bodily dwelling.

Chapter Three turns to a different kind of relatedness, that of desire towards and distancing from this thing called ‘anorexia’. Here I introduce a term coined by Battaglia — ‘agency play’ — a concept that, akin to Bourdieu’s notion of play and struggle, explores the differing identities and agencies that people with anorexia use and discard according to differing sites. Concealment and revelation are central to these plays of agency, for exclusion from families and social networks propelled participants to different belongings, in this case, to the secrecy associated with anorexia. Within anorexia, secrecy and hierarchy create distinction and difference, not only between those who are ‘outside anorexia’, but within their ‘own ranks’. Secrecy, as described in this chapter, does not rely on the polarisations of individual/society that traditional studies have used, but suggests that the dialectics of concealing and revealing are more useful in highlighting the relational and complex transformations that people with anorexia (both individually and collectively) experienced. In people’s experiences of anorexia, secrecy (and its power) is an instrumental part of relatedness.

Moreover, my argument extends beyond a disembodied discourse of individual/society, for I was being made aware of a particular sensibility, a different ontology of sensations and motives that was often hidden from others. Chapter Four explores this ontology by analysing the relationship that participants had with different foods. Rather than reproducing well-documented views on fear of fats and calories as being based on an avoidance of weight gain, I develop a different understanding of the fear of food. Many people with anorexia described foods, and fats and oils in particular, as dirty, disgusting and contaminating. Others were more concerned to avoid imbibing the smells of food, fearful that the air was carrying unwanted calories.

Critiquing and extending both Douglas's structuralist typology and Kristeva's concept of abjection, I argue that it was the amorphous nature of fats and calories, and their ability to move, seep and infiltrate the body through the interplay of senses (sight, smell, taste and touch), that rendered them abject. As such, fats were the worst food to come into contact with, and a range of measures were practiced to cast out, avoid and cleanse the dirt and contamination associated with their abject qualities. This chapter also documents how, for some participants, the fear of contamination extended beyond food to other people, fundamentally changing the very nature of their everyday social relationships.

Although Chapter Four is concerned with the interconnected relationships between people and food, the ethnographic establishment of abjection forms the foundation of the remainder of this thesis. As a central theme, abjection not only pertains to foods, but also to gendered experiences (including events, places and their memories). Chapters Five and Six explore the ways in which the women in this project experienced their bodies, and bodily processes, as dirty. Menstruation, pregnancy, sex, sexual abuse and

dangers associated with 'being female' (implicitly female sexuality) were all construed as disgusting and 'too close for comfort'.

To feel disgusted, Probyn writes, is "to be fully, indeed physically, conscious of being within the realm of uneasy categories ... [disgust] causes the body to hide, to run away from its own cringing self" (Probyn 2000: 131-2). Disgust motivated people to protect themselves, clean themselves and physically disappear. Chapter Six deals specifically with the gamut of hygiene practices in which people cleansed their bodies and environments. Bathrooms, kitchens, and bedrooms were spotlighted as the spaces where cleansing occurred, but they were also the most problematic, as this was where bodies, food and waste coalesced, where dirt and cleanliness, pleasure and disgust came together. It was in these spaces that transformations of relatedness were effected by cleansing (washing of hands, bodies, teeth and clothes) and purging through vomiting, taking laxatives and blood letting. It was through the passage of fluids (water, vomit, blood, urine and diarrhoea) that bodies were cleansed and in the same process emotional states of shame, guilt and disgust were temporarily erased.

Chapter Six clearly describes the relationships between gender and hygiene, most particularly how gender roles are informed by the persuasive rhetoric and practices of the 'hygiene habitus'. Two points regarding this discussion need to be made as they have ramifications for the overall thesis. Firstly, the small number of men involved in this project precludes their full inclusion. Rather than draw generalised comparisons or conclusions from the limited data on men's bodily experiences, I include them throughout this thesis when possible, and briefly speculate as to the implications for further research. The discussion of hygiene in Chapter Six therefore focuses solely on the female participants.

Secondly, the linking of gender roles with anorexia feeds into much of the feminist (and non-feminist) literature which I have outlined under the heading ‘discursive approaches’. This literature seeks to find an underlying cause for why women are predominantly attributed this diagnosis, and assumes that gender relations or certain characteristics of femininity are to blame. While my research takes place in a context that identifies anorexia to be a problem for women, I do not seek to ‘explain’ why women predominate, or to find the ‘causes’ of anorexia. Rather my intention is to explore the practices of anorexia in these women and men’s lives.

Seeking to find a singular understanding or cause for anorexia is a common pursuit, and in the concluding chapter I reflect on how this very research was co-opted by the international and national media into this agenda. In using examples from the print media I reveal how the complexities of anorexia that I presented were shaped into simple frameworks. The resultant exoticisation and primitivisation of my work not only proved to be a grave injustice to the participants of this project, it highlighted the very powerful and pervasive imaginings and stereotypes that surround anorexia. These fixed characterisations, however, provided me with a foil to bring together the major themes of this work: of the complex, transformative and processual nature of relatedness and abjection.

### **Writing about embodiment and ambiguity**

I use the term ‘embodiment’ throughout this thesis, and I briefly want to signal the very specific form of that usage. In criticising the epistemological pitfalls of Cartesian structures, many post-structuralist and feminist writers use theories of embodiment as a new point of analytic departure. Of these writers, I am indebted to Csordas (1990, 1994), who argues that “the body is not an object to be studied in relation to culture, but is to be considered as the subject of culture, or in other words, as the existential ground

of culture” (1990: 5). Rather than take the body as an empirical thing and analytical theme (as the former ‘anthropology of the body’ has done), Csordas argues that a paradigm of embodiment highlights the ‘existential immediacy’ of ‘being-in-the-world’. Clearly drawing from Merleau-Ponty and Bourdieu (both of whom have used embodiment to collapse Cartesian dualities), the body that Csordas invokes is an experiencing agent, one that is intersubjective, relational, dynamic, sentient and indeterminate in nature.

With a few notable exceptions (Roseman 1991; Howes 1991; Seremetakis 1994; Stoller 1989, 1997) the sentient aspects of ethnographic fieldwork are often lost in the theory of embodiment. Stoller warns that recent writings on embodiment tend to be profoundly disembodied, most particularly through their use of dense and abstract ‘bloodless’ language. To overcome this problem he suggests that “writers tack between the analytical and the sensible, in which embodied form as well as disembodied logic constitute scholarly argument” (1997: xv). This thesis follows Stoller’s suggestion, bringing to the fore much of what is lost in a textual reading of the body, that is, the smells, tastes, textures and sensations with which my fieldwork was redolent. At the heart of people’s experiences was the embodied sentience of anorexia: of sticky blood dripping from cut forearms, the greasy texture of butter on a tongue, wincing with nausea at the very sight of food, and experiencing hunger as a searing pull on an already empty stomach. These were the ways in which bodies were consumed.

In writing about embodiment one cannot ignore the spatio-temporal dimensions of such a concept. In my fieldwork embodiment was indeterminate in that it was marked by presence and absence, distance and closeness, and those things that were intensely felt and also ‘comfortably numb’. Participants told stories that journeyed between intimate memories from childhoods, future dreams and the predicaments of their immediate

lives, all of which evoked immediate and sometimes turbulent emotions. Rapport (2000), drawing on Abu-Lughod (1991), suggests that telling stories such as these are:

... 'ethnographies of the particular' — narratives of people contesting, strategising, feeling pain, making choices, struggling, arguing, contradicting themselves, facing new pressures, failing in their predictions — [that] can be used as instruments of a tactical humanism 'against culture': against that which would incarcerate 'others' in a bounded, homogeneous, coherent and discrete place and time. (Abu-Lughod 1991: 147-59, cited in Rapport 2000: 89)

People's experiences of anorexia could not be placed into neat, categorical and homogeneous times or spaces. On the contrary, I was continually struck by the ambiguity of experiences and of the repeated descriptions of exasperated family members and friends who found the 'disorder' confusing and contradictory.

Experience, as Wolf highlights, "is messy ... when human behaviour is the data, a tolerance for ambiguity, multiplicity, contradiction, and instability is essential ... we must constantly remind ourselves that life is unstable, complex, and disorderly" (Wolf 1992: 129). The problem, however, is in writing ethnography how does one convey the complexity of experience without losing its very nature? In recognising this

conundrum Strathern writes that:

Complexity is intrinsic to both the ethnographic and comparative enterprise. Anthropologists are concerned to demonstrate the social and cultural entailments of phenomena, though they must in the demonstration simplify the complexity enough to make it visible. What appears to be the object of description — demonstrating complex linkages between elements — also makes description less easy. (Strathern 1991: xiii)

Jackson similarly notes that the complexities of ambiguous experience are especially difficult to write about because they are predicated on the simultaneity of double and multiple meanings. Ambiguity, he argues, challenges many of the conventions of writing ethnography for it:

Call[s] into question many of the category distinctions that anthropologists construct for purely instrumental reasons — to systemise their fieldwork experience, identify themselves professionally, and promote the notion that that while the world may not be subject to administrative order, it can at least be

domesticated and subjugated through logic, theory and academic argot. (Jackson 1998: 33).

Very few anthropologists write at any great length about ambiguity (see Battaglia 1997; Jackson 1998; Nuckolls 1996), precisely because it is not amenable to the argot that Jackson suggests. An anthropology of ambiguity, Battaglia suggests, “breaks from models that take ambiguation as a textual problem rather than as a *practice* of removing or disturbing those constraints on human relations that categories and boundaries impose” (1997: 508-9, my emphasis). Anorexia, as I understand it, does exactly what Battaglia calls for: it disturbs the taken-for-granted practices and understandings of relatedness. Moreover, abjection provides a theoretical framework for understanding these practices, for it allows a theoretical space for ambiguity, of the ways in which tensions are created by the relationships between contradictory elements.



# CHAPTER 1

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## STEERING A COURSE BETWEEN FIELDS

In a recent edited volume Marcus (1999) discusses the distinctiveness and juxtaposition of the papers in ways that parallel the position I have adopted in my fieldwork. The distinctiveness of this volume, Marcus suggests:

Lies in the strangeness of the positions in which a number of the writers found themselves in the field. This is not the traditional, exotic strangeness of anthropological fieldwork, of being immersed in other worlds of difference that anthropology itself has prepared one for. It is rather the loss of this condition that provides strangeness here, the strangeness of being immersed in writings, inquiries, and commitments that precede one, surround one, and to which one must define a relationship precisely in order to pursue one's ethnographic endeavours. (1999: 3)

As an object of study, anorexia was a complex and dynamic process that was mobile and multiply situated. It appeared in a network of often-conflicting perspectives: as a physiological state of an individual human body, a series of embodied experiences, and in representations. As Good (1994) argues, illness is always constituted and embedded in a series of interconnecting spaces, and in this fieldwork it was through medical institutions, community health centres, media representations, and in people's homes and public spaces that anorexia was articulated and practiced. People thus came to know anorexia through differing means — through a mixture of personal, social, political and medical avenues. It was the politics of knowing anorexia — the embodied authority to speak and act — which was at stake.

There are two interconnected sections to this chapter. The first focuses on the complex social spaces in which my fieldwork literally moved. This provides a context, spelling out the initial planning that was as much a part of the ethnography as events 'in the field'. It outlines my conscious strategy of multi-sited fieldwork, a strategy that extends



conventional modes of ethnography by moving between quite different spatial domains. In these domains I encountered the overlapping and differing sites of treatment, domestic homes and public spaces, as well as the public imagining and representations of anorexia. I was, however, not only documenting the variety of experiences that participants had, but also interrogating the politics behind the category of anorexia in a number of seemingly disparate global sites. This, I argue, is the power of multi-sited ethnography, for it allowed me to move between and across local and global fields and in doing so, explore the “relationships, connections, and indeed cultures of connection, association, and circulation that are completely missed through the use and naming of the object of study in terms of categories “natural” to subjects’ pre-existing discourses about them” (Marcus 1998: 16).

Having described the field sites, the second section of this chapter draws upon Bourdieu’s concept of field (and related key concepts of *habitus* and symbolic capital) to examine the relationships between them. As an analytical device, this concept is complimentary to multi-sited fieldwork for it seeks to elucidate the underlying and invisible relations in and between social spaces. As Swartz suggests, Bourdieu’s field:

Directs the researcher’s attention to a level of analysis capable of revealing the integrating logic of competition between opposing viewpoints. It encourages the researcher to seek out sources of conflict in a given domain, relate that conflict to the broader areas of ... power, and identify underlying shared assumptions. (Swartz 1997: 126)

The fields that this chapter focuses on were positioned in opposition to one another: those of clinical medicine practiced in institutions and ‘alternative’ therapy delivered in smaller ‘community’ institutions. I examine the different claims of authority to speak about and treat those with anorexia, looking beyond the power of language to examine the embodied effects (and silences) that imbue the category of anorexia with symbolic power.

This chapter thus steers a course between description and analysis, between field sites and fields of struggle. It demonstrates the challenge of constructing an argument through description, and arguing for particular relationships and connections not at all obvious to the seemingly arbitrary category of anorexia. It is concerned with how ‘anorexia nervosa’ came to be mobilised in different fields, and the subsequent relationships of positioning, struggles and strategies that pivot around it.

## **ETHNOGRAPHY ON THE MOVE**

My first sense of ‘doing fieldwork’ was during the peak hour rush early one morning on a crowded bus in Vancouver. I was standing amongst a group of eight women who were part of an eating disorder recovery program, accompanying them from the community house (*Vista*) where they were living, to the hospital. As we stood clinging to the overhead handrails, Angela turned her head to mine and said that the journey reminded her of “going to school”, back packs in hand and jackets around our waists in case it rained. After a fifteen minute ride we manoeuvred ourselves off the bus, jaywalked across a busy city road, and entered the side entrance of the red brick institution, a large, downtown public hospital that ran a range of programs (both in- and out-patient) for people with eating disorders. Once inside, the women became noticeably less ‘chatty’, and with a weary familiarity took the lift to the fourth floor, collected their named breakfast trays from the waiting trolley and sat down to eat around an oblong table in a small dining room.

These women, who came from throughout the Canadian province of British Columbia, were participating in the community residential program, travelling between the hospital and the community residence each day for a period of up to four months. The week days of this program were highly structured, and included timetables of group therapy sessions, body image classes, communal breakfast and lunches, weekly ‘weigh

ins' and skin fold tests (a day that they called "hell Tuesday"), assertiveness training and a range of other sessions. These sessions were held on the fourth floor of the hospital, a separate space from that of the in-patient acute care on the psychiatric ward two floors below.

When members of the group had individual sessions with psychiatrists and psychologists (from which I was excluded), I often explored other parts of the hospital. Sonya asked me to accompany her to the medical day-ward on the ninth floor, to help break the monotony while she lay on the bed having her weekly magnesium infusion. During the four hour treatment she pointed out landmarks of the skyline through the large window that afforded a magnificent view of the city. Another time she introduced me to her friend Steve who was waiting for an available bed in the psychiatric ward for the treatment of anorexia. We would sometimes meet to have a cigarette on the roof garden, and when he became frailer and unable to walk, I visited him whilst he rested on his bed on a medical ward. Steve had agreed to participate in this project, but later withdrew due to his declining health.

Twice a week I would 'sit in' on medical ward rounds on the psychiatric ward, listening to the 'team' — dietitians, psychiatrists, ward nurses, occupational therapists, students — outline each patient's progress (or lack thereof).<sup>1</sup> I accompanied the ward doctors on their rounds, visiting people at 'their bedside' behind closed curtains, observing the delicate negotiations that would happen about treatment plans. With some patients' permission, I would return later to speak at length about what it was like to be on the ward, and what this 'thing' called anorexia meant to them. Some of these people were hoping to move on to the residential program once they had reached and maintained their target weight, a pre-requisite for those living in *Vista*. At other times I would visit

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<sup>1</sup> Barrett (1996) notes how "multidisciplinary teams arose within Australian mental health services during the 1960s as part of a widespread expansion and reform of psychiatric hospitals throughout the developed world" (1996: 74). These teams were similarly constituted in each field site.

the Eating Disorder Resource Centre on the second floor of the hospital, a small, lamp lit room overflowing with information for patients, relatives and friends and the general public. Here I chatted to staff and students who were doing placements, watched videos about prevention of and recovery from eating disorders, read newsletters, journal articles, books and pamphlets.

As well as spending time with and interviewing staff from each site, I attended in-service lectures and research meetings. I shared lunches with staff members (secretaries, research assistants, psychiatrists and social workers) at the numerous cafes surrounding the hospital. Indeed, my first introduction to the eating disorder 'team' was at a lunch-time picnic on a nearby beach. I caught buses into the suburbs of Vancouver and met volunteer staff at community eating disorder organisations and counsellors at a family therapy unit. I saw the art work from an exhibition entitled *House of Mirrors*, a visual arts installation of 26 full length mirrors onto which the female artists portrayed the impact of the media, diet, fashion and cosmetic surgery industries had on their lives.<sup>2</sup>

At the end of these days, exhausted, I would travel back to the community house and spend the evening participating in activities, or return to my college accommodation to write up fieldnotes. Although *Vista* was directed by the hospital, it was not a clinical environment and had a 'chaos' to it that any busy household might have. The casually dressed staff took a 'back seat' role, always available in their small office inside the front door, appearing only to facilitate group sessions and eat with the residents. Up to eight people could reside at the house at the one time (having signed a 'contract'), participating in the communal cooking, shopping and day-to-day running of the house. Close friendships were formed, with many residents meeting each other's family

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<sup>2</sup> The residents at *Vista* had already visited this exhibition prior to my arrival.

members and friends when they were invited to dinner one night a week. For Anna, being at *Vista* afforded her the connections that being part of a family offered:

I really enjoy living here actually. We have a really great group right now - we work together really well. There's no sort of cliques or individuals ... I kind of miss it if I go home on the weekend. We have quite a bit of fun 'cause sometimes we go out on picnics or meals and stuff. We watch *Happy Days* in the morning and we make jokes so it's kind of like a family....

In addition to participating in group activities, I had many formal and informal conversations with the women (including taped open-ended interviews which I later transcribed).<sup>3</sup> Being a sprawling, four storey house, there were many 'corners' to which residents took me: down the steep wooden steps to the basement, where the art and computer rooms were nestled amongst the washing machines and boilers, to the wooden table under a large shade giving tree in the back garden, to sit on beds and floors in the hot upstairs bedrooms and on the porch where the smokers congregated on old chairs. In this context, where anorexia was the defining characteristic of the household, the women's seeking of privacy for these interviews signalled the private nature of anorexia and its disclosure.

When the treatment program came to an end a graduation ceremony was held, the women returned to their homes and families, some finding apartments to share together, some preferring not to maintain contact for fear of "slipping back into anorexia", and one moving to another country. After completing the program one woman invited me to her nearby apartment, and on other occasions we would meet for lunch in a crowded café in the city. Following graduation the intimacy of relationships dispersed (although many vowed to keep in touch via phone, letter and e-mail contact), and a new group of residents moved in to *Vista*. I moved on to a new field site in Edinburgh.

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<sup>3</sup> In extracts from transcripts used throughout this thesis, italics indicate where words were emphasised in conversation and ... indicates that part of the transcript has been omitted. Editorial explanations and bodily actions, such as crying, sighing or rolling eyes, are enclosed in parentheses.

The point in describing this particular fieldwork experience is to convey a sense of the amorphous nature of the fields in which I moved. Movement was the distinctive tenor of my fieldwork, of moving to and from, in and out, and passing through (Clifford 1997: 198). There was no fixed route or trajectory to these people's experiences of anorexia, it was a process in which people felt euphoric, unwell, partially recovered, or increasingly declined in health.

I turn now to describe how I came to be on a bus in Vancouver with a group of people with anorexia. The importance of writing about the ways in which researchers enter their field sites is highlighted by Abu-Lughod in *Veiled Sentiments* (1986). In introducing the reader to the ways in which she entered people's lives in the Bedouin community in which she lived for two years (through reciprocal relationships of guest and daughter), Abu-Lughod reflects on her own perspectives, the type of analysis she sought, and the possibilities and limits of the field. The importance of writing about this initial planning she writes, is that:

.... the nature and quality of what anthropologists learn is profoundly affected by the unique shape of their fieldwork; this should be spelled out ... I do not believe that the encounter between anthropologists and their hosts should be the sole object of enquiry ... however to ignore the encounter not only denies the power of such factors as personality, social location in the community, intimacy of contact, and luck (not to mention theoretical orientation and self conscious methodology) to shape fieldwork and its product but also perpetuates the conventional fictions of objectivity and omniscience that mark the ethnographic genre. (Abu-Lughod 1986: 10)

My fieldwork was shaped by the deliberate choice of multi-sited methodology for a number of reasons. Firstly, unlike the traditional concepts of anthropology's 'field site' or 'community' there is no one geographical location where people with anorexia live or congregate for extended periods of time, other than when they are in-patients. There was no "stable group with which to 'settle in'" (Tsing 1993: 65). In this respect the residential program in Vancouver was unusual as most treatment programs actively discouraged people with anorexia from spending time together due to the competitive

nature of the disorder. This was the only time when I could ‘dwell’ for a brief period of time in the one place with the same people.

I could have conducted an institutional study, locating myself in an eating disorders unit, but to circumscribe fieldwork to such a site would give me access only to those positioned as ‘patients’ in a very specific time and space. Had my fieldwork location been restricted to a hospital I would have no understanding of people’s lives beyond the wards, of their day-to-day experiences of work, study, relationships and social gatherings. My fieldwork strategy was, as Marcus suggests, perhaps the most obvious and conventional mode of materialising a multi-sited ethnography (1998: 90). Like other multi-sited ethnographies (Rouse 1991; Foley 1990; Brown 1991) my aim was to learn of what happens to people in multiple sites.

Although the notion of mobility in fieldwork has most often been associated with travelling into and out of the field, the concept of moving *between and across* multiple locations is described as more ‘novel’, as Marcus and Fischer suggest:

The realisation of multi-locale ethnographic texts may entail a novel kind of fieldwork. Rather than being situated in one, or perhaps two, communities for the entire period of research, the fieldworker must be mobile, covering a network of sites that *encompass a process* which is, in fact, the object of study. (1986: 94, my emphasis)

For me, this process was anorexia; the intimate, everyday experiences of those with such a diagnosis, and the salience and circulation of this medical category in a global context.

In recognizing the fieldwork experience as a process, Clifford (1992) attempts to decentre the field as a naturalised practice of dwelling by proposing a crosscutting metaphor — fieldwork as travel encounters. This, he argues, is not to reject the concept of dwelling, for fieldwork has always been a mixture of dwelling and travelling

(although the rapport, initiation, and familiarity associated with long-term dwelling have tended to remain dominant) (Clifford 1997: 198).

A moment of caution is needed here. My use of travel is quite distinct from the everyday, common sense associations of tourism. Desjarlais (1992) makes this point in critiquing the plethora of ‘experience-near’ ethnographies that are currently in favour.

“Experience-near ethnographies”, he writes:

... jump into the muddy terrain of lived experience and paint the tastes and odours of a Third World bus stop ... [giving the reader] the sense that she is sitting inside the bus stop, drinking coffee alongside the anthropologist, and feeling what the bus driver feels. But my guess is that many of these studies simply reiterate what any tourist might get wind of. They do not explain, in any significant way, how cultural categories shape the form, tenor, or meaning of bodily experience and so contribute to the potentially vast cultural differences in the smells and senses of a cup of coffee shared between friends. (1992: 37)

It could easily be argued that my descriptions of ‘being there’, of accompanying the women on their daily routes could be similarly evoked by others who were also there (cf. Desjarlais 1992: 37; Hastrup 1995: 19). But the words ‘being there’ — ‘I know because I was there’ — privileges the grounds for authority by fixing the location of knowing into a singular moment. Travel, as used in this ethnography, does not refer to ‘being there’, but is used as a methodological device. What I wanted to research was the changing relationships between places and people, rather than the simple movement of participants from one place to another. On another level, I wanted to examine the circulation of cultural meanings associated with the category of anorexia in diffuse time-space. It was by way of travel that these connections were made.

Ethnography, and the subsequent fieldwork from which it is evoked, is a dual process of description and interpretation, of examining the connections and disconnections between sites and people, and the underpinning cultural categories that give rise to



experiences.<sup>4</sup> It is the relationship between sites that brings me to the second important reason for conducting multi-sited research. Although historically defined by psychiatry, anorexia had a range of differing and at times, contentious meanings within the different fields. In preparing for fieldwork I reviewed the competing and overlapping discourses concerning this ‘disorder’. The two main ‘players’ (and by no means the only ones) came from medicine and feminism, each articulating different causes, explanations, methods of treatment and prevention.

These differing conceptualisations circulated in all sites I encountered (to varying degrees) and provided me with shifting ‘lenses’ through which to view anorexia. Some called the phenomenon I was interested in anorexia, others called it an eating disorder, self starving, or personified it by giving it a name. Anorexia meant different things to different people. In the second half of this chapter I focus on the contestations between these specific domains, providing a context for an ethnography of diagnosis.

### **Travelling to, from and through**

My fifteen month fieldwork period (August 1998 – October 1999) was divided between a number of different geographical sites. The reason I conducted fieldwork overseas (four months in Vancouver and Edinburgh) and eleven months in an Australian metropolitan city was a mixture of circumstance and strategy.

In 1997 I was awarded a South Australian government scholarship<sup>5</sup>, on the premise of travelling overseas to examine a number of different treatment options available to people with anorexia. More specifically, my focus was on what ‘recovery’ meant to those people who were attending these programs.

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<sup>4</sup> In *Fluid Signs* (1984) Daniel discusses the central role of movement (both physical and intellectual) involved in anthropological methodology: “A cultural account is by definition an interpretive account, and as an interpretive account it must be capable of conveying information even as a metaphor does. Interpretation entails a movement, a movement that brings the interpretive subject and the interpretive object together in partial coalescence” (Daniel 1984: 52).

<sup>5</sup> The Catherine Helen Spence Travelling Scholarship.

There are various treatment ‘paths’ that people with eating disorders can take.

Although not mutually exclusive, they fall into five main categories: psychiatric wards in public and private institutions, general medical wards, residential community programs such as *Vista*, counselling and support through volunteer organisations, and out-patient care with community mental health workers or general practitioners.

Despite the range of services (which are predominantly psychiatric), eating disorders are notoriously difficult to treat and recovery rates remain low (Herzog 1988; Herzog *et al.* 1997; Ben-Tovim *et al.* 2001). Robertson observes that treatment efficacy has not improved in the last fifty years (1992: 70). In light of this I was particularly interested in exploring ‘alternative’ options to the more conventional approach of in-patient psychiatric treatments.

Having the opportunity to travel to international centres meant that selections had to be made.<sup>6</sup> I asked those with years of professional experience in the fields of eating disorders their opinions of differing international services. I searched through journals (such as *The International Journal of Eating Disorders*) for descriptions of different programs, and sent many introductory letters and e-mails to prospective places. After much negotiation and information seeking, I distilled my choice to two overseas centres: St Paul’s Hospital in Vancouver and The Cullen Centre in Edinburgh. Both were internationally renowned for providing innovative programs with a range of services from day programs, community based residential programs and out-patient consultancies. And both were able and willing to accommodate me.

What was innovative about both these centres were their focus on out-patient, rather than in-patient treatment of eating disorders. This strategy was reflected in the diversity

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<sup>6</sup> I approached the Montreaux Clinic in Victoria, Canada, but they were unwilling to participate. I later learnt from another source that this clinic was under review by the Canadian Government for alleged mistreatment of patients and that it would not have been appropriate to have a researcher there at that time. Another site in England, Rhodes Farm, also refused me entry. Both of these clinics have been at the centre of international media focus for their ‘unorthodox’ (ie. non-psychiatric) approaches to the treatment of eating disorders.

of clinical services on offer at St Pauls, which included ten different programs (with only one of these being in-patient stay). I was particularly interested in the residential program (*Vista*), a specialised service that aimed to provide a safe and supportive living environment for people with eating disorders. The program did not focus its concerns on weight gain, but rather challenged residents' beliefs concerning food and non-eating, and tackled in practical ways the everyday difficulties surrounding food (such as shopping, cooking and eating in public). In a similar vein, The Cullen Centre also treated the majority of clients on an out-patient basis. The staff believed that it was possible to work with people who were significantly underweight, and unlike many programs they did not have criteria for treatment based on weight status. They did monitor life-threatening situations and acted accordingly, but in-patient treatment and weight gain was not seen as a first line of care.

The most innovative aspect of these centres was their dialogue with other 'expert' fields of knowledge, most particularly with feminist understandings of eating disorders. Rather than position themselves as opposed to other knowledges or forms of treatment, they readily engaged and embraced narrative therapy, feminist politics, reflexive work, Foucault's theories of discourse and power, and the politics of identity (cf. White & Epston 1989).

The award of the Catherine Helen Spence scholarship was the impetus for my enrolment in a PhD in the dual fields of Anthropology and Gender Studies. Upon returning to Australia I continued a further eleven months of fieldwork in Adelaide. The wider study of the structures of treatment programs narrowed into a closer study of everyday life, a study that involved institutions, but also moved beyond them into people's own homes and daily lives.

The ease with which I was able to merge these two projects was extremely telling, for it highlighted the way in which the term anorexia (despite its various interpretations) was readily understood and transported across differing international sites. Ethics committees in Adelaide, Canada and Scotland were all familiar with anorexia, and granted ethics approval based on the taken-for-granted acknowledgment of the seriousness of such a disorder. Customs and immigration officials did not query my basis for entry to different countries, and sometimes offered personal anecdotes about friends or relatives who had anorexia as they stamped my passport. Many participants (including many health professionals) in Adelaide were familiar with the treatment programs I visited overseas, and were keen to hear my opinions (and vice versa). Not once during my fieldwork was I asked to explain what anorexia was; more often it was the intersection of anthropology and anorexia that provoked people's interest. To return to the beginning quote of this chapter, anorexia was always immersed in a whole series of constructions and imaginings that preceded and travelled with this research.

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Despite the variations in the understanding and treatment of anorexia, hospital settings were, in most instances, the initial sites of entry to all fields, as there were no other means of gaining access to people being treated in a medical setting.<sup>7</sup> Strict institutional procedures meant that I had to firstly negotiate (in writing and/or in person) with psychiatrists and psychologists (some of whom I never met), community mental health nurses, chief executive officers, program directors and a large number of ethics committees (five in all). In many ways these guidelines and procedures influenced the design of my project.

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<sup>7</sup> I could have placed an advertisement for participants in a local paper (Garrett (1998) 'recruited' participants for her study into spiritual narratives of recovery from anorexia in *The Sydney Morning Herald*, Tuesday 29<sup>th</sup> October 1991) but I wanted to have access to hospitals as well.

Again, the process of selection and negotiation took place as to how I would gain introductions to people with anorexia. Three sites in Adelaide were chosen: a Weight Disorder Unit within a major public hospital, a program run from a community hospital, and a community volunteer organisation. I briefly describe these three sites below.

- The Weight Disorder Unit was located in a major teaching hospital in the southern suburbs of Adelaide, and offered a number of in- and out-patient services for people with eating disorders. In-patient treatment took place in a general psychiatric ward, where six of the twenty ward beds were allocated to the Weight Disorder Unit. Three in-patient programs were offered: a two week assessment, a six week bed program and a target weight program. Other services such as emergency admissions and intensive care facilities were also offered. Trained staff provided support and guidance in re-establishing physical health, addressing emotional and social issues surrounding the eating disorder and reintegration back into community life. The unit was directed by a male psychiatrist, and included a large ‘team’ of professionals: rotating psychiatric registrars, a dietitian, community mental health nurses, social worker, occupational therapist, pharmacist and research staff. I was positioned by the staff as part of the research team.
- The program at Blackwood Community Hospital in the hills of Adelaide described itself as a “a multi-disciplinary, multi-faceted unit offering more than clinical services alone” (Coopman 1995: 4). This program claimed to be unique to Australia in philosophy and style, and grew out of “the disillusionment of other health workers and consumers with in-patient regimes which exert strict control, restraint and punishment of eating disordered behaviours” (ibid). It offered an alternative to the more conventional treatments run by major hospitals, explicitly subverting the dominance of the medical model in the understanding and treatment of ‘self starving’ (rather than anorexia). The all female team called themselves ‘returned soldiers’ — those who have recovered from eating disorders. Staff comprised one full time worker who acted as counsellor, physiotherapist and dietetics manager, and two part time occupational therapists. The six in-patient beds for those with eating disorders were housed in the same ward as women about to give birth, or who had just given birth. Unfortunately, with government funding cuts and amalgamation of obstetric and maternity services, the birthing facility was devolved prior to my fieldwork.
- The Anorexia and Bulimia Nervosa Association (ABNA) was a small volunteer-run organisation that was established in 1983 and was housed on the first floor of a heritage building in Adelaide’s CBD. It provided support groups, a drop-in centre, telephone ‘help lines’ and education for people with concerns about their body image. It also acted as a resource centre for the general public — encouraging people to use their library and view educational videos in a TV room on site, as well as playing an active role in peer and school education programs. ABNA also organised eating disorder prevention programs for the annual “International No Diet Day” event and the “Why Weight? Week”. Funded by the State government’s

Mental Health Services (on what was referred to as “a shoe string budget”), the service had one fully waged female worker, running on the support of an ‘army’ of volunteers (mainly women). I registered as a volunteer at ABNA, working on the editorial committee of their quarterly newsletter and attending some group activities.

There were many advantages to having a privileged insight into these centres. I was to be a participant observer in these places (and volunteer at one), gaining an introduction to the institutions, staff, day-to-day routines, treatment regimes and understandings of anorexia that each place worked with. I became familiar with ward spaces; the heavy doors that were always closed on psychiatric wards, the smells from the kitchen, and the sound of pool cues hitting balls in games rooms. As entry points, each different site gave me access to other social and more intimate spaces of relatedness, peoples own homes (their kitchens, bathrooms and bedrooms), informal networks, their use of public spaces and friends, family members and strangers. Once these relationships were established the ethnographic focus accordingly shifted into what Haraway (1988) termed “web-like interconnections” between different locations (cited in Gupta & Ferguson 1997: 39).

The way in which I initially contacted people felt somewhat convoluted, but was stipulated by ethics committees and individual clinicians. I gave prepared information sheets to health professionals, who in turn handed them on to ‘patients’ or ‘clients’. If people agreed to participate their names and telephone numbers were passed on to me by the clinicians, community health workers or their secretaries. For the group living together at *Vista* in Vancouver, I made a short audiotape explaining the project, which they listened to at an evening group session. This gave them the opportunity to vote on my ‘admission’ to the house prior to meeting me.<sup>8</sup> Initially one woman objected (for reasons which were not divulged to me), but a few days later agreed and I was invited

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<sup>8</sup> This ‘democratic’ process, of group members having the final decision as to my entry, reflected the measure of control that was afforded residents. *Vista* was very much the resident’s space and they had control and responsibility for what happened under its roof.

into the house. At other community support meetings staff introduced me, and it was often after this general introduction that people approached me and enquired about my project.

The advantage of this intermediary process was that I could rely on established relationships of trust that were developed (sometimes over years) between clinicians/therapists and their clients. If someone did not wish to be involved, there would be no embarrassment or awkward moment of refusal, as they would not have met me.

There were a number of occasions when gate-keeping did not occur; for example, following a presentation to a group of university postgraduates about research methodologies a young female student approached me to ask if she could participate in my project. Another time a friend of mine mentioned my research in a university tutorial and a fellow student passed on her phone number to him in order to give to me, as she wished to be involved. At a major shopping centre in Edinburgh, whilst staffing a health promotion stand put together by the Cullen Centre for Scottish Mental Health Week, I met two young women with anorexia. These women had independently come to ask for advice about eating disorders. They started talking to each other, openly comparing notes about their experiences, one lifting up the numerous layers of jumpers she was wearing to prove how cold she was. Naomi was “feeling her way” into treatment and Jamie had been grappling with recovery for a number of years. Both (who were co-incidentally known to the treatment centre I was working from) were interested in the project, invited to participate and included. They left the display together, exchanging phone numbers, anorexia acting as a connecting point of friendship.

This self-selection process (that was most often mediated by clinicians) meant that access to people was refracted through an institutional lens. The actual naming of a condition — through diagnosis — meant that all the forty six participants had some level of engagement with a treatment service and had subsequently shared the common diagnosis of anorexia nervosa. By entering the field via a diagnostic system I immediately waived access to those who did not seek any form of treatment at all (the existence of such a group is assumed though its size and complexion is unknown). Nor did I have access to those who were considered to be ‘too unwell’ to be involved in such a project.

Once introductions were made over the telephone (or sometimes in person) we arranged to meet wherever was most convenient or comfortable. I drove to people’s homes, visited them in hospital, and met them in public parks, cafes, pubs, and shopping malls. For those who were on hospital ‘bed’ programs, my visits were often welcomed as a break to the monotony of being on a bed twenty-four hours a day. Amanda and I would joke about the numbers that she had painted on paper and stuck on the wall of her hospital room, a countdown to the day when she was free to move around the ward of her own accord. I was always struck by the dramatic change of seeing people standing up for the first time after having seen them confined to a bed for six weeks — the transition to an upright frame would immediately transform a ‘patient’ into a ‘person’. We could stand, walk and talk together, leave the room and, at times, the hospital. When Elise was ‘off the bed program’ we would leave the ward and drive to the city to go shopping or down the coast to a café. To leave the ward we had to gain written permission from her parents (who lived interstate), as Elise was considered a ‘minor’ at fifteen.



In many respects my project was not dissimilar from Brown's project *Mama Lola: A Vodou Priestess in Brooklyn* (1991), in which she travelled to the field by car, or on the New York Subway from her home in Manhattan. Brown's ethnography was:

... less a practice of intensive dwelling [the Malinowskian tent in the village] and more a matter of repeated visiting, collaborative work ... [it was] situated less by a discrete place, a field she enters and inhabits for a time, than by interpersonal relationships — a mixture of observation, dialogue, apprenticeship and friendship. (Clifford 1997: 188-9)

Throughout this time I kept comprehensive fieldnotes in small books that I took with me; a mixture of verbatim quotes, observations (such as the setting, how we sat, tones of voices), genealogies, maps of spaces and my own reactions to encounters. Most often these hand written, pencil 'scratch notes' (Ottenberg 1990: 148) were made whilst I was with people. In hospital ward rounds I found it easy to write lengthy notes, as the practices of writing and constructing people into patients and case notes was taken for granted in these settings (cf. Barrett 1988). When spending time with participants though, my notes were often pared down to parts of sentences, scribbled notes to myself or abbreviations. My aim was to listen, talk and engage with people without the constant interruptions of writing (which could easily have been misconstrued as the taking of clinical notes and the objectification/surveillance that that implied).

As soon as possible after any meeting or event I would add in specific details and my own interpretations, keeping my 'voice' on a separate page from that of participants. Sanjek (1990: 97) refers to this process as the second stage of fieldnote production — of transforming scratch notes to descriptive fieldnotes. These often exhaustive elaborations would also highlight themes, theoretical ideas, commonalities and differences between people, follow-up questions, notes on uncomfortable moments (questions or words which raised anger, precipitated tears or stirred emotions in me) or those points of conversation where laughter and joking occurred. I usually wrote these extended notes in 'transit' spaces: in my parked car, on the steps of the hospital, whilst

waiting for a bus, on the bus, in crowded supermarkets or public spaces, and sometimes even on aeroplanes between field sites.

In addition to my fieldnote books I also had another level of field records in the form of transcribed and printed texts. All audio-recorded interviews/conversations were transcribed (in the field when possible and whilst on maternity leave). With each transcribed interview I entered the detailed descriptions from my fieldnote books, descriptions of everything that the spoken word did not capture. In between transcribed interviews I entered most other fieldnote observations and interpretations. These files were then coded (with indexing and NUD\*IST)<sup>9</sup> both for management and cross referencing of major themes. The end result was a large number of bound volumes of printed field records that included a chronology of interviews, descriptions, observations, my lengthy comments and interpretations, pages of genealogies, documents collected in the field (one participant, for example, had been ‘written up’ as a case study in a prestigious medical journal), photographs, media clippings, maps of household spaces, written selections from hospital case notes, and copies of personal diaries/poems and journals. It was these records, and my fieldnote books, that became my ‘bread and butter’ for writing another text, this thesis.

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As I moved through different fieldsites my own position also changed. ‘Doing research’ in these places meant that I as ethnographer was identified as many things: I was a guest in someone’s home, a visitor in a hospital, a researcher, and a researcher *with* medical training. I was also at times a friend, a confidante, and on two occasions I became unintentionally involved in suicidal situations that demanded an immediate, appropriate and ethical response. I was always careful when visiting participants in

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<sup>9</sup> NUD\*IST is a computer package designed to assist in organising and coding qualitative data.

hospital, aware that my casual chatting with doctors and nurses or emerging from the 'staff only' ward rounds could be construed as forging an alliance, or interpreted as a discussion of confidential information. Confidentiality had different connotations for different people as Elise explained to me: "I'm able to tell you things that I wouldn't tell them [the staff] as they would write it in the case notes and talk about it at meetings and then everyone would know". Similarly, I was careful not to articulate close friendships with participants to those in psychiatric circles, as entering into social relationships (which potentially spilled over into friendships) had already been questioned by the staff in relation to the way in which ethnographic fieldwork was conducted. On two separate occasions when explaining my methodological approach to community psychiatric nurses I was told: "but you can't become friends with them".

While it is often those who are the subject of ethnography who are seen as tactically managing their identity, the positioning of the ethnographer often gets lost or forgotten within the dynamic and contingent circumstances of fieldwork experiences. Like participants, I was also continually crossing, articulating, constructing and 'playing down' my identity according to differing circumstances. I was constantly aware of the required renegotiation of my position, a reflexive process that Tsing captures in her descriptions of 'walking fieldwork' on the Meratus Mountains of South Kalimantan:

In the process of moving around, I acquired various names, dialects, kinship statuses, and friendships. Certainly this kept me juggling competing definitions of appropriate behaviour. At every festival, for example, I had to choose (or waffle) between identifying with the hosts or the guests. If I had friends in both groups who were less than cordial with each other, it was a wrenching choice. (Tsing 1993: 65)

There was one field site in particular that confronted with me with a very tricky type of 'juggling', for I was in the unusual position of having worked in one of my fieldsites in a completely different capacity. Whilst I was completing my undergraduate degree in anthropology I supported myself financially through work as a registered nurse in the

same major public hospital that later became one of my field sites. Although I hadn't worked in the psychiatric ward I had familiarity with the spatial layout of the hospital and the etiquette of ward rounds. I was remembered (and still known) by some of the hospital staff. My subsequent work as a research assistant in a university department of psychiatry (as an anthropologist) also introduced me to some clinical practices and psychiatric language. Despite these experiences, I was careful not to reproduce the taken-for-granted language and practices that health professionals use, and my positioning as a researcher, guest and visitor meant that I was treated differently than in my previous role as a nurse. It was through this different positioning that I was able to experience the wards, the people in them, their spaces and routines, smells and sounds, in an entirely new way.

I did not introduce myself to participants as having a background in nursing as it would have tempered relationships and, I believe, restricted access to certain types of experiences and information. I was interested in aspects of participants' lives that they said they had never been asked about before, and we did things together that they would never do with 'their nurses'. I spent unlimited time with them. I was a young woman of seemingly 'normal weight'<sup>10</sup>, I had no vested interest in whether they ate or not, and I did not have a set of portable scales in my bag (as some community nurses did). I posed no threat in terms of forcing them to confront or change behaviours. I could be considered "one of them" as several suggested – although clearly I did not have anorexia, it was my positioning away from psychiatry that allowed them to include me in different ways. We often joked about the practices they engaged in, the ways in

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<sup>10</sup> Malson and Ussher (1996) similarly note that the weight of the interviewer in their study was central to relationships:

... as a thin woman of a similar age to many of the interviewees, the interviewer's own subject positions may have been significant in diminishing the power differential between researcher and the researched since there was a sharing of some subject positions and experiences. The (partial) sharing of discourses, subject positions and experiences between interviewer and interviewees will have had some effect on the dynamics of the interview process and, thereby, on the ways in which the interviewees articulated their ideas and experiences. (1996: 509)

which they had ‘tricked’ the staff or *perruqued* the system — participating in this type of humour was in itself a way of ‘marking me off’ from others. If my nursing training arose in conversation I did not deny it, and in fact it was sometimes a point of connection between those participants who also had medical backgrounds (five of the women with anorexia had medical training – four were nurses and one was a general practitioner).

Although the relationships I had with many participants were considered to be distinct from those with health professionals, ethical responsibilities were always paramount. On several occasions participants who had given me informed consent to view their hospital case records asked me to divulge what was written about them and their families. While one or two treatment teams were willing to show hospital records to patients (and in one instance encouraged them to write their own comments in the notes), case notes were generally positioned as private hospital documents. Bound by the confidentiality of such institutional systems, I did not pass on any information that I had read in case notes, heard in ward rounds, or discussed informally with health professionals. I similarly did not pass on any information to staff that had been discussed with participants.

There were however, as mentioned above, several occasions when I was concerned about a person’s well-being or safety and I did contact their community health nurse or psychiatrist. One such instance involved Natalia. An evening spent with Natalia at her suburban home had come to a grinding halt because she had talked at length about a sexual assault perpetrated by her brother and his friend when she was 13. It was a shocking attack that forever changed her sense of self-worth and her relationship with food, her body, her family and all other people. She had waited several months to tell me the story, and this night she felt it was important to speak of it if I was to understand why she wanted to physically disappear, why she was frightened of touching people,

having relationships and nurturing a body that she loathed. With each little bit of information she imparted she became physically smaller, tighter, and less able to talk. I stopped asking questions and taking notes, and directed my attention to Natalia's obvious distress. Much later in the night, and after great deliberation and reassurance from Natalia that she would be alright on her own, I decided to leave. Natalia walked me to the front door, and as I stood on the verandah in the cold darkness she slid down the wall in the hallway and slumped on the floor. She refused to close the door, hoping to invite danger, and telling me that she sometimes walks alone late at night to put herself at risk. I shut the door and reluctantly left.

The following morning I contacted Natalia's community nurse and explained my concerns for her safety. Not long after this conversation Natalia rang me on my mobile phone to let me know that she had spoken to 'her nurse', and had decided to take a few days off work and made an appointment to see her doctor. She reiterated that I should not feel responsible for her emotional response to her "shitty illness", and asked if we could meet again in a week or so. Such an encounter not only emphasises the importance of and continual prominence of ethics in such a project, but also the potential impacts of research on those involved.

It was in these contexts that I shared as many experiences as I could with people. This included seemingly mundane activities such as grocery shopping, as well as other more idiosyncratic outings such as driving to an antique shop to collect a wooden sewing mannequin that had been put on hold, dropping people off at appointments or the social security office, and going to a theatre performance in which one participant was acting. At the 'premiere' of a short film about eating disorders made by two occupational health students at ABNA (in which I, as a researcher, was interviewed) I was surprised to see so many familiar faces. I sat next to an occupational therapist from one of the hospitals, and mingled in the foyer afterwards with many women (and their families)

who had been involved in this fieldwork. It was not that my participants necessarily knew one another, but the commonality of an eating disorder drew them together.

Although the concept of sharing social experiences lies at the heart of anthropological fieldwork and theory, it is not devoid of problems. Despite the recent rhetoric of lived experience, or experience-near ethnographies as discussed earlier in the chapter, experience cannot be taken as an unproblematic given (Desjarlais 1996a: 70-6; Grosz 1994: 95; Hastrup 1995: 79). Experience, like other universalising epistemologies of self and culture, is based on the principle of unity, in which:

A set of phrasings of depth, interiority, and authenticity, sensibilities of holism and transcendence, and practices of reading and writing have, in the modern era, crafted a mode of being that many in the West call experience. (Desjarlais 1996a: 75)

As such, it is not an existential given but rather a historically and culturally constituted process predicated on continually changing ways of being in the world. Without looking at the ways in which experience is constituted, of its various knowledges, social practices and multiple possibilities, Desjarlais argues, then one assumes an “esperanto of lived experience” (Desjarlais 1992: 250), where experience is “taken as a fundamental, authentic, and unchanging constant in human life” (Desjarlais 1996a: 72).

Desjarlais makes a clear argument for the reflexive and relational qualities of experience, rather than attributing to it an ontological primacy. Hastrup similarly emphasises the dangers of not addressing the reflexive and constructed nature of experience:

In contrast to a phenomenology of experience that reflects ‘an experience which, by definition, does not reflect itself’, (Bourdieu 1990:25)<sup>11</sup>, anthropology must always question the conditions for experience and explore the ‘coincidence of the objective structures and the internalised structures which provides the

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<sup>11</sup> I do not share the view put forward by Levi-Strauss (1973, 1981), Bourdieu (1990) or Geertz that suggest that all forms of phenomenology are “privacy theories of meaning” (Geertz 1973: 12), or simply a philosophy of the self. Such an understanding of social phenomenology is in my view limited and flawed. Jackson (1996), citing Merleau-Ponty (1973), argues: “...praxis is seldom a matter of individuals acting alone. It is a mode of shared endeavour as well as conflict, of mutual adjustment as well as violence. Subjectivity is in effect a matter of intersubjectivity and experience is inter-experience” (Merleau-Ponty 1973: 56, cited in Jackson 1996: 26).

illusion of immediate understanding, characteristic of practical experience of the familiar universe' (ibid: 26). In short, in so far as anthropology takes off in the real social experience of people, it cannot continue to accept radical discontinuity between mind and body, culture and action. (Hastrup 1995: 85)

Experience then, as I use it in this ethnography, is intersubjective and relational; it is not individual and fixed, but irredeemably social and processual (Moore 1994: 3). As Jackson argues: "the task for anthropology is to recover the sense in which experience is situated *within* relationships and *between* persons" (Jackson 1996: 26, emphasis in original).

Of course it would be arrogant of me to assume that my position afforded me unrestricted access to people's lives and experiences. There were limitations to what I was included in, and these restrictions were often due to the secrecy and privacy surrounding eating disorders. One young woman became angry with me when I rang her at work to arrange a time to meet. In hushed, angry tones she explained that the eating disorder was a very private 'thing' and something she did not want her work colleagues to know about. My intrusion into her work space jeopardised the secrecy surrounding her eating disorder, and she declined to participate. I was always aware that participants shared only what they wanted to with me. While most allowed me to read through their case notes (a request made well into relationships), several refused as they were "too embarrassed" about past behaviours that they knew had been documented in a very particular way. For these people, the possibility of an alternative and supposedly more 'legitimate' rendering of their experiences was a threat to their own authorisations of experience. Revealing knowledge was also dependent on people's health. Some days people were so exhausted that they didn't have the energy to engage with anyone, as I discovered when I went to visit Angelique, who had spent several days in an intensive care unit following a dramatic drop in weight. Another woman explained that she was able to tell me things that she "would never tell a psychologist or doctor because she was 'sort of recovering'" and was leaving the



secrecy associated with anorexia. She commented that if I had met her several months earlier she would not have been able to discuss these things: “you don’t share that until you’ve left the cult — and then you might be a traitor and tell”. Her departure from the collective of anorexia, which I explore in Chapter Three, allowed her to explain secret practices. What people shared was always dependent on how close or distant they were in their relationship with anorexia.

Another major area that I did not have access to was people’s everyday relationships with family members. While I often met and spent time with family (usually parents, partners and/or children of participants), there were limits to the extent of my relationships with them. Only one participant discussed her experiences of anorexia openly with me while her partner was present. More often, I was taken to a private space where doors could be closed (usually a bedroom or lounge room in family homes), or to the anonymity of public spaces. If parents or partners did come in it was to ask quick questions (if we’d like a cup of tea) and they often apologised for interrupting. I am not suggesting that participants did not discuss their experiences with family members (as many told me they did), but in the context of this research there was a overriding sense that what people shared with me was intensely personal and confidential.

I suspect that the predominance of one to one relationships with those with anorexia in this research was due to a number of factors. Many were able to speak about their eating disorders in a therapeutic context (in the safety of support groups or in the ‘private’ rooms of psychiatrists), and my research was co-opted into this familiar framing of privacy. While we were able to share many events outside of this framing, there was a taken-for-granted assumption that what we shared was premised on the intimacy of our personal relationship. When, for example, I met participants in social contexts outside of the set fieldwork phase (which I often did), discussion of anorexia

often took a back seat, or was not mentioned at all. This was particularly the case if other people were present, and if the question arose as to how we knew each other a vague response such as “oh, we met at uni” would cover any potential breach of confidence. Some participants, however, did not conceal our relationship and openly outlined the context of their involvement in this research.

The other factor that prevented me from observing and participating in family relationships was the associated secrecy and shame, as Carolyn stated:

My parents just blame me for everything. They won't accept any responsibility for me being anorexic. They're ashamed that I've had anorexia because they feel that it's all my fault. “Look at the others [siblings]”, mum said “they didn't become anorexic - it's your fault”.

Carolyn did not discuss anorexia with her mother or sister, and there were many aspects of her experiences that she kept hidden from them. Moreover, like one third of the participants, Carolyn lived on her own and it was simply not possible for me to participate in the distanced relationships she had with her family and her small circle of friends.

## **ETHNOGRAPHY OF DIAGNOSIS – MOVING VIEWPOINTS**

### **Fields as sites of struggle**

Thus far, I have been focusing on only one aspect of ‘the field’, of the multiple places in which I conducted research. To leave a discussion of field positioned within a ‘location’, ‘context’ or ‘milieu’ is problematic, for it does not reveal the complexities and contestations that occurred in participants’ everyday lives. Field sites are far more than geographical spaces. They are positioned within what Bourdieu metaphorically terms ‘fields’, the social spaces that encompass a set of objective, historically conditioned relations between agents. Bourdieu defines a field as:

... a network, or a configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their

present and potential situation ... in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.). (Bourdieu & Wacquant 1992: 97)

A field therefore, is a structured system of social positions occupied by individuals and institutions. It is also a system of forces that exist between these positions, for it is structured internally in terms of power relations. Positions stand in relationships of domination, subordination or equivalence to each other by virtue of the access they afford to the capital at stake in the field (Jenkins 1992: 85).

Each field generates its own specific *habitus*; “a system of lasting, transposable dispositions” (Bourdieu 1977: 95) that provide individuals with a sense of how to act and respond in the course of their daily lives (ibid 1991: 12-3). As a theory of action, *habitus* generates multiple strategies within an agent’s trajectory through a field that is not static (Pizani 2000: 159), and is practical rather than discursive, prereflective rather than conscious, and embodied as well as cognitive (Swartz 1997: 101). The *habitus* thus functions anonymously and pervasively, “saturating the presence of the world with a field of taken-for-granted meanings which define its practical sense” (Ostrow 1981: 288). Cultural practices, Bourdieu suggests, are produced in and by the encounter between the *habitus* and its dispositions on the one hand, and the constraints, demands and opportunities of the social field on the other. The interaction of field and *habitus* then, “engages the most fundamental principles of construction and evaluation of the social world” (Bourdieu 1984: 466), for it creates *ways of knowing*.

In the field of anorexia, there were multiple agents and institutions competing for and against the dominant understanding of this phenomenon. Psychiatrists, health professionals, those given the diagnosis of anorexia and ‘lay people’ all vied for authority in this field. These struggles not only took place in institutions and

organisations, but in people's own homes, in the media and the public 'imagining' of anorexia. These latter two constructions of anorexia were particularly pervasive and persuasive, and are discussed in the conclusion to this thesis. Everybody it seemed had some familiarity with anorexia and had an opinion.

The disparate ways in which anorexia is discursively understood and treated has been comprehensively (and repeatedly) surveyed (see for example Bordo 1988; Garrett 1998; Hepworth 1999; Malson 1998). Three main areas come to the fore: historical analyses that argue for and against historical continuity between ascetic practices and contemporary anorexia (see Chapter Five); the medical construction of 'anorexia nervosa'; and a wide number of feminist critiques of the implicit biomedical values of this latter formulation. It is, however, the arguments between medicine and feminism that have created the most contention (cf. Lester 1997).

Despite the many variations within both medicine and feminism, the understandings of anorexia fall into two polarised camps. Malson (1997) argues that medicine (in its many guises):

... has been largely concerned with producing objective 'facts' about 'anorexia nervosa' as an *individual* pathology; with identifying *individual* characteristics thought to be typical of those diagnosed as anorexic and with seeking to provide individualistic (and often universalistic) causal explanations ... [and within this context] attention to the physical aspects of 'anorexia' — whether in terms of proposed organic aetiology or secondary effects of starvation — has retained an almost exclusive biomedical orientation. (Malson 1997: 223, emphasis in original)

Feminist analyses are markedly different from these accounts, as they are concerned with the relationship between eating disorders and the social construction of gender or with social responses to sexual difference. Their critique of the medical profession's lack of understanding of the gender issues involved in anorexia has led them to set up alternative explanations of the condition. 'Anorexia' (a term which is often marked as problematic in recent feminist writings by the use of single quotations) is said to be

“expressive of a multiplicity of societal as well as individual concerns and conflicts about femininity, gender power relations, consumption, control and individualistic competitiveness” (Malson 1997: 225; cf. Brumberg 1988; Malson & Ussher 1996).

As with any field, there is no univocal interpretation and it is not my intention to provide (and thus reproduce) the comprehensive account of the multiple explanations and approaches to anorexia. Even within these fields there are contestations, as demonstrated by the critiques of earlier feminist writings (including Chernin 1986; MacLead 1981; Orbach 1986), which were criticised for reproducing the medical and psychiatric language of anorexia. These writers described what they saw as the oppression of women and the limits of medical discourse and then proceeded to discuss the woman and her symptoms within parameters drawn from that discourse (Robertson 1992: 52; Hepworth 1999: 63). My point in outlining the politics of the field is to explore what Bray terms “an epidemic of significations” (1996: 413) surrounding the ‘anorexic body’.

What was at issue in this field was the very category of ‘anorexia nervosa’; this was the symbolic capital at stake in my fieldwork. Capital for Bourdieu, although borrowed from the language of economics, is not simply the buying and selling of commodities. Rather, it is the logic in which practices are orientated towards “the augmentation of *some* kind of ‘capital’ (e.g. cultural or economic capital)” (Bourdieu 1991: 15) which has the effect of increasing status, prestige and authority. Bourdieu contends that various types of capital can be exchanged or ‘converted’ for other types of capital. The most powerful conversion to be made, Bourdieu argues, is to symbolic capital — another name for distinction (Bourdieu 1985: 731) — for “it is in this form that the different [types] of capital are perceived and recognised as legitimate” (Harker *et al.* 1990: 13). Medical students, for example, can convert years of study at a university into the prestige afforded the title of doctor. The symbolic capital attached to the title

and the “august array of insignia adorning persons of ‘capacity and ‘competence’” (Bourdieu 1975: 20), such as the white coat and stethoscope, immediately confer a degree of authority and status, as well as the power to diagnose and heal. The following section explores how the category of anorexia nervosa was invested with symbolic capital and power in different fields.

### **‘Fields of expertise’: fields of symbolic power**

Bourdieu argues that “all scientific practices are directed towards the acquisition of scientific authority” (1975: 21). Naming a new disease carries enormous potential for symbolic capital, of prestige, recognition and fame: “It is an idle dream of many a physician with academic ambitions to be recorded in the history of medicine as the discoverer of a new syndrome, preferably named after the illustrious scholar so that his [sic] name be immortalised” (Vandereycken & van Deth 1994: 153). Indeed, many diseases are named after the doctors and scientists who ‘discovered’ them (Crohn’s, Addison’s, or Parkinson’s disease)<sup>12</sup>, much like the early surveyors who named the land they mapped after themselves (cf. Carter 1987). Unlike geographical formations though, anorexia nervosa did not exist independently of medical language, waiting to be revealed by scientific discourse (Malson 1998: 49). Rather it was constituted and created through the medical discourses that defined and treated it. It was, as Robertson notes, created as an illness category because:

... it was meaningful to the medical profession — not the starver — a set of symptoms and patterns of behaviour which were unreasonable and inexplicable. Anorexia nervosa was rendered an abnormality by a discourse which was privileged to define what was normal. (1992: xiv)

The medical ‘discovery’ of anorexia is usually attributed to two scientists, the British physician Gull and the French psychiatrist Lasegue (Vandereycken & van Deth 1994: 155), both of whom hoped to secure a position as “one of the nineteenth century’s Great

<sup>12</sup> Burrill Crohn was an American gastroenterologist (1884-1983); and Thomas Addison (1793-1860) and James Parkinson (1755-1824) were English physicians (Stedman 1995).

men of Science” (Hepworth 1999: 31). The question, however, of who discovered anorexia is entirely irrelevant for my purposes. What is important is the language that is used to describe this process, language that is most redolent of Bourdieu’s fields, of struggles, competition, authority and prestige. In their history of self starvation, Vandereycken and van Deth describe “a race” in which the “competitors” — Gull and Lasegue — struggled to win the prize of diagnostic discovery. It is generally assumed that the “honour” of naming anorexia lies with Gull. It is he “who claimed ‘parenthood’ of anorexia nervosa” (Vandereycken and van Deth 1994: 159) through prestigious clinical addresses (at the British Medical Association in Oxford in 1868) and scientific contributions to prestigious medical and scientific journals. Gull published descriptions of anorexia in the medical journal *The Lancet* (1888), and it was following this definition that anorexia nervosa became a distinct disease category.

Once officially named, anorexia nervosa became legitimated, authorised and instituted by the powerful taxonomies of medicine. As a category it entered the field of psychiatry, and a host of hypotheses and speculations on the causes and meanings of this phenomenon ensued. As Sours notes, the history of anorexia within psychiatry “recapitulates the megalithic history of psychiatry” (Sours 1980: 8), spanning all the four major psychiatric orientations: the biomedical, the psychoanalytic, the behaviourist and the psychodynamic (Gremillion 1992: 60).<sup>13</sup> Despite these different approaches, anorexia nervosa was unquestioningly accepted as a psychiatric phenomenon that resulted from individual psychopathology. The influence of this early classification can be seen in the present categorisation of anorexia nervosa within the Diagnostic and

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<sup>13</sup> From a biological point of view, metabolic and hormonal disturbances were called into question when trying to explicate anorexia. Psychoanalysts argued that food refusal was a defence against oral impregnation (cf. Freud 1958: 268), and behaviourists argued that people with anorexia needed conditioned hospital environments where weight gain could be monitored and positively reinforced (cf. Gremillion 1992: 62). From a psychodynamic point of view, people with anorexia are represented as being afraid of sexual maturation and female growth and prefer to live a “childish, asexual life” (Vandereycken & van Deth 1994: 3). Others viewed anorexia as a sign of disturbed structures and interactions within the family. Equally, there are many different ways of treating anorexia within these models.

Statistical Manual of Mental Disorders – IV Revised (*DSM-IV*), (American Psychiatric Association, 1994). The *DSM-IV* is a guide that sets international standards for classifying mental illnesses, delineating specific criteria that must be met before any given illness can be diagnosed (Gremillion 1992: 69).

The ability to name and classify is for Bourdieu a form of symbolic power. Although Bourdieu did not write specifically about medicine, his writings on religion, law, politics and intellectuals offer different angles on the same basic phenomenon. Like other fields of law or education, medicine is:

... the form par excellence of the symbolic power of naming and classifying that creates the things named, and particularly groups; it confers upon the realities emerging out of its operations of classification all the permanence, that of things, that a historical institution is capable of granting to historical institutions. (Bourdieu & Wacquant 1992: 167)

It could be argued that the concept of field is another way of describing Foucault's use of discourse and orders of discipline. Despite the 'surface similarities', there are a number of major differences between the discursive production of selves and Bourdieu's notion of field.<sup>14</sup> Foucault's discussion of discourse centres on institutions — prisons, schools, hospitals — and a subsequent theory of domination as self-discipline. Although Bourdieu's field can designate what is often thought of as an institution, "fields are not conceptually equated with institutions. Fields can be inter or intra-institutional in scope; they can span institutions, which may represent positions within fields" (Bourdieu & Wacquant 1992: 232). Fields then are not confined "to particular arenas of agents and activities, such as the family, education, religion, or law ..." (Swartz: 120-1). On the contrary, they allow us "to incorporate the most mundane details of everyday life into our analyses" (Moi 1991: 1019), what Eagleton (1991) refers to as a 'microtheory of social power'.

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<sup>14</sup> I thank Dr Kingsley Garbett for sharing and discussing his opinions on these differences with me.



Bourdieu's fields also differ from Foucault's discourses because they are spaces of conflict *and* competition. This competition cannot be simplified to a technique of domination, for fields, unlike discourses, constitute *open* spaces of play "whose boundaries are *dynamic borders* which are the stake of struggles within the field itself" (Bourdieu & Wacquant 1992: 104). Within this space of play social agents are knowing agents who contribute to resistance, struggle, subversion, domination, with some even desiring "the condition imposed upon [them]" (ibid: 167). It is thus the movement of fields, their plurality and intersections, that distinguishes them from Foucault's discourse.

And lastly, in bringing agency and practice to the fore, the interdependent nature of fields and *habitus* allow gender to enter the discussion. In examining the question of gender as social construction, Bourdieu argues (as many taking a materialist line do) that sex is an arbitrary cultural construction that is used to legitimate and explain sexual difference: "It [sexism] aims to ascribe historically produced social differences to a biological nature functioning like an essence from which every actual act in life will be implacably deduced" ('Domination': 12, cited in Moi 1991: 1030). This arbitrary 'fact' of biology is produced, expressed and reproduced through the fine grained details of *habitus*, via embodied movements of gestures, facial expressions, manners, ways of walking, sitting and talking. Gender, as a manifestation of sexual difference, thus appears as 'natural' and the symbolic violence of sexual oppression is misrecognised.

The attraction of theorising gender in Bourdieuan terms is that it allows writers to reconceptualise gender as a social category in a way that goes beyond essentialist/nonessentialist divides. In taking Bourdieu's approach, "gender is a socially *variable* entity, that carries different amounts of symbolic capital in different contexts" (Moi 1991: 1036). Gender, like all of Bourdieu's categories, is always relational, always determined by its fluctuating relationship to other categories (ibid: 1038). What

Bourdieu offers in terms of gender is a powerful way of understanding both the arbitrary, and therefore contestable, nature of the social, and its compelling presence and effectiveness (Lovell 2000: 15).

To illustrate the relevance of Bourdieu's concept of field and the struggles within and between them, the following section describes my introductions to two different sites, exploring the symbolic valiance of the category 'anorexia'. Gender is implicated in the open play of these social fields, and central to the strategising and struggles that ensued around different forms of power.

I start with my initial observations of one psychiatric ward round in a public hospital, for it was this speciality of medicine that claimed eating disorders as "its legitimate province" (Peters 1995: 45). Ward rounds were held every Monday at 11.30 am sharp in the library, a small room with no windows that was located just outside the entrance doors of the psychiatric ward. Space was limited, and it was often the case that the room was overflowing with students and staff, with several late-comers clustered around the doorway. Attending health professionals included psychiatrists, social workers, community nurses, community workers, dietitians, occupational therapists, psychologists and a pharmacist — all highly trained in what they call their 'fields of expertise', in this case, eating disorders.

The first time I came to this meeting I arrived early and sat at the end of the oblong table, perusing the volumes of psychiatric text books that lined three of the four walls. A woman arrived (who later introduced herself as the dietitian) and immediately warned me that I was sitting in the chair that was usually occupied by the 'head' of the Weight Disorder Unit. I moved, and this chair was left free until his arrival.

There was always a distinct ordering to these meetings, with each in-patient being 'presented as a case' to the group (although the presenter's eyes were often only

directed to the ‘head’ psychiatrist) by the assigned trainee psychiatrist (or medical student). This presentation — of speaking and writing — took the form of progress updates for in-patients, or a lengthier reading from the case notes for new patients. In interviews with medical students, Good notes that case presentations offer opportunities of performance, a chance to “be in the limelight ... gain respect ... of your colleagues, and especially your superiors” (1994: 79-80). Presentations have a set format, and a ‘persuasive’ and skilful presentation impresses on the audience that the speaker has attained a level of knowledge and ‘mastery’ concerning the patient’s condition, the disease process, the diagnostic possibilities, and the appropriate treatments (*ibid*).

In psychiatric ward rounds, patients were presented as a biological trajectory, a linear progression from age, weight, stressors, history (including past medical history and a developmental history that was divided into social, personal and family), mental state examination and a final culmination of diagnosis. The language of presentation canvassed medical terminology, acronyms, diagnoses and medications: OCD (obsessive compulsive disorder), CSA (childhood sexual abuse), ETOH (alcohol) abuse, depression, phobic disorders, amenorrhoea (absence of periods), EE (expressed emotion), BMI (body mass index), CBT (cognitive behavioural therapy), and blood tests involving FBC’s (full blood counts), LFT’s (liver function tests), and TFT’s (thyroid function tests). These presentations could take up to twenty minutes each, with questions and comments being reserved for the end, and treatment decisions deferred to the ‘head’ of the unit.

This very distinctive language of clinical medicine, Good argues, “is a highly technical language of the biosciences, grounded in a natural science view of the relation between language, biology and experience” (1994: 8). Although Good argues that language in this context was a performance and “not simply forms of literary representation” (*ibid*: 81), he nonetheless tends to over-emphasise it as a basis for power within institutions.

For example, in describing illness as embedded in social spaces he continually privileges spoken language and texts. Disease, he argues, is heterologous, and is found in the complex relationships between biology, experience and representations:

... in the *literature* of the biomedical sciences, in the *conversations* of clinicians and the information produced by their technologies, in the host of ‘*opinions*’ on the condition *articulated* in the social world, and in the *documents* produced by administrative and political bodies which have authority to classify disease and disability. (1994: 167, my emphasis)

Barrett similarly privileges language in his ethnography of a psychiatric institution, arguing that patients are constructed through the basic tools of clinical work: of writing and talking (Barrett 1996: 1). Written and spoken accounts of patients are produced through clinical discourse, via the written clinical processes of interviewing and documenting case histories, as well as the spoken language at case conferences, ward rounds and the less formal settings such as staff tea rooms (*ibid*: 17).

This privileging of writing and speaking comes directly from Foucauldian theory, where discourse is reduced to texts and language (Foucault 1972). In institutions, writing and speaking are thus central to the “machines of meticulous observation, examination, measurement and documentation” (Barrett 1996: 17). Douglas similarly contends (1987) that the main function of an institution is to name (1987: 101-5).

Institutions I argue, have a much broader discursive and active role. Saris, following Lyotard (1984) and Bourdieu (1984, 1991), defines institutions:

... as bundles of technologies, narrative styles, modes of discourse, and, as importantly, erasures and silences. Culturally and historically situated subjects produce and reproduce these knowledges, practices, and silences as a condition of being within the orbit of the institution. (Saris 1995: 42)

While attention to the literal/metaphorical representation of language is undeniably important (as I have argued earlier), it reveals little of the embodied speaking subject, that is, the “whole dimension of authorised language, its rhetoric, syntax, vocabulary and even pronunciation, which exists purely to underline the authority of its author and

the trust he [sic] demands ...” (Bourdieu 1991: 76). Good and Barrett fail to discuss exactly how it is that language represents, produces and imposes importance and credibility. Manifestations of competence in the sense of the right to speech and the *power through speech* are performances of symbolic power that are underpinned by a host of embodied dispositions.

One of these attributes of symbolic power is what Bourdieu calls “the social conditions of the *institution* of the ministry” (1991: 75; cf. 1985: 740), of the social conditions that make it possible for someone (and not just anybody) to say ‘by the power invested in me’. “The real source of the magic of performative utterances”, Bourdieu argues “lies in the mystery of ministry, ie. the delegation by virtue of which an individual — king, priest or spokesperson — is mandated to speak and act on behalf of a group, thus constituted in him and by him” (ibid). A judge, for example, need say no more than “I find you guilty” because there is a set of agents and institutions which guarantee that the sentence will be executed. Similarly, when a psychiatrist tells a patient “you have anorexia”, the symbolic power associated with medicine reinforces the ‘weight’ of such a statement.

Moreover, a person invested with power need not say anything, for it is also by way of silences and erasures that power is wielded. Within ward rounds the tacit rules that governed strategies and practices were the measures of competence and legitimacy. In many ways, these rules were unspeakable, for once learnt, they became internalised, taken for granted and unspoken. The power of speech, Bourdieu writes, lies in a much broader embodied practice than speaking and writing assumes, for it is “in the pronunciation and intonation, everything transcription eradicates, from body language, gestures, demeanor, mimicry and looks, to silences, innuendos, and slips of the tongue that power is performed” (Bourdieu & Accardo 1999: 2).

With this broader view of language and embodied power, I now turn to another treatment site, one in which the power to authoritatively speak about anorexia was legitimated and performed through a different embodied presence.

In stark contrast to these ward rounds was my engagement with Monica, the director of an eating disorder program at a smaller community hospital (the ‘team’ here consisted of three members). Before I conducted research at this hospital Monica advised that I should meet with the chief executive officer (CEO), a meeting that transpired to be a calculation of my positioning within the politicised fields. I was told that this particular program had been ‘unjustly’ criticised by others and that the hospital management strongly supported Monica’s work. In response I assured the CEO that I was interested in people’s experiences of anorexia, rather than evaluating the different eating disorder programs. With this information, and following consultation with the medical advisory committee, my project was supported.

I first met Monica in her ‘office’, a large, comfortable ground floor space that overlooked a well-tended garden. Monica literally dragged the two large, floral couches across the floor so we would be facing each other, suggesting that if I wanted to kick my shoes off and relax that would be okay. She did exactly this, reclining back on the large couch, explaining that this was what she did with her ‘clients’<sup>15</sup> to make them feel ‘more at home’. Making people feel comfortable was a high priority for Monica, and was reflected in the casual clothes that she wore, her sense of humour, frequent loud laughter and her casual demeanour. This casualness was best exemplified by a meeting we had in which Monica had just finished a therapy session with a client and was wearing a faux-fur ‘leopard’ headband covered in fawn and white spots and sporting little ears.

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<sup>15</sup> The term ‘client’ and ‘patient’ circulate in different contexts and each have a clear political agenda. The word ‘client’ was historically introduced to overcome some of the inequalities ingrained in the language of the ‘doctor-patient relationship’ (cf. Taussig 1980). ‘Client’ is a term that is more often used in health settings outside of large institutions.

Monica spoke at length about her own experiences of anorexia and bulimia, legitimating her knowledge of eating disorders through her own personal experiences. It was a strategy on which she based her own treatment, for “if you haven’t been there you don’t understand it”.<sup>16</sup> She characterised anorexia as a journey to the underworld, where the “sufferer” was seduced by the trickery of the male engendered voice of anorexia. Along this journey her descriptions of anorexia oscillated between the positive characterisations of “a shining angel”, “a fiancée”, and “a best friend”, to the more insidious descriptions of “an enemy”, “an abusive partner” and “the grim reaper”. Anorexia was seductive. There were times when Monica would become teary and angry, an emotive display that gave support and credence to her ‘battle’ with eating disorders.

Monica’s characterisations of anorexia as a person/entity with whom she had a relationship was in stark contrast to the clinical language used in the public hospital ward rounds. Her use of language aimed to re-author anorexia, for it was only through renaming it and personifying it that she could subvert what she saw as the dominance of the psychiatric (and patriarchal) ownership of anorexia. One of the ways in which she re-claimed ownership of her experiences was by using the term “self starver” or “troubled eating” interchangeably with anorexia (cf. Tanzer 1997: 65). These terms were not as ‘fixed’ as the category of anorexia nervosa suggests, and included both restricting and purging, rather than one or the other. Anorexia and bulimia, many participants told me, rather than being two discreet entities, were “two sides of the same coin”, and many had experienced both.<sup>17</sup>

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<sup>16</sup> This positionality of ‘I know because I’ve been there’ is as Moore notes, “particularly troublesome when linked to grounds of authority” (Moore 1994: 2). What worries Moore is the way in which “experience is reduced to its linguistic and cognitive elements ... encouraging a view of experience which sees it as ontological, singular and fixed” (ibid: 2).

<sup>17</sup> The APA reflects this experiential dimensions of eating disorders and describes anorexia nervosa as “... a continuum between anorexia and bulimia, [with] many patients demonstrating a mixture of both anorexic and bulimic behaviours” (2000: 19).

Despite the differences of authorship, both Monica and the psychiatrists presented their cases for expert knowledge. And each 'performed' their expert knowledge through very particular public acts of speaking and gesturing. These contestations represented two extreme positions in the understanding of anorexia. Each field and its occupants were seeking to maintain what they saw as legitimate claims to the understanding and treatment of anorexia. As Bourdieu contends:

The individuals who participate in these struggles will have differing aims — some will seek to preserve the status quo, others to change it — and differing chances of winning or losing, depending on where they are located in the structured positions. But all individuals, whatever their aims and chances of success, will share in common certain fundamental presuppositions. All participants must believe in the game they are playing, and in the value of what is at stake in the struggles they are waging. The very existence and persistence of the game or field presupposes a total and unconditional 'investment', a practical and unquestioning belief, in the game and its stakes. (1991: 14)

Both Monica and the staff at the hospital had unquestioning belief in their legitimate claims to treat anorexia. These beliefs were underpinned by claims to specific types of cultural capital (of personal experience and educational qualifications), which could be said to rest on dichotomies such as objective/ subjective, male/female, mind/body and individual/social.

The most pressing struggle in this field was concerned with subjective and objective knowledges, an opposition that Bourdieu sees as "a permanent feature of everyday struggles for distinction and power" (Swartz 1997: 55). Psychiatry is a science that evolved as a specialty arm of medicine during the last years of the eighteenth century (Barrett 1996: 183). Like all medical/scientific discourses its practice is based on rationality, control and objectivity (cf. Desjarlais 1996b). Case presentation of patients in ward rounds characterised this objectivity through the staff's language and demeanour. Anorexia, for example, was discussed in terms of measurements (of body weights and body mass indexes), of blood chemistry results, and nutritional intake (caloric consumption). The presentation of people's biographies, which often involved



recounting horrific stories of abuse and misfortune, was similarly presented as measured, serious and in a ‘professional’ manner (cf. Shullem 1988, cited in Murphy 1997: 4). While I wanted to widen my eyes and shake my head in disbelief at these stories, many staff members remained motionless, their faces not ‘giving away’ any emotional signs of empathy that they felt. The distinctly ‘unemotional’ atmosphere of these clinical rounds is part of the discourse in which “emotion is constructed ... as dysfunctional, within the realm of the irrational” (Ariss 1993: 27).

Monica, on the other hand, embodied and epitomised the complete antithesis of this so-called rational mode of knowing. Her personal experiences of eating disorders (including treatment in a psychiatric ward) led her to move away from those programs that she considered to reinforce ‘male dominated’ values of surveillance, control and power. Her program, she claimed, was vastly different from any others in Australia, for she did not distance herself from clients, but incorporated them into her own life, taking them home for dinner, hugging them, crying with them and even teaching some to drive a car. Her positioning as both a “returned soldier” (a recovered anorexic) and therapist literally crossed the bridge between patient/healer, blurring the hierarchy of power.

Monica was not trained as a psychiatrist and her mode of treatment drew on narrative therapy. Narrative is not a new phenomenon, and has a long tradition in various disciplinary fields (Hepworth 1999: 113), including psychiatry and anthropology (cf. Kleinman 1988; Saris 1995).<sup>18</sup> Narrative therapy, as a derivative of family therapy,

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<sup>18</sup> The term ‘narrative’ has currency within medicine and anthropology, as epitomised by the development of the term ‘illness narratives’ by Arthur Kleinman (1988), himself a psychiatrist and anthropologist. Narrative though, has different understandings in each field and cannot be transferred or taken unproblematically across differing fields. Anthropologists have taken on board, criticised and extended the usefulness of narrative in fieldwork (see Rapport (2000) who focuses solely on the transcription of words; Weiner (1995) who disparages narratives as ‘feeble anthropology’ (despite his own fieldwork collection of myths) and Good (1994) who foregrounds experience as prior to narrative). The sticking point in these different uses of narrative centres around the literary construction of the term and the fields (or lack of) in which they are constituted. Illness narratives, according to Kleinman are like literary texts, consisting of “content, structure, rhetorical devices, plot, and story line” (1988: 233). In critiquing this model, Saris (1995) and Lucas (1999) for example, point to the ‘symbolic violence’ embedded in the collection and interpretation of illness narratives, of the institutional contexts in which they are framed and the relationship between agency, meaning and power. Moreover, Lucas suggests that the indeterminate ways of ‘telling a story’ are not simply about

gives central weight to the ‘personal stories’ of clients, using language as both a site of individual problems and potential change (Hepworth 1999: 112). In the case of anorexia, clients are encouraged to personify and ‘externalise’ anorexia, positioning it outside of the body. In this process, clients are deemed to have control over anorexia, rather than vice versa. What is valued by narrative therapists is the ways in which clients construct experiences, rather than the interpretation of these experiences as pathology. Experiences of female embodiment, rather than the invocation of authoritarian medical discourse, is deemed to be the most valuable component of this therapeutic skill (cf. Robertson 1992: 74).

The professional differences between ‘eliciting and owning’ stories/narratives was crucial. Monica encouraged clients to construct and manipulate their own personal narratives through art work, writing, and encouraged them to physically take up more space and speak louder than a whisper. Clinicians who did not follow a narrative therapy style described people’s demeanour and body language, and elicited, interpreted and presented interviews as psychiatric case histories. Jackson argues that the spatio-temporal tellings of these stories is crucial:

The most telling difference between the life story and the scientific tract is not epistemological but social .... This is because the authority of the scientific essay stems not from a *communis sententia* arrived at through shared experiences of mundane life but from an exclusive knowledge that defines the precinct of a professional and privileged class (Lyotard 1984: 25). Always arcane, always couched in cabbalistic language, always the preserve of an elite, essayist knowledge implicitly divides those in the know from those in the dark ... the return to the narrative is a political act (cf. Abu-Lughod 1993: 16-9)... not only does it imply a critique of metaphysics and transcendence, it attempts to undercut discursive conventions that foster hierarchy and division. (Jackson 1998: 35)

The undercutting of medical discourse was precisely what Monica aimed to achieve.

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words, they are also about gestures, images, silences and erasures. He suggests that the ways in which *agency* is manifest as storytelling, of how it is constituted (and not just mediated) by an institutional field, is a more interesting question (1999: 12).

Another major site of struggle was in the philosophical values underpinning care. Psychiatry was firmly located in a large ‘medical’ institution (as a teaching institution it was affiliated with both the hospital and adjacent university), whereas Monica was located in a much smaller ‘community’ hospital, removed from the auspices of psychiatry. Monica espoused the philosophies of community health, emphasising the social, economic and political contexts of health and illness, rather than locating illness in individual, ungendered bodies. Her ‘clients’, rather than ‘patients’, were encouraged to participate in their own treatment, for example, by choosing their own meal plans, in an attempt to incorporate them into decisions about their own health and reduce their fear of certain foods. Rather than try and modify people’s behaviour, Monica would suggest, for example, that if they were going to vomit to do it outside, as the cleaners would be annoyed with the blocked plumbing. For Monica, the treatment of anorexia belonged under the rubric of community or public health, rather than psychiatric care.

These vastly different politics of treatment created professional tensions. Sometimes these were conveyed in no uncertain terms, and at other times they were suggested through gesture: the rolling of eyes, loud sighs, or in comments made under one’s breath or ‘off the record’ in ward rounds. Some clinicians saw little room for movement between sites, and despite the fact that participants with eating disorders had often tried a variety of treatment options (including both of these), several staff members described ‘irreconcilable differences’ existing between programs. Staff from each of the two opposing treatment sites told me that people with eating disorders would die if they were admitted to the other. The sense of where those with eating disorders belonged was fixed according to specific politics of power and knowledge.

Although these two examples represent the extremes in a range of treatment options, the distance between conventional psychiatric treatment and ‘alternative’ programs remains vast, both in Australia and internationally. Treatment centres that ‘deviate’

from in-patient psychiatric treatment are well known to any health professional working in the field. The Cullen Centre in Edinburgh, for example, was referred to by a Australian hospital psychiatrist as “that place where starving people walk the streets”, or that place “where they let them get down to ridiculously low weights”. Hospital programs are equally aware of how they are perceived by others, as one consultant psychiatrist commented: “we are seen as too rigid and too punitive”.

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While this chapter has described two different understandings of fields (as descriptive sites and as an analytical concept), it has also demonstrated the usefulness of placing these terms side by side and examining their convergences. In a slightly different vein, Clifford suggests that it “may be useful to think of the ‘field’ as a *habitus* rather than as a place, a cluster of embodied dispositions and practices” (1997: 199). Although I do not fully agree with his collapsing of *habitus* and fieldwork (as fieldwork is not a practice that is inculcated at an early age, nor is it a mode of research that takes everyday practices for granted, in fact quite the opposite) the critique and extension of traditional spatial notions of field through Bourdieu is helpful in retheorising contemporary ethnographic practices.

As an object of study, the medical category of anorexia carried a set of assumptions that readily ‘translated’ across continents and allowed me access to treatment sites and people’s lives. It was the category of anorexia that connected me with people and places in order to conduct fieldwork. As such, anorexia was already ‘bounded’ and described before my ethnography began. On the other hand however, anorexia was not a homogenous category. In employing Bourdieu’s relational concept of field, this chapter has highlighted the complex and contentious nature of struggles for power and legitimation surrounding the understanding and treatment of anorexia. Anorexia was

not a static entity, but one that varied according to people's different positionings within the field. Very different perspectives, for example, could be elicited from psychiatrists in ward rounds and community health practitioners. Gender, positionings of power and one's own experiences were all pivotal in how people came to know anorexia. These perspectives, I argued, were informed by hierarchies of different epistemologies: ways of knowing that were pitted against each other in struggles for power and authority.

The mapping of fields in this chapter, of delineating the relationships between fields as geographical sites and spaces of symbolic struggles, is important to the trajectory of this thesis. People who were given a diagnosis of anorexia were deeply enmeshed in the politics and powers of these fields. Moreover, as will be described in Chapter Three, they recognised and played with the power of anorexia, transforming the seemingly inert category of anorexia into a new way of relating to themselves, others and the world. Through this research I too became enmeshed in the powers at play, for the relationships that participants had with anorexia and health professionals tailored their interactions with me. The next chapter describes these changing and negotiated relationships. This is not to proffer another competing claim for singular authority. On the contrary, the argument positions knowledges and experiences squarely in the realm of the relational; in the embodied realms of interexperience and intersubjectivity.

## CHAPTER 2

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### KNOWING THROUGH THE BODY

This chapter explores what Rabinow refers to as the central conundrum of ethnography: of how I negotiated fieldwork relationships amongst a group of people with whom I did not share a common set of assumptions, experiences or traditions (Rabinow 1977: 155). These negotiations were complex, for they operated simultaneously on a number of levels and were constantly fluctuating. I was not simply observing people with anorexia; I was interacting with them, continually finding common grounds and differences, and by this very implication, challenging my own assumptions about food and eating. I was not only entering into new relationships with people, but also entering into a new relationship with my own sense of embodiment.

Trying to capture these simultaneous moments of fieldwork in language is a difficult task, as I noted in the introduction. In writing this chapter I attempt to display the interwoven nature of fieldwork relationships and experiences. For the reader though, there are clear demarcations to signal important themes of negotiation: structures of time and space (of where and when I met participants) and the practices of bodily knowledge and experience (how we ‘came to know’). This textual strategy, I emphasise, is a heuristic device which I use to convey differing levels of negotiation. Negotiation is, after all, a flexible and moving process that continually returns to the spaces between parameters of difference and common ground.

My starting point with participants was on a somewhat tenuous common ground — an interest in food, and the minutiae of experience that accompanied everyday practices. It was through this convergence that we were able to explore the meanings of anorexia. People with anorexia were often entirely pre-occupied with the characteristics and

effects of food; with the exact caloric and fat content of every fluid and food. Some meticulously recorded every bodily consumption and expenditure, twenty-four hours a day. They did not take food practices for granted; these were the *central* focus of their worlds. I, however, came to this fieldwork with an entirely different understanding of food: it posed no threat of contamination, I did not know the caloric value of every item in my pantry and I could eat almost anything, at any location and time. In Heidegger's terms, foods and all their associated 'trimmings' were familiar and 'ready-to-hand' to me, and as such mostly overlooked in my day-to-day routines.

Our differences in the 'readiness-to-hand' of food practices had direct effects on establishing and maintaining fieldwork relationships. Participants had very particular routines around food and eating, often eating alone and in private spaces and thus excluding all others, including me. These spatio-temporal constraints determined the nature of my research, as where and when I met people was continually shaped by people's day-to-day routines.

Negotiating relationships was, however, not simply concerned with the pragmatics of timetabling. Although Heidegger did not use his concept of ready-to-hand to focus on embodiment (a task taken up by Merleau-Ponty), by extension it provides a useful framework to explore visceral, embodied experiences of being. As well as differing routines around food, I was simultaneously challenged with differing embodied and visceral experiences. Unlike people with anorexia, I was not aware of bodily sensations, such as food travelling through my body beyond an initial register of taste and smell, or how sheer exhaustion alerts you to the heaviness of your feet as each leg wearily lifts them up each step of a staircase. Observations and language could only convey in part, so how could I come to know or glean any sense of what it *felt* like to have anorexia?

The turning point was entirely unplanned and fortuitous. Becoming pregnant six months into my fieldwork built previously unexplored and analogous bridges of embodiment with many participants. Suddenly my body changed, and my sense of home — of bodily dwelling — began shifting between states of familiarity and strangeness. My changing body became one focus of interplay between participants and myself, and helped to establish intersubjectivity on an entirely different level. Of course, no one can ever replicate another's experience (and replication was not my aim), but my embodied presence in the field was acutely heightened because of my own transformation through pregnancy. It was in this analogous space — in the negotiated, intersubjective realm — that I was able to explore what anorexia, of a body in process, could mean for each of us.

## FLUCTUATING BAROMETERS

In her comprehensive book *Food, the Body and Self* (1996) Lupton focuses on the development of meanings around food and eating, and explores the sites of acculturation that engender eating preferences, practices and bodily deportment. In this analysis she highlights the commensality that accompanies food practices<sup>1</sup>:

The sharing of food is a vital part of kinship and friendship networks in all societies. The extent to which an individual is invited to share food with another individual is a sign of how close a friend or relative that person is deemed to be. While casual acquaintances may be invited to share a hot or alcoholic drink, perhaps accompanied by snack foods such as biscuits or hors-d'oeuvres, closer friends or relatives share full meals, with the sharing of dinner the highest level of closeness. (1996: 37)

While there is nothing untoward in her observations and I agree with them, nothing could be further from the experiences of people who have anorexia. The taken-for-granted rules of commensality did not happen, simply because most people had very

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<sup>1</sup> Commensality is a word that traditionally means "those that gather around a table to share food" (Visser 1992: 83). I am using it in a much broader sense to denote a wider *habitus*; the embodied rules of etiquette, hygiene and spaces of commensality.



different beliefs about the meaning of food and its embodied sensations. During my fieldwork, anything to do with eating and drinking was always negotiated. I could never assume that just because I had known someone for a year that we would eat together, or that on our first meeting we could ‘break the ice’ over a cup of coffee.

Sahlins comes closer to the contingent nature of food and relationships in *Stone Age Economics* (1972) where he observes: “Food dealings are a delicate barometer, a ritual statement as it were, of social relations, and food is thus employed instrumentally as a starting, a sustaining, or a destroying mechanism of sociability” (1972: 215). The notion of a barometer is an apt metaphor, as I engaged with people whose lives fluctuated according to what they had or hadn’t eaten. Food itself was such a powerful trigger for painful emotions, memories and sensations that it tailored every aspect of my fieldwork.

Perhaps the most obvious fluctuations of the barometer happened in my meetings with Natalia. During our 12 month relationship I watched the remarkable transformations that were totally dependent on whether she was “in an eating phase” or not, and whether our topic of conversation turned to food and its associations. Natalia has lived with what she described as “the living nightmare of anorexia” for most of her 32 years. We first met when she was an in-patient on a psychiatric ward, where she was being assessed for a treatment program. She was dressed for warmth and comfort in a casual grey tracksuit, a long sleeved ‘rugby’ jumper, and white sneakers. Her long brown hair was tied at the nape of her neck, and she wore no make up, and just her glasses. Natalia seemed hesitant and didn’t know whether to invite me into the room she shared with three other in-patients, and asked a staff member where we should go. The female psychiatric nurse directed us to the quiet of the patient dining room and we sat opposite each other at the end of a large, white laminated table. Natalia sat in a plastic chair, her

legs tucked up against her chest with her chin resting on her knees, eyes down cast and her voice barely audible at times. Her body shifted in the chair as she told me I could leave if I found her boring, as she was sure that what she said was really of no value anyway.

Although there was a certain awkwardness to our first meeting, Natalia discussed the more pressing effects of being in a hospital environment, of having to eat three meals every day (and snacks in between) in this communal dining room. For someone who may only have fluids for several days, this amount of food made her feel nervous, depressed and despising of her body. The fact that we were sitting in the only 'private' space on the ward — the patient dining room — although inconsequential to me, had an entirely different significance for Natalia.

After Natalia was discharged from hospital she invited me to her home to look at her collection of Japanese memorabilia, a collection that extended to sasanqua camellias and bonsai in her garden. When she was explaining her passion for everything Japanese she was the most animated I had seen, laughing and excited. But later when we talked about the meal plans that the dietitian had outlined for her to eat at home she became angry, silent and physically immobilised. She curled herself up into a small ball on the sheep skin rug that she used as padding for her bony frame on the lounge room floor, unable to talk and move, sobbing that she hated herself and wanting to simply disappear. Her hands were wrapped around her body, under the layers of thick woolly jumpers, with her feet curled up to her chest.

The next time we met I could not hide my amazement at her transformation. She had come straight from work in the city, and strode into the busy cafe in high heels, a short, tight black skirt and jacket, laughing loudly and smiling. Her poise, sweeping hair, lipstick and jewellery were all in stark contrast to the track suits and over sized jumpers

that she had worn at home or in hospital. She asked *me* what I'd like to drink, ordered it, paid for both drinks and chose to sit at the most visible space in the café, on stools at the front window that overlooked the seated patrons and the passers by. Despite much cajoling, Natalia had never been for a coffee with the community nurse she has been seeing for a number of years. I asked her why she was able to meet me publicly and she said it was because she had decided not to eat and as a consequence she felt "empty, strong and confident". And unlike the community nurse, I had no vested interest in seeing or expecting Natalia to eat, so it was 'safer' and more comfortable for her to meet with me. She drew my attention to the fact that she was having a cappuccino, with 'real' milk froth, chocolate dusting and a sachet of sugar stirred in. This was what she called her "meal for the day".

### **Illuminating the 'readiness-to-hand'**

Natalia demonstrated how I could never take meanings of food and its associated practices for granted. The hospital dining room where we first met, for example, did not hold the same resonance for us. Instead it was a place stripped of all potential commensality, and invested with dread. It wasn't until Natalia explained what a coffee meant to her that I began to understand the possibility of different meanings.

I reflected on the times when I had shared a table with other participants. Ingrid and I always met in the same café in the student quarters of Edinburgh, after she had finished work (she volunteered to work overtime) in a busy retail outlet in the city. I considered the time and space of our regular meetings in a new light. The most convenient time for Ingrid was usually around 7 p.m. I'd have something to eat and she'd sip on one cappuccino over the next two to three hours. Occasionally she'd eat the marshmallow on the saucer. I came to realise that these drinks were not only her evening meal, but she wanted to meet at that time as it provided her with an excuse to exit the family

home and avoid what she called a “hot, sit down dinner”. I could no longer overlook or ignore a simple cup of coffee, nor the different spaces in which we sat, how we moved our bodies, the effects of what was spoken about, or the emotions tied to eating and not eating.

The overlooking or ‘forgetting’ of everyday practices is central to Heidegger’s arguments in *Basic Problems of Phenomenology* (1982). In this work he describes how everyday practices are performed without reflection, arguing that they are so familiar that they are ignored and forgotten as meaningful to our sense of Being. As he emphasises, we are so immersed in the taken for granted, lived experience of our everydayness that we do not hold it in view:

The world as already unveiled in advance is such that we do not specifically occupy ourselves with it, or apprehend it, but instead it is so self evident, so much a matter of course, that we are completely oblivious to it. (Heidegger 1982: 165)

Part of the reason why Being-in-the-world has been overlooked, Heidegger argues, is that it is so pervasive and it only appears to us in a conscious way when disruption or breakdown occur. In Heidegger’s terms, as long as the ‘ready-to-hand’ piece of equipment works properly it is hidden from view and unthematized. He describes such a situation:

When we lift a hammer or drive a car [or take a piece of toast to our mouths] we are before we know it enmeshed in a series of meaningful relationships with things. We take up the hammer in order to drive a nail through the shingle in the roof so the rain won’t penetrate; we put on the left turn signal well in advance of a turn so that the driver behind can brake and avoid an accident. (Heidegger 1977: 20)

In short, Heidegger’s analysis of ready-to-hand is alerting us to our unreflective mode of existence. For the most part we do not have subject-object relations with the entities in our world. Practical manipulations that focus attention on particular entities and goals force one to presuppose and thus forget the encompassing horizon (Sass 1992:

123, cf. Olafson 1987: 162). As a result we miss the meaning that is made intelligible through the linguistic and cultural skills and practices given by the world (Leonard 1989: 45). It is only when the taken-for-granted skills and practices of everyday lived experience fail (for example, when one becomes ill) that we become conscious of its readiness-to-hand.<sup>2</sup>

Of course what Heidegger is talking about is all too familiar to anthropological practice and theory. The reasons that I am highlighting it are twofold: firstly to explore the ways in which people with anorexia do not take food or eating for granted. They were all too aware of the ‘readiness-to-hand’ of food — the minute details that accompany every aspect of food — so aware that it dominated their every turn. The women and men with whom I spent time agonised over every detail of food: the thought of eating, when and where to eat, what to eat, how to avoid sharing food and what to eat first, second and last on their plate. The actual process of opening the door of the fridge, taking a packet of cheese out, slicing a piece off, and then deliberating whether to eat it, was in itself a calculated and momentous task. Lara, who was a stage performer, ‘acted out’ the battle of even contemplating putting food into her body through a conversation with herself:

I do challenge my thinking. I go “this is a piece of cheese and it’s got approximately 50 calories in it. Will I allow myself to eat it or will I not? I shouldn’t really because it’s fattening but yes I will because it’s not going to kill me and it’s not going to do me any harm and I’m sure I can work off the calories tomorrow. Okay, eat it”. But I go through that with everything.

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<sup>2</sup> Many people with illnesses or conditions that are diet related (such as diabetes, high cholesterol or allergies) are all too aware of the readiness-to-hand of food. Illness and health is one area where the taken-for-granted nature of one’s embodiment is thrown into relief. A woman whom I resided with whilst doing fieldwork in Edinburgh was similarly conscious of her everyday diet for she was a practicing Buddhist, a vegan and allergic to a long list of foods. She circumscribed her dietary intake because of these factors.

Many kept meticulous recordings of what they consumed over a day, some even detailing the sensory aspects of their bodies at particular times and in particular spaces.<sup>3</sup>

Maddy filled her diaries with such intimate and detailed reflexive recordings:

I love the smells I associate with Christmas. Firstly the fresh, sharp odour of pine needles - a live Christmas tree is definitely better than those stupid plastic 'evergreen' ones. Then ripe apricots, and cherries, always eaten lots at Christmas.

I have one waiting to be eaten now with my breakfast.

Better still, all these things look and feel (in the case of the fruit) and taste, as good as they smell. What do pine needles taste like? I imagine a sharp small burst of pungent juice, almost of imperceptible size.

There's a correct way to eat oysters, so too there is a correct way to eat apricots. The key with the first is to choose the fruit carefully, and savour every moment.

1) Enjoy the touch of a perfect apricot, soft, smooth furred skin, more delicate than a peach. The flesh neither sloppy nor hard.

2) DO NOT PEEL.

3) Smell. Savour the light yet pungent fruity tang for as long as you dare.

4) Contemplate the fruit, noting the golden-orange skin, the smooth dividing line. Is the flesh room temperature or cool? Decide the perfect temperature.

5) This achieved, take a first bite. Do you merely graze the skin to allow the first juices to tingle on your tongue? Or do you sink your teeth straight in?

6) Eat the fruit worshipfully with the most enjoyment.

The second important reason to bring Heidegger into view is to signal my own concerns about doing fieldwork around a practice that was for me, 'ready-to-hand'. Unlike going to a field site that is immediately unfamiliar, I was faced with the opposite task of understanding the familiar in a very different way.

Eating<sup>4</sup> is so intrinsic to my daily routine, and it is precisely the routinisation of eating that allows me to be unaware of it. I can plan a dinner for four people or arrange to

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<sup>3</sup> Connecting feelings to eating is an integral part of cognitive behavioural therapy, a popular form of treatment for eating disorders.

<sup>4</sup> 'Eating' itself could not be taken for granted, as people had different types of eating : binge eating, for example, was characterised as hurriedly eating large amounts of food and was viewed as dangerous (in terms of desire) and redolent with emotion. The oldest participant Carolyn, who had binged, starved and vomited since she was a teenager (when I met her she was 55 years of age), characterised binge eating as:

... just throwing things in really fast and it's not sort of sitting down and enjoying it - you're just forcing it in as much as you can. Til you're completely bursting ... I'd get milk from the

meet a colleague for lunch, but the memory of what I prepared or the tastes and smells fade in comparison to the importance of, say, why we met or what was said. As Lupton (1996) highlighted earlier, the importance of food and eating is what it allowed me to do. I had come to know it as a way of sharing, as a way of establishing and maintaining relationships, as a vehicle of communication and interaction. The actual mechanics of food and eating are forgotten. I rarely reflect on what I've eaten, what time I've eaten, or where I've eaten, unless it was associated with a special occasion or it's had some dire consequences. I give even less thought to how I've eaten – the sensation of my teeth chewing the food, how my body moved as I brought the food to my mouth or the satiation of hunger.

My ability to become attuned to the presence and details of something that was for the most part 'forgotten' in my everyday practice was at the forefront of my research. I was already acutely aware of the criticisms of doing anthropology 'at home' – for the perceived inability on the part of the anthropologist to self-consciously reflect upon her or his predominant and familiar cultural world.

The critique of doing anthropology 'at home' however, has a number of limitations that stem from a privileged spatial understanding of 'at home' and 'in the field'. These cultural categories — home and field — immediately denote geographical spaces that are invested with a hierarchical significance. 'The field' (area, domain or site) was (and continues to be) the unfamiliar and distant place to which anthropologists traditionally travelled in order to conduct ethnographic work.<sup>5</sup> 'Home' by comparison, was the place where anthropologists 'wrote up' their fieldwork, it was familiar and close. This spatial

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hospital trolley and I'd put flavouring in it and drink a huge lot of that - probably at least - I reckon 3 litres on top of all the food I'd eaten to make it easier to throw it up.

<sup>5</sup> Wafer (1996) notes the romantic imaginings of 'the field':

"The field" has various resonances; it evokes, simultaneously, peripherality and nature (since fields are in the country), and "the real world" (as distinct from the library or the laboratory). It is thus a romantic notion, because it suggests the possibility of an alternative to the centralisation, artifice, and "unreality" of contemporary intellectual life. (Wafer 1996: 240)

separation, which has been subject to considerable critique (cf. Messerschmidt 1981; Wafer 1996; Gupta & Ferguson 1992, 1997; Peirano 1998; Marcus 1999; Caputo 2000), is too narrow a concept, for 'home' is not a homogenous space, and within concepts of home, the grounds of familiarity and strangeness are constantly shifting. 'The field' and 'home' can simultaneously be experienced as strange and familiar, close and distant.<sup>6</sup>

Lucas (1999) highlights the spurious separation between home and field in his ethnographic account of people's experiences of schizophrenia in the city in which he lived. Ordinary spaces that he encountered in people's homes, such as lounge rooms, bedrooms and hallways, were sometimes rendered completely unfamiliar. They were stripped of their function and transformed into sanctuaries, shrines and elaborate self-conscious displays of self and identity (1999: 165-6). Walking around the corner from his own house to an informant's apartment was a journey from the familiar spaces and routines of suburban life into a world of interconnecting dreams, images and realities.

Lucas was not only entering unfamiliar spaces, but also engaging with people who had entirely different *perceptions and embodied sensations*. The people involved in his fieldwork had experiences that were deemed to be outside 'normal reality' (and thus identified as 'schizophrenic'); they engaged telepathically with characters from the television, had extra-sensory perception, spoke to spiritual figures or were subject to electro-magnetic radiation. Some described their brains being on fire, music vibrating through their body, their heart bleeding, twisted vertebrae and feeling another's breath within their body. From these 'extra-ordinary experiences', one cannot assume that

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<sup>6</sup> After time, the strangeness of the field dissipates and becomes familiar. Kondo momentarily gazed at the reflection of a typical Japanese housewife in a shop window, before realising that she had "caught a glimpse of nothing less than [her] own reflection" (1986: 74). And coming home or 'out of the field', rather than being a return to familiarity, can be a profoundly disorientating and disturbing experience, as Desjarlais notes: "When I left Nepal, I could not shake off the sensibilities that helped me get about, and found, when I tried to speak with friends or buy a pair of sneakers, that I had lost the knack of being American" (Desjarlais 1992: 251).



being ‘at home’ is the same for all, for to do so would be to ignore the range of differences (both spatial and embodied) that co-exist within complex cultural settings.

Similarly, the people with anorexia who lived in the same city as I do did not share my sense of home. Many, as described in Chapters Three and Five, did not feel at home in their own bodies, characterising their bodies as alien, strange and unfamiliar, yet intimately known. To have anorexia, as Mukai recounts, means having “a different language, a different value system, different ways of interpreting and responding to situations” (Mukai 1989: 634). This engagement was multiple and in a state of constant flux, as participants and I continually moved between the central fieldwork tropes of distance and closeness, familiarity and strangeness.<sup>7</sup>

## **SPATIO-TEMPORAL ASPECTS OF INTERACTION**

A major focus of the different ways of interpreting and responding to situations related to everyday routines around food. A common assumption surrounding eating disorders is that people with anorexia don’t eat. They do, but only very specific things, at specific times and often in specific places. The diagnostic criteria for anorexia nervosa focuses on these specificities as a sign of diagnosis. ‘Food rituals’ as they are described in the psychiatric literature (a word that is taken up with great ease by participants) include:

Unusual eating habits, for example, food avoidance, playing with food, cutting food into small pieces, using abnormal utensils – a teaspoon to eat cereal, dawdling over meals, making unusual concoctions by mixing food together, increased spice use, increased coffee/tea/fluid consumption, refusal to eat with others or wanting to eat in privacy. Along with the intense preoccupation with food and eating – such as collecting recipes, cookbooks and menus, excessive

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<sup>7</sup> While Edwards (2000) does discuss and defend her choice of ethnographic locale in her homeland of Britain, she also suggests, and I agree with her, that the time has come for debates about anthropology at home to move on:

There is something unhelpful, it seems to me, in perpetuating the notion that there is an anthropology at home, which then requires, as its counterpart, an anthropology elsewhere. We need to focus attention instead on the way in which certain items of information come to be of anthropological interest — to tease out some of our reasons for homing-in on certain things and not others — and this requires more than a methodological reflexivity. (Edwards 2000: 11)

thinking and conversations about food and food related dreams. (Women's Health Project 1992: 2)

These 'unusual eating habits' tailored every aspect of my fieldwork. A seemingly quick phone call to arrange a time to meet with someone might take twenty minutes as it had to be scheduled into a highly structured daytime regime. Tanya described how she planned her days around when she would eat, what she would eat and the exercise regime in-between. She only allowed herself to eat at very specific times, and what she ate — whether it was a few Cornflakes or a piece of toast — must take at least an hour to consume. She would then wait an hour before she exercised, which she did for three hours every afternoon, and then wait for an hour afterwards. This, she said, was her full time occupation, as she literally did not have the time to fit work or study into the daytime routine. I asked her what her response was when something unexpected happened to her routine:

I remember one day mum wanted me to go out to lunch with her and I was terrified because I didn't want to go out to lunch and then I said 'what if we have lunch together at home?' And she said 'okay' and that made me feel better and I'd planned what time that was going to happen and what I was going to eat and all that sort of stuff ... mum was running late and I got so angry. I was almost in tears because I couldn't eat at the time that I'd said to myself I was going to eat. I thought 'why am I so upset about this' but I couldn't stop myself feeling it. Even now I'm sort of rigid in the things I do but nowhere near as I used to be ... I just didn't like anything to muck up my routine or my schedule.

One woman joked when arranging a time to meet me: "let's *not* do the lunch thing", as the trauma of having to eat in public, choose what to eat, and pretend that this was a normal, everyday occurrence was too much to contemplate. We always met in the afternoons and we never met on Sundays, as this was her "eating day". Once she opened a packet of chocolate biscuits at her house, placed them on a plate in front of me and washed her hands. I (somewhat naively) asked her if she was going to have one,

and she shook her head. Although we met regularly and often shared a coffee or a diet coke, we never ate together over the two and a half years of our relationship.<sup>8</sup>

Negotiating the commensality around food was a constant dilemma for participants.

Lara joked about the bluffing that she regularly goes through with friends who do not know she has anorexia. When they phone to invite her to dinner and ask “is there anything you don’t eat?”, she always politely says:

‘Oh, no, no, I eat anything’! (laughs). And I don’t know why I do that - it’s like ‘I’m fine, I eat anything but the only thing I don’t like is (she pauses) olives’ (laughs). And I think ‘why do you say that?’ because you are no doubt going to be presented with something and you’re going to look at it and mumble to yourself ‘I can’t eat that’ ... I have to talk to myself and ‘it’s alright, it’s not going to kill you, it’s not going to do you any harm, it’s a one off and maybe you won’t have so much tomorrow and you won’t be eating it again tomorrow - so it’s like a treat - just eat it for god’s sake’ (laughs) and so you do and then you feign enthusiasm and say ‘oh its lovely’ and you get through it as best as possible, but it’s not the most enjoyable of experiences sadly, which is a great shame because that’s what food all about - sharing.

My fieldwork was often structured around events and places that did not involve food, or the attached social obligations or practical routines around which it revolved. In people’s homes we rarely sat around a kitchen table, and when we did it was a clean sparse surface with no hint of its function. Natalia’s ‘dining room’ was like a museum exhibition, for it was a space of display for its contents (See Plate 1). On the floor was a Japanese table with four brown velour cushions around it and four place settings, four folded napkins, four sets of unsealed chopsticks and a circular centrepiece with twelve miniature animals depicting the Japanese calendar years. I asked her if she had friends over to share Japanese cuisine and she immediately laughed at the absurdity of such a suggestion. The only other table in the house was a round table belonging to her grandmother, hidden in a corner with a spotless surface and waiting to be thrown out. Natalia told me that she didn’t need a table to eat from as she would never use it. She

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<sup>8</sup> Relationships with some participants have continued beyond the fieldwork phase, and we have kept in touch through e-mail or hand-written letters, or meet socially from time to time.



Plate 1. Natalia's 'dining' room

either sat on the floor in the lounge room, walked around the house or ‘distracted’ herself whilst eating as she worked on her home computer. I began to take note of the presence and positioning of dinner tables in other people’s homes, often finding none, and if there was one, noting its impermanence (fold up tables or card tables) or its disguise (covered in papers or clothes).

Another activity that was avoided by participants was grocery shopping. Prior to fieldwork I had assumed that I would be able to accompany people to the supermarket, but for some the thought of going near one drew looks of horror. Natalia refused such a suggestion outright and jokingly pleaded “anything but that”. She was terrified of shopping, afraid of entering a space brimming with food and indecision, and the possibility of ‘running’ into someone she knew. To counter these fears, Natalia would often drive miles to a supermarket in an unfamiliar suburb, and carry a small basket that could be dropped and abandoned if she needed to suddenly flee. The difficulty associated with supermarkets was illustrated in an anecdote that Rita shared with me. In recounting a form of therapy she had many years ago, Rita played with the pleasurable and disgusting connections associated with food and sex:

He explored sex a lot with me (laughs) - intellectually, as a therapist ... he even took me to a sex shop once because he thought I must have had a hang up about sex - which I sort of did but the sex shop was a big yawn - there were gadgets and do das in there that I thought were funny. I find supermarkets harder than sex shops.

The trauma of shopping for Natalia came to light when she offered me a cup of tea and a plate of biscuits in her home one day, many months into our relationship. She relayed how she bought the biscuits, ‘whipping in’ and out of a nearby petrol station, explaining that the speed of her purchase meant that she could remain anonymous and not have to linger around food. When I left her house that day she insisted that I take the remaining biscuits as she was going to throw them in the bin or give them to the neighbour’s

children. Because Natalia rarely had guests to her home, I became a sounding board, someone to ‘check’ the cultural rules of commensality with: “what do you do when you have guests, what do you offer them?”

Bettina explained that when she was “at [her] worst” she would spend two or three hours grocery shopping and “only just get a bag of fruit and vegetables”. She described why it was such a time consuming task:

You know the phrase ‘you are what you eat?’ - well I took it literally ... and if I wanted to be perfect then everything had to be perfect that I consumed, put on, did, the washing - everything.

*So how did that affect the way you shopped?*

(She sighs) Oh dreadfully - it narrowed everything down because the selection process - I’d search through 200 apples in the supermarket to find the perfect one and think ‘yes this is worthy of going into my body to make me a perfect person’ - it’s horrendous.

The few participants who did shop with me demonstrated the struggles they encountered. It was, as Bettina foretold, a time-consuming exercise in which a variety of very explicit and calculated choices were made. *Every* packet of food was scrutinised for its fat and calorie content and then compared within the range of different brand names (one woman took her calculator just for this exercise). As well as food, much attention was also given to choice of household cleaning, sanitary and hygiene products. Tamara and I deliberated over such questions as: “is anti-bacterial soap better than ‘normal soap’?”; “should one have a separate cleaning fluid and sponge for different surfaces and spaces in the home?” My experience of the familiar (and often social) task of going to the supermarket, taking a trolley and selecting items from the shelf (with little reflection) was far removed from these women’s shopping experiences.

## Learning the [body] language

Like Heidegger foretells, it was when the taken-for-granted skills and practices fail that we become conscious of an object's readiness-to-hand. When I casually said to a participant around midday, "I'm starving", I got a sideways look and a quick lesson in curbing language that was deemed inappropriate. "You're starving – you have no idea what it is to starve". Similarly, when I was attending a volunteer meeting at the Anorexia and Bulimia Nervosa Association I was curtly reprimanded for my use of language. We were looking at the program for a conference entitled *The Body Culture*, which took place in Melbourne in July 1999. The international guest speaker was Susie Orbach, renowned author of the book *Fat is a Feminist Issue* (1978). One of the volunteer counsellors asked who she was and I exclaimed that she was a 'biggie', meaning her influence in the academic area of eating disorders rather than her physical weight. I was immediately told off – "We don't use *that* word around here" was the curt retort.

I also learnt that a casual greeting could be interpreted quite differently from its original intention. Tanya, who had done a number of weight gain programs on a psychiatric ward, explained that comments from well-meaning relatives and friends such as "you look great", "you're looking well/better or healthy" could easily be misconstrued to mean "you're looking fat". Moreover, such a direct link between increased weight and healthiness overlooked the fact that many could still be grappling with the day-to-day struggles of anorexia. Elise, for example, was terrified to see people when she had reached her target weight as she found it much harder to explain to people that she still had anorexia. The way around such dilemmas of greeting and recovery, Tanya told me, was to avoid any comments of appearance or connections to weight at all and "say something like: 'it's good to see you smile or to hear you laugh'. That's better than

saying ‘you look so much better’, or ‘you look like you’ve put on weight’ or ‘there’s more of you’ ...”.

The first time I was eating with a group of in-patients on an eating disorder unit in Vancouver I lifted the lid off the hospital lunch tray and exclaimed with wide eyes that I could never eat that amount of food. All the young women in the dining room were on a weight gain program and eating considerably larger and more frequent amounts of food in order to attain what was deemed to be a minimum weight. There was no response to my comment and everybody, almost mechanically, went about the onerous task of having to eat lunch. Eating in this environment, under the watchful eye of a staff nurse, left me at a loss as to how to proceed. Food was not a focus of interaction, of sharing, or of communication. I decided to take the women’s interactions as a cue – Yvette sat down one end of the table with her head in a cross word puzzle, moving the book sideways as she slowly lifted the fork to her mouth. The noise of the radio in the small room allowed some to ‘tune out’ and provided an excuse not to talk. Brianna uncovered each dish on her tray to survey the amount of food, and then rearranged each plate so they would fit more neatly. It was a methodical stalling of time.

The conversation was stilted to start with, as a stranger at the table, who was researching people’s relationship to food, was not an everyday occurrence and made all of us, including me, slightly uncomfortable. The young women around the table were as unsure about me as I was about how to eat with and respond to them. Once everyone had finished their meal (which happened within a ‘prescribed’ time frame), they quickly took their trays back to the kitchen trolley in the hallway and went to the therapy room to lie on the floor for a nap before the long afternoon sessions. I went to the toilet in the same hallway and then remembered that this was ‘not ward protocol’, as there are certain behaviours (such as going to the toilet straight after a meal) that were viewed



with much suspicion by staff and in-patients. In some treatment programs it is explicitly stated that patients are not allowed to visit the toilet after any meal, and that they must sit in a communal room (television room) with others for a set time (usually one hour). This rule was simply to prevent people from purging the contents of their meals straight after eating.

In the community treatment house (*Vista*) described earlier the evening meals were prepared and eaten back at the community house - a four storey historic home located in the beachside suburbs of Vancouver. The philosophy behind the community house was to reintegrate people back into everyday living: teach them how to eat, cook, live, talk and shop in a communal environment. One night I refused the offer of dessert as we all sat around the large mahogany dining room table. It was 'a challenge' night where ice cream was on the menu – a 'scary' food with which the two women cooking had decided to take a risk. I was repeatedly asked if I wanted the ice cream, not realising that this was a communal act – that to tackle the scariness of ice cream, *all* had to eat it. My innocent refusal was a rebuttal to the practices of eating which people expected and took for granted in the house. Food in this context was stripped of its meanings as a choice/desire/preference and instead eaten as a compulsory act. My refusal was exercising a preference that was not available to them. I had to defend my position later when one of the young women quizzically asked me: "I hope you don't have an eating disorder". How I ate, and what I did and said when I ate (or chose not to) was very important to relationships in the field.<sup>9</sup>

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<sup>9</sup> There were also times when I ate communally with the staff of eating disorder units. One ward round would break between in-patient and out-patient meetings for a communal staff lunch and I always ensured I had an assortment of foods containing fats, as to skip lunch or take a salad might be viewed with suspicion.

## Solitary practices

The main reason why I couldn't share food with people was because eating for those with anorexia was a solitary act. People did not eat with their families or friends, they did not like to eat in public and they ate at very specific times and in specific places, often very late at night and in their bedrooms. Natalia had started to eat in her car on the way to work, a very public space but one that had a distinct sense of privacy:

What I've also found now is that I'll take food with me and eat while I'm in the car - like while I'm driving along then I'll take a quick bite of an apple because I figure that people who are driving concentrate on what they are doing - the road ahead - so they're not going to be watching what I'm doing, and they're not going to be watching whether I'm eating or not because they're going to be concentrating on driving, so actually I find that I do that a lot - a lot more than I was aware of.

The solitary nature of eating was unwittingly reproduced and reinforced by the goals of one treatment program in an eating disorder unit. Whilst visiting Amanda on a bed program (a six week treatment program in a single room where she was required to conserve energy and remain on her bed) I was asked by a staff member to leave the room whilst she ate her lunch. I hurried after the nurse to ask her why they did this, as the only times that I had ever been asked to leave a room in a hospital was when someone needed to do something that was deemed 'private', such as using a bedpan or having part of their body attended to (an open wound dressing or an invasive bodily procedure). The nurse explained that eating alone was a stipulation of the bed program for it allowed Amanda to concentrate on the task of eating with no competing distractions. This solitary and concealed nature of eating in many ways highlighted and reproduced practices that were otherwise seen as pathological and/or deviant.

Participants knew that their food practices were unusual and tried to hide them from others. When Grant was 'in an anorexic phase' he would eat only in his bedroom, and in a very particular way. At the house which he shared with his parents and sister he took me to his bedroom and showed me how he would sit to eat, kneeling on the floor

next to his bed and resting his upper body on it. He had taken the adage ‘get off your arse you lazy slob’ to its literal extreme, believing that sitting down would make him fat and lazy: “I used to basically walk around a lot ... I thought if I sat down I’d put on stacks, and stacks and stacks of weight”. As a result he never sat to eat and he slept on his side as he thought that any pressure on his bottom would make it fat. In a similar vein, Natalia would only ever stand to eat in her house because she believed that standing used more calories than sitting. For these participants, you are not only what you eat, but also how you eat.

Every time Grant ate he would watch the clock in his bedroom, making sure that the food sat in his mouth for exactly one minute. He had been taping a television program about dieting which suggested that you must take at least 20 seconds between mouthfuls of food to give your metabolism a chance to work on each mouthful. The slower you eat your food, Grant thought, the better chance your metabolism has of digesting it. So instead of 20 seconds between mouthfuls, he lengthened it to one minute.

Reflecting on these practices (which he no longer does), Grant accepted that others saw them as “quite bizarre behaviours” (as was recorded in his case notes), or as his family commented, as “stupid” and “weird”. Despite protestations from his family (including his sister who had also been diagnosed with anorexia) Grant continued with what he called “an insane logic ... I knew it was stupid at the time and I looked stupid standing up everywhere but I didn’t care. It wasn’t a problem for me ... the whole focus for me was to keep the weight off”. To avoid confrontation with his parents, who (somewhat ironically) wanted to “sit down and talk things over” with him, he retreated to the privacy of his bedroom.

## ETHNOGRAPHIC ANALOGY

Community mental health workers knew first-hand the angst that suggestions of shopping, or eating in public, would arouse. Melinda, who had years of experience working in an eating disorder unit, would often meet with out-patients in cafes in an attempt to ease their fears about choosing, ordering and eating a meal in a public space. She recounted what she termed an ‘unsuccessful’ lunchtime meeting that she’d recently had with one her ‘clients’ (who was also a participant of this project), an incident that epitomised the rapidly fluctuating barometer of food negotiations. Angela, who had not long discharged herself before completing a treatment program, shouted at Melinda when she suggested she try a milkshake instead of the diet drink that she had ordered. The shop owners and customers looked on in surprise, as Angela “flew off the handle” in the small cafe.

These battles with the actual mechanics or technologies of food are, however, not just about practical skills. Although Heidegger was mounting a critique of Husserl’s approach to phenomenology and his use of Cartesian metaphysics (the philosophical positioning of a subject explaining an external, objective world), he adds little to my concern with embodiment. Abstract concepts such as ready-to-hand, unready-to-hand and the understanding of Being are framed by cognition, and have, in Heidegger’s philosophy, no connection to the sensory world of embodiment. As outlined in Chapter One, my ethnography is concerned with a range of knowledges, and most particularly with ‘affective modes of knowing’ (cf. Kondo 1986), of knowing through the body.

Becoming pregnant whilst doing fieldwork gave my embodied presence an unplanned immediacy. I was at first more concerned than anyone about how my pregnancy and growing physical size would affect relationships with participants as several people had

already told me that they could trust me because of my ‘normal’ size.<sup>10</sup> Some didn’t want to touch those who were overweight, handle anything they had touched, or even walk in their shadow as they might be contaminated or transformed. I found, though, that rather than view my growing body as ‘fat’, participants made a clear distinction between being pregnant and being overweight. Several were pleased to see that as my pregnancy progressed I remained “compact, with a tight tummy”, and that my tight stomach was “not flabby like fat”. Some tentatively and excitedly asked if they could feel my stomach, and others found the swelling and movement to be too ‘alien’ a concept to embrace. In this range of responses it was I who became the focus, my body was observed, felt and surveyed with intense interest.

Being pregnant was a turning point in my fieldwork for it unwittingly helped to establish relationships between some participants and myself, and opened up new directions of exploration. Jackson has suggested the concept of analogy, through comparison, in answer to his own question: “how can one enter the world of another?”

Clearly, it cannot be achieved mimetically. Attempting to go native by decking oneself out in the costume of the other can only end in parody ... It can, I believe, be accomplished through analogy. Unlike imitation, analogy does not eclipse self in an attempt to become other. Its strategy is, by contrast, to have recourse to common images — such as the metaphors of paths and bridges — that are already part of the discursive repertoire of human relationships. Analogy does not, therefore, presume a merging of self and other but a comparison that begins with something already held in common. It is inspired by empathy rather than mimicry ... Ethnographic empathy ... is grounded in engagement. (Jackson 1998: 97)

Obviously, being pregnant was a totally different experience from having anorexia, but participants were quick to draw analogies about the rapid bodily transformations that

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<sup>10</sup> Female staff in one eating disorder unit discussed the importance of their size in terms of establishing and maintaining relationships with clients. A social worker recounted how she had been told by patients: “I feel I can trust you because you’re slim”. Participants similarly told me that they could not trust staff who were overweight. One young woman exclaimed with credulation: “how am I meant to trust Jenny [a dietitian] when she’s overweight herself. She obviously has her own issues with food”. (Cf. Katzman 1993).



both involved.<sup>11</sup> Natalia, for example, said to me one day: “I’m going to say something profound. While I need to put on 14 kg to gain a life you need to put on 14 kg to make a life”. Knowing that Natalia had had several emergency admissions to hospital with life threatening cardiac arrhythmias (heart disturbances) induced by lack of food and fluids made her analogy about moving towards death or life indeed quite profound.

The analogy between pregnancy and anorexia has been made explicitly by Soros, who, having experienced both states, reflects on their similarities and differences:

My stomach had swelled from the starvation, ballooning over my pants to resemble the tight belly of an expectant woman. As my mother tried to feed me, I rejected her, flailing like an infant, pulling my head wordlessly away from the spoon. Here lies madness: the harder I tried to carve history from my body, the more pregnant I became ... When I was pregnant, I was revisited by my past. Just as the anorexia performed pregnancy, the pregnancy performed anorexia: for weeks I was so nauseated I could hardly eat, hardly bring in the outside. (1998: 14-5)

For the few participants who had children, my being pregnant opened up discussion about their experiences, of how they dealt with morning sickness, the swollen ankles and “feeling fat”.<sup>12</sup> Danielle welcomed this commonality, and would spend hours reminiscing about her own pregnancy, all the while ensuring that I was warm enough, comfortable and drinking and eating. For most of her adult life she felt as if she didn’t belong, that she wasn’t really “a part of anything”. Being pregnant was when she felt “special - the only time” she said, “that I have felt that I am like other women was when I was pregnant ... I got pregnant and I had my baby and I was the same as everyone else. I did that and that is the only time that I’ve felt that I had a place in the world”. It

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<sup>11</sup> Hastrup (1995) makes a similar point: “While we cannot, obviously, experience the world from the perspective of others, we can still share their social experience. In fact, there is no social experience that is not shared ... ethnography is based in a social experience that is shared by the ethnographer and ‘her people’” (1995: 51).

<sup>12</sup> Grace knew from her own pregnancy that pregnant women can become constipated and as we stood in front of the dried fruits in the supermarket she gave me a recipe to allay constipation. “Soak the prunes in water overnight and the drink the fluid and eat the fruits”, she advised. It was a recipe that she used to overcome constipation when she wasn’t eating or drinking.

was through a connection of pregnancy, of sameness and difference, that Danielle and I based our engagement.<sup>13</sup>

Pregnancy and anorexia were also construed as times when women's bodies become "more public than normal", highly visible and the centre of attention. Strangers made uninvited comments about both bodies, felt compelled to pass on dietary advice, or point out the obviousness of weight loss or gain. Jemma vividly remembers being on holiday in Australia and young men screaming abuse at her from a passing car, telling her she was "a fuckin' anorexic":

No-one had ever called me anorexic before straight to my face. It was just like 'whoaa'. I was really upset and taken aback ... I pretty much ignored it. And on the streets here in Vancouver people come up to me and say 'do you eat?, why don't you eat?' and I just get stares and glares.

My pregnant body was also subject to a similar scrutiny from strangers. A man whom I had never met came up behind me at a party and placing his hands on my bare stomach, said to my friend: "so, who is your fat friend?" People who are underweight or pregnant draw attention in ways that someone who is equally as visible (disabled or overweight) does not experience.

I asked Natalia why it was that strangers could pass on their concerns about her body size. "Anorexia is close to death" she said, "it scares and intrigues people, we are walking skeletons ... death in our culture is scary, and people see us wanting to die and find that bizarre ... they either want to save us or slander us".<sup>14</sup> She similarly spoke of the ways in which pregnant bodies are at the opposite end of the scale, "radiant, in bloom" and about to give life. Both states of personhood are clearly marked by their

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<sup>13</sup> Abu-Lughod reflects on the ways in which different, but common experiences bring women together (1995: 347). "A tale of two pregnancies" is concerned with Abu-Lughod's own experience of being pregnant and the lives of the women with whom she spent her fieldwork time in the Western Desert of Egypt. Her ethnography of Bedouin women's pregnancies, births and children, as well as her own biomedical experiences, helped to shape her own constructions and experiences of her IVF assisted pregnancy.

<sup>14</sup> Hornbacher similarly captures the uncanny presence of death in her own experiences of anorexia: "Death is at your shoulder, death is your shadow, your scent, your waking and dreaming companion" (Hornbacher 1999: 125).

closeness to something — close to *the brink* of death and *near* to term — the beginning and ends of life. They both anticipate, they both move towards.

Through my pregnancy, new interactions and reciprocity were thus opened up to me: explorations of childbirth experiences, sexuality and giving through food and gifts for the unborn child and myself. Some felt the need to feed me, warming cups of hot chocolate to sustain my energy levels, and wrapping banana cake in grease proof paper for later in the day.

Being pregnant was also pivotal because it not only changed my relationships with people, it changed my relationship and sensations with my own body. Suddenly *I* had a new identity; I was pregnant and expected to do certain things (give up cigarettes and alcohol). Food no longer became a mundane, routinised experience. What I ate suddenly became important. I read books telling me what to eat, what to avoid eating, when to eat and how much to eat. The most remarkable thing, though, was a totally new experience of embodiment. I felt new experiences: waves of nausea when I thought of or smelt certain foods, the sensation of my stomach touching me legs when I bent over was strange, and my sense of smell was so heightened that the air was always heavy with the smell of spring flowering jasmine, car fumes and foods. Smell became a primary marker of place and introduced me to new sensations wherever I went. My whole sense of time and space was transformed through this new way of being.

Changing senses enabled participants and I to ‘play’ with and explore experiences.

When Grace (who is a trained cordon bleu chef) and I spent an hour in a suburban green grocers sniffing and praising every sweet and distinct smell of fruit and vegetables we drew worried looks from the staff. Grace was recovering from anorexia and her sense of smell and taste had returned, and we were both excitedly comparing our heightened senses. Other people also described changing senses. When Rita asked me what it felt



like to be pregnant and I described the sharpness of smell, she turned the conversation to her own changed sense of smell since having an eating disorder. The change was difficult to describe, she said, but she likened it to the smell of death — of desiccation — of having no fluids and drying up. She was very conscious of “this sickening and offensive smell”, wearing perfume to disguise it and distancing herself from any chance of physical contact.

These interexperiences — of the relation between my experience of participants and their experiences of me — were central to my understanding of anorexia. They not only allowed me to explore the observable mechanics of food and eating, but also the important realm of the unobservable, the corporeal and embodied sensations that people with anorexia experienced. This was not to set up two camps of the observer and the observed. Rather, as Jackson (1989) and Stoller (1997) point out, it was to focus on the interactions between the two:

Our understanding of others can only proceed from within our own experience, and this experience involves our personalities and histories as much as our field research. Accordingly our task is to find some common ground with others and explore differences from there. (Jackson 1989: 17)

In borrowing from William James, Jackson calls this path ‘radical empiricism’, a path that involves reciprocal activities of intersubjectivity and interexperience — “the ways in which selfhood emerges and is negotiated in a field of interpersonal relations, as a mode of being in the world” (Jackson 1998: 28).

The importance of this view for anthropology Jackson goes on to argue:

... is that it stresses the ethnographer’s *interactions* with those he or she lives with and studies, while urging us to clarify the ways in which our knowledge is grounded in our practical, personal, and participatory experience in the field as much as our detached observations. Unlike traditional empiricism, which draws a definite boundary between observer and observed, between method and object, radical empiricism denies the validity of such cuts and makes the *interplay* between these domains the focus of interest ... It is the *interaction* of observer and observed which is crucial. (Jackson 1989: 3)

In his ethnography of Songhay sorcery, Stoller (1997: 5) similarly argues that even the best studies – such as Evans Pritchard’s *Witchcraft, Oracles and Magic Among the Azande* (1976), or Levi Strauss’ *The Sorcerer and His Magic* (1957) — are incomplete because they share the same disembodied, objectivist epistemology. They lead us far away, he writes, “from the ideas, feelings and sensibilities co-constituted with the people that these great authors sought to understand”. What is often overlooked, Stoller argues, is “the sensuous body — its smells, tastes, textures and sensations” (1997: xv). Stoller’s ethnography is far from a disembodied gaze; he literally embodies the notion of ‘experience-in-the-field’.<sup>15</sup> He writes that comprehension of Songhay sorcery demands:

The presence, not the absence, of the ethnographer ... the full presence of the ethnographer’s body in the field also demands a fuller awareness of the smells, tastes, sounds and textures of life among the others. It demands ... that ethnographers open themselves to others and absorb their worlds. Such is the meaning of embodiment. For ethnographers embodiment is more than the realisation that our bodily experience gives rise to metaphorical meaning to our experience; it is rather the realisation that, like Songhay sorcerers, we too are consumed by the sensual world, that ethnographic things capture us through our bodies, that profound lessons are learned when sharp pains streak up our legs in the middle of the night. (Stoller 1997: 23)

I was not only entering relationships with people, but also questioning my embodied presence in the field. I could no longer ignore the way I shopped, how I selected items from a shelf, the feeling or sound of my stomach rumbling, or the taste of food on my tongue. My fieldwork experiences were thus as much about experiences with myself, as with participants.

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<sup>15</sup> In discussing her own embodied acculturation of Malay symbolism Laderman writes:

Anthropologists use their own bodies and minds [sic] as primary tools for the investigation of cultures. They participate as deeply as possible in the lives of those they study, at the same time maintaining sufficient distance to observe the workings of culture. They become insider-outsiders ... (Laderman 1994: 192). Jackson (1989) similarly suggests that using one’s own body in fieldwork yields knowledge that might be otherwise unavailable (Jackson 1989: 146-9).

This chapter has explored the complex layering of relationships that were continually negotiated in order to conduct this fieldwork. These were not simply between myself and those who had anorexia, between self and other, but included “sets of relations both *within* relationships and *between* persons” (Jackson 1996: 26). Participants similarly described changing relationships with themselves, with others and with the material objects of their everyday environments (spaces and foods). Their experiences of the everyday details of food, commensality and of embodiment were continually made, reshaped and dismantled. Moreover, conducting fieldwork in an area that was taken for granted by me (in terms of commensality and the embodied sentience of food) meant that I too had to examine and re-negotiate these sets of relations.

The differing priorities given to objective/subjective modes of knowing that were used by clinicians and health professionals to ‘claim’ ownership of anorexia, were not applicable to my engagement with participants. On the contrary, traditional separations of self/other, home/field, distant/close, familiar/unfamiliar were continually collapsed in this fieldwork, and shown to be entirely relational and variable. It was the spaces within and between these categories that enabled the interplay of intersubjectivity to take shape. This taking shape, as Jackson writes, should not be misconstrued “as a synonym for shared experience, empathic understanding of fellow feeling” (Jackson 1998: 4), but rather signals the “give and take of intersubjective life” (ibid). Relations that people have, as the following chapter reveals, are sites of constructive, destructive and reconstructive interaction.

## CHAPTER 3

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### RECONFIGURING RELATEDNESS

*... the body must be seen as a series of processes of becoming, rather than as a fixed state of being ...* (Grosz 1994: 12)

This chapter is concerned with the ways in which people with anorexia understood and experienced relatedness in their everyday lives, that is, how they continually transformed connections by truncating, creating, sustaining and abandoning them. As stated in the introduction to this thesis, my use of relatedness stems from recent approaches to kinship (Carsten 2000b; Edwards 1993, 2000) that have been critical of the traditional divide between biological and social understandings. Relatedness, as I use the term, is about the *intersection* of the social and biological, an intersection that, as Stafford suggests:

Refers to literally *any* kind of relation between persons — including those seemingly ‘given’ by biology and/or ‘produced’ via social interactions — and is thus obviously intended to encompass formal and informal relations of kinship and much else besides. The justification for using such a decidedly general term is ... that the boundaries between various categories of human social relations ... are often very malleable indeed. (2000: 37-8)

This malleability allows for what I consider to be a fundamental feature of relatedness to come to the fore, that is, its dynamic, divisive, processual, and at times, ambiguous, nature. The constantly changing nature of relatedness was akin to how people with anorexia understood and explained their experiences, most particularly through their shifting senses of belonging.

Chapter One outlined how differing and competing knowledges were positioned within the field of anorexia. With this positioning came a chain of claims, most notably that of where people with anorexia ‘belonged’ — to either psychiatric settings or alternative

care. Belonging in this frame was premised on what Edwards and Strathern (2000) refer to as a “contiguous association of meaning in English, from ownership, to belonging to association to link” (2000: 153). A diagnosis of anorexia nervosa given in a hospital, for example, set in motion a whole series of placements that designated one as a patient who belonged to psychiatric care and a psychiatric ward, and once entered into hospital records belonged to what staff termed “the psychiatric community” of people with eating disorders. In different treatment settings (not just psychiatric) people with anorexia were commonly referred to as “my girls” by health practitioners, denoting a taken-for-granted association of ownership, belonging and gender.

Although the ways in which people came to be represented as anorexic is important, it is not the central focus of this chapter. This chapter looks beyond the discursive naming of anorexia to examine its effects: in particular how desire and everyday practices of concealing and revealing became central to relatedness. My aim is not to show how classificatory systems of psychiatry were applied, but rather to show how participants strategically used them for their own means. As one might expect, participants described very different experiences of belonging and identity to those described in the paragraph above. These experiences were not fixed by the identity of anorexia; they were constantly moving, and always dependent on people’s changing positions in the field. This chapter is thus concerned with how people with anorexia performed belonging – both through bodily practice and spoken language – to and away from a psychiatric diagnosis.

The first section of this chapter outlines the ways in which I intend to use belonging. Building on established critiques of anthropological concepts of belonging and identity, I argue that there are a number of problems with an inclusive approach to belonging. Like the concept of ‘home’, ‘belonging’ is a term that is replete with sentimentalist

overtones, similar to what Edwards and Strathern refer to as the “romantic view of connections as benign and community as harmonious” (2000: 152). It is assumed that the desire to belong to a collective — be it family, community or place — is a universal motivation. I argue that an exclusive focus on inclusion (which undoubtedly does carry a great force) works to the detriment of exclusion, or rather, the inherent tension of exclusion in belonging. Edwards and Strathern remind us that belonging *includes* exclusion, not in the sense of owning or being disowned, but in operating to cut networks and truncate chains of relations (ibid: 164). Belonging is about the creation of non-relatedness as much as it is about relatedness.

The ethnography presented in this chapter clearly points to the dialectical relationship between belonging and exclusion, of how one can have a diagnosis of anorexia but simultaneously be an “outside anorexic”. In discussing these dynamics of relatedness I have drawn from the work of Probyn (1996), de Certeau (1984) and Desjarlais (1992, 1996a, 1996b), bringing their analyses together to reveal the strategic plays of anorexia, and highlight the positive and negative value on transformations, displacements, disconnections and ruptures that people deployed.

The second part of the chapter deals with these multiple values of belonging through a discussion of what was referred to as the “secret world of anorexia”. Secrecy operated on a number of levels and extended beyond the simple spatial dichotomies of insider/outsider, to the more nuanced processes and performances of concealing and revealing. Secrecy was concealed and revealed in very particular ways. Some participants concealed weight loss practices from all others, reluctant to reveal the intimate relationship that they had with “their friend”. For many, anorexia was embodied not as illness, but personified as a friend (and an enemy) that offered support,

companionship and advice. It made them feel ‘not alone’ when they were in fact quite alone.

In treatment settings, however, secrets were often revealed to other in-patients as a way of extending knowledge, creating networks and hiding practices from staff. These were the social spaces where individual secrecy was transformed into a collective dynamic, through the exchange of secret knowledges and practices, and the formation of allegiances and hierarchies. Although these points of connection had the potential to offer positive support in terms of motivation towards recovery, the revealing of secrets in close-knit therapeutic groups still operated on the basic premises of secrecy — of confidentiality and trust. Anorexia, I argue, offered new forms of relatedness based on both the concealing and revealing of secrecy, where the associations of sickness were transformed into a productive state of being and belonging.

## **OUTSIDE ANOREXIA**

In comparing experiences with other anthropologists, it seems that some of the most pivotal understandings of the complexity of social life come from unexpected or completely unanticipated moments in the field.<sup>1</sup> An offhand comment, for example, or a joke amongst a group of in-patients could sometimes throw just enough light in my direction to illuminate connections that I had not noticed or had assumed to be idiosyncratic or unrelated. One such pivotal moment was when Estelle was describing her ‘recovery phase’. The most abiding memory she had of this eight week period in a large public hospital was one of feeling like an “outside anorexic”. I was immediately intrigued by this phrase as my understanding up to this point was that one either had a

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<sup>1</sup> Gell, in *Reflections on a cut finger* (1996) comments how a small incident in which he cut his finger and put it to his mouth drew expressions of disgust and shocked countenances from the Umeda of the West Sepik District. He discovered that he was breaking a central food taboo, a breach par excellence that led him to examine the nature of taboo and its role in the definition of self, and in the articulation of the self into a social world (1996: 115-6). See also Stoller’s account of being ‘served bad sauce’ and the importance of that for his fieldwork (Stoller 1989: 32-4).

diagnosis of anorexia or did not — how could you, whilst being treated for anorexia, be “an outside anorexic?”

Estelle explained that she felt like this because she had complied with the treatment program: “I was there eating all my meals and stuff and like trying to be really good and the nurses were coming in my room and searching for food because they wouldn’t believe me — they thought there was something up”. Because of her compliance she was also challenged by other in-patients with anorexia — “you’re not really an anorexic” they taunted. “That”, she said, “for some reason offended me because I was like ‘well what the fuck am I then?’ — if I’m not a real anorexic and not a real, normal person — what am I? — why should I be a real anorexic anyway?”

Before examining the complexities of Estelle’s statement I firstly want to turn to the analytical concept of belonging, for it is not an unproblematic term. When writing about belonging, Anthony Cohen’s work is often cited as it provides a comprehensive analysis from which to spring (see Gray 1999). His substantial body of work around this topic (1982, 1985, 1987, 2000a) has made important inroads into the anthropological ‘writing’ of belonging, identity and community, providing both ethnographic and analytical examples of this genre. For example, in his ethnography of the island community of Whalsay in Scotland, Cohen defines belonging as:

... very much more than merely having been born in a place. It suggests that one is an integral piece of the marvellously complicated fabric which constitutes the community; that one is a recipient of its proudly distinctive and consciously preserved culture — a repository of its traditions and values, a performer of its hallowed skills, an expert in its idioms and idiosyncrasies. (Cohen 1982: 21)

By focusing on particular kinship groups and neighbourhoods, Cohen is describing the structures of social organization that engender a sense of belonging in the people of Whalsay and distinguish them from the ‘world outside’.



Yet it is not only the structures of social organization that inform a sense of belonging. Cohen furthers his argument by examining the ‘substance of belonging’, which he describes as:

The nebulous threads running through the life of a culture that are felt, experienced, understood, but almost never explicitly expressed. They provide a subterranean level of meaning which is not readily accessible to the cultural outsider. They are the substance of belonging, and they belie the apparent familiarity to outsiders of the culture’s structural forms. They are ‘what it means to members to belong’ and therefore, for the anthropologist they are the only terms in which belonging can be properly understood. They are what bind members to their cultures so closely that they take from it the means by which to make their world known to themselves, and to make themselves known to the world. (ibid: 11-2)

What Cohen is highlighting is the different layers of belonging: the pragmatic, observable structures of social organization and the experienced, intersubjective modes of belonging that happen within and outside these structures. Both reveal the ways in which relationships are formed between members of groups to produce distinctive identities and boundaries.

There are limitations, however, to Cohen’s early formulations. The complexities of belonging are somewhat reduced to structuralist polemics through his analysis as belonging is characterised as an experience marked by outsiders and insiders, familiarity and unfamiliarity. Belonging thus works to fix identity by ‘binding’ people into a ‘repository’ of a ‘preserved culture’. It is contained within a given (and unproblematized) single geographical space. Moreover, as indicated in the introduction to this chapter, there is a one-sided focus on harmonious embracement and inclusion, of the ‘binding’ and ‘familiar’ bonds of community.

These problems I have with Cohen’s early work are part and parcel of the extensive critique that has developed around the concept of ‘identity’. Along with many other essentialist concepts, ‘identity’ has been subject to a ‘decentering’ theoretical approach that has attacked its fixed, unified and integral assumptions. Critiques have been far

and wide — most successfully from feminist, postmodern and postcolonial authors (see for example, Butler 1993; Bhabha 1996; Hall & du Gay 1996). Although I agree with these critiques, the outcome of this post structuralist challenge brings forward two problems. Firstly, in deconstructing essentialist ‘truths’, the language used to replace these canons has the potential to recreate exactly the same problematisation it set out to critique.<sup>2</sup> Furthermore, as Murray (2001), Scott (1999) and Alexander and Mohanty (1997) suggest, in erasing theoretical concepts such as race or identity one also runs the risk of erasing those very real effects in people’s everyday lives. “If”, for example, “we dissolve the category of race ... it becomes difficult to claim the experience of racism and the constructions of self and identity occurring in a particular place or moment” (Alexander & Mohanty 1997: xviii).

Rather than ‘throw the baby out with the bath water’, I think it is more useful to re-examine concepts such as identity and belonging in light of the critique — not to erase them, but to engage with them and rethink their decentering ‘ethnographically’. This has already happened as evidenced by the numerous works that deal with national and ethnic identities (Gupta & Ferguson 1997; Chakrabarty 2000). These works accept that:

Identities are never unified and ... increasingly fragmented and fractured; never singular but multiply constructed across different, often intersecting and antagonistic discourses, practices and positions. They are subject to radical historicization, and are constantly in the process of change and transformation. (Hall 1996: 4)

In keeping with these critiques of identity, Cohen himself has re-examined and re-informed the ways in which concepts of identification are used within anthropology. His most recent edited work *Signifying Identities* (2000a), raises questions about the “transient and ephemeral” (2000b: 3) nature of identity, the “elusive and nebulous”

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<sup>2</sup> In reformulating the concept of identity through the concept of identification, Hall (1996) notes that “identification turns out to be one of the least well-understood concepts – almost as tricky, though preferable to, ‘identity’ itself: and certainly no guarantee against the conceptual difficulties which have beset the latter” (Hall 1996: 2).

(ibid: 5) concept of boundary and the “contested and contestable” (ibid) notion of authenticity.

However, a central problem remains. I return to my earlier ethnographic question — how is it that Estelle was considered to have anorexia yet be outside anorexia? Estelle was *simultaneously placed* and identified (by psychiatry) and *displaced* and re-identified (by other patients). She embodied this ambiguous tension. Probyn suggests that one way to explore the coexistence of different forms of social relations and modes of belonging is by focusing on ‘the outside’. This, she argues, is “a more adequate figure for thinking about social relations and the social than either an interior/exterior or a center marginal model” (Probyn 1996: 11).

Being an ‘outside anorexic’ is an evocative term, and one that has direct relevance to the overarching themes of this thesis. Probyn poses the term ‘outside belonging’ in her book of the same name, arguing that it is a theoretical concept created within the much broader theoretical critique of Cartesian metaphysics that I described above. In looking *through* identity, Probyn aims to “speak of something more than the term *identity* can catch” (ibid: 5, emphasis in original). She is interested in the spaces of experience prior to, around and inbetween identity, the ways in which people come to belong or not belong, or as she simply states – “how individuals make sense of their lives” (ibid). Making sense, Probyn argues, “inspires a mode of thinking about how people get along, how various forms of belonging are articulated, how individuals conjugate difference into manners of being, and how desires to become are played out in everyday circumstances” (ibid).

Although in proposing the term ‘outside belonging’ Probyn runs the risk of having her language immediately conflated with the taken-for-granted concepts of outside, it

should not be confused with dichotomous thinking.<sup>3</sup> Her notion of outside attempts to “emphasise the ways in which belonging is situated as threshold ... It designates a profoundly affective manner of being, always performed with the experience of being within and inbetween sets of social relations” (1996: 12-3). Thinking about belonging entails, then, thinking about relations of proximity and movement. One wishes to belong or not belong — one moves away from something in order to cease to belong. It is a constant process of becoming and unbecoming.

Participants did not say to me ‘I am anorexic’ — rather their identity was articulated through shifting notions of belonging. Although they were diagnosed as belonging to this specific disorder, their sense of belonging was often inbetween — wanting to have the distinction that anorexia gave them, but not wanting to be anorexic (in fact actively denying it). Relatedness for people with anorexia oscillated between these dynamics, and as the following section describes, was concerned with reconfiguring taken-for-granted ways of relating.

### **Being outside — being ‘out of place’**

Exploring people’s identification with anorexia takes a very different approach from the psychiatric sense of belonging, as participants chartered courses that moved from being out of place, finding a place of identity in anorexia, fighting to keep it, moving towards death, moving away again and then the difficult task of trying to reintegrate and ‘belong’ to a way of life that they had been removed from, often for many years. It was not a simple polarisation of belonging or not — people were always mapping out the

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<sup>3</sup> In expanding her notion of ‘outside’ Probyn also draws on Foucault’s concept of heterotopia, for it, ... provides an analytic space in which to consider forms of belonging outside the divisiveness of categorising ... “Heterotopia juxtaposes in one real place several different spaces, ‘several sites that are in themselves incompatible’ or foreign to one another” (Foucault, cited in Soja 1995: 15). As Edward Soja puts it, these are “places where many spaces converge and become entangled” (Soja 1995: 15). (Probyn 1996: 10-11)

As both inside and outside, heterotopic spaces are inextricably double, and foreground the changing configurations of social relations. In this formulation, hospital spaces were sites of heterotopia, where the possibilities of being anorexic and not being anorexic were played out.

complexities of belonging that continually changed, and at times appeared contradictory.

For the purposes of ‘writing belonging’, I start with what I term a ‘biography of belonging’ — a narrative that people used to explain how they came to move towards anorexia. Biography is an apt term for these narratives, for they were unfoldings of social relations (Ingold 1991) that were constructed from past memories and events in order to explain a presence.<sup>4</sup> People described feeling displaced — in childhood, from families, from origins, and out of place in their own bodies or not belonging to their ascribed gender. In Heidegger’s terms they were not at home.

In talking about belonging, participants would sometimes map out a biography to signal pivotal moments in their lives when anorexia was thought to have begun. Some may argue that the ways in which history and origins were invoked in these self-narrativisations is precisely what I am trying to avoid – a fixed and unchanging identity located in specific historical moments. Rather than read these narratives as a return to one’s roots, I see it as Gilroy (1994) does – a ‘coming-to-terms with our routes’. Routes and roots, as Friedman states, “imply travel, physical and psychical displacements in space .... the crossing of borders and contact with difference” (Friedman 1998: 151). This conceptualisation of narratives as embodiment of spatial practices or routes (which draws upon de Certeau 1984 and Clifford 1997) is more akin to my general theme of movement and process.

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<sup>4</sup> I recognise that this ‘mapping’ could be an effect of psychiatric or therapeutic intervention, where patients are encouraged to ‘tell their stories’ and rationalise them. Fiona Place, in her autobiographical story *Cardboard Lives* (1986), suggests:

Life, for people who have been using anorexic eyes/metaphors long term, has often become only the description of the symptoms of their illness, and possibly of numerous admissions and discharges over the years or experiences of other methods of treatment. They so often reach the stage whereby they give their life history as a psychiatric history, using solely the associated jargon and therefore experiencing it as such. (Place 1989: 257)

Maria, for example, recounted that she would never sit down and eat her lunch with the other children at primary school — the beginnings, she said, of the development of anorexia. It was often the telling of memories, such as feeding problems as a baby, or feeling completely out of place at a family wedding ceremony, that highlighted the ways in which “the processes of belonging [can be] tainted with deep insecurities about the possibility of truly fitting in, of even getting in” (Probyn 1996: 40).

Belonging is thus hinged on not belonging, on not fitting in, on being different, on being excluded. Writers including Derrida (1981), Laclau (1990) and Butler (1993) have already shown that identities are constructed through, not outside, difference. They argue that the ‘positive’ meaning of any term such as identity can only be constructed because of its very capacity to exclude, leave out, to render elements to be ‘outside’ and abject (Hall 1996: 5). This entails the recognition that identities are the “byproduct of interrelationships” (Jackson 1996: 27); relational and continually under construction.

Exclusion and difference were recurrent themes of participants’ narratives. A number talked at length about their feelings of abandonment and alienation from families, a sense that was experienced from a very early age. Now aged forty, Bettina’s abiding memory of her childhood is one filled with constant exasperations from her mother — “how did we ever get you?... where did you come from? ... you don’t look like any of us — you are so different”. She paints a picture of her childhood as one in which she felt like an ‘outsider’:

I was forever told that I didn’t belong and that I don’t look like any member of the family - I’m totally different, totally, totally different ... I knew I was abnormal. I knew that I didn’t belong to other groups of people and I used to think that I was alien. I used to think that I was born somewhere out there (she motions with her hand up to the sky).

Bettina knew she was different from other people because she constantly “worried about things”. Everything in her environment had “to be perfect” — in line and in

order. This included her body, and the only way in which she could become perfect was to eat perfect food and remove every blemish from her body.<sup>5</sup> Her image of perfect was petite, white, clean, smooth and without defect – like the porcelain faces of her doll collection.

Exclusion and a sense of not belonging to family networks were, however, not always framed in negative terms. In their critique of the concept of belonging, Edwards and Strathern (2000) suggest that the positive associations of such a term, (of the desire to belong and to connect), are taken for granted by much of the Euro-American commentary of an academic kind. Connections, they suggest, appear as:

... intrinsically desirable. People take pleasure in making links of logic or narrative, as people take pleasure in claiming personal links. Linkages may also appear exciting, especially when they cross apparent boundaries. (2000: 153)

People with anorexia confounded such an embracing effect and often took pleasure in being outside of taken-for-granted connections. Maddy illustrated the point to me by jumping up off the couch in her lounge room and returning with a photograph of herself and a group of friends going to a high school formal. She proudly pointed out how she and her partner were visibly different by their unusual choice of clothes, and how many of her friends (including her partner) were gay and/or bisexual: “see — we are all people who really didn’t fit in”. The theme of sexuality was particularly significant for Maddy, as over the fieldwork period she confided in me her growing awareness of, and experimentation with, her sexual desires for women.<sup>6</sup>

Others felt so out of place that they believed, and *wanted* to believe, that they were adopted into their families. When I first met Tracey she talked about the tension she

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<sup>5</sup> Bettina said that over the years she had spent “thousands of dollars” on skin care products, treatments and minor cosmetic surgery in her quest to achieve this perfection.

<sup>6</sup> Interestingly, Maddy’s own productive desire for other women came after she had ‘recovered’ from anorexia. Prior to this she spent a number of years confused and angry at her partner’s sexual liaisons with men, all the while continuing a sexual relationship with her. His behaviour led her to question her own desirability, wondering whether he had simply been attracted to her because, as she recounted: “I’m a bit of a Tom boy and I don’t have a curvy figure or big breasts”.

felt as a very young child between her own sense of creative identity and that imposed upon her by her family. As a child she remembered having a strong will and artistic imagination; virtues that were seen as “disobedient” and “wayward” in her strict Lutheran family. Her parents asserted their authority, she said, silenced her opinions and dampened her artistic flair. As a result she grew to feel alienated from her family and was deeply disappointed to discover that she wasn’t adopted. This, she said, would explain her displacement and sense of other identity — “I wanted to be adopted because then I had permission to be different, right. I had permission to feel I didn’t belong. I didn’t belong”.<sup>7</sup>

When I sat with Natalia on her lounge room floor mapping her genealogy I coloured in the circle identifying her with my black pen. She asked if I was marking her as the ‘black sheep’ of the family. I explained that I wasn’t, but she followed with a long discussion as to the symbolism of being “the odd one out”.

I don’t really fit into that family ... I used to ask my parents a lot if I was adopted ... I can’t possibly have been born to these people because I don’t match any of this at all ... I just asked them all the time (she laughed) - ‘are you sure I’m not adopted?’ - because I could handle it if I was - you wouldn’t have to be afraid to tell me I was’.

Natalia, Tracey, Maddy and Bettina (and others) were highlighting the fundamental lack of relatedness they felt with their families and friends. Their metaphors of disconnection — of adoption, alienation and sexual difference — all drew on and truncated the powerful and taken-for-granted concepts of biological and social relatedness. Their disassociation was not framed as a negative, but as a matter of distinction and positive difference.

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<sup>7</sup> Holden (1991) has noted the higher than average rates of adoption amongst patients admitted for eating disorders to the Maudsley psychiatric hospital in London than in the general population.



For most participants though, not feeling at home in one's own body was an unwelcome and powerful source of displacement and is discussed in length in Chapter Five.<sup>8</sup> Every person with a diagnosis of anorexia had at one time or another encountered their own body as repugnant, some even loathing it to the point of fantasising about cutting layers of flesh from their limbs.<sup>9</sup> I use the word 'encountered' because people often spoke about themselves in the second or third person as "you" – "your body" they said, "was the enemy, it worked against you" and was subsequently objectified through the language of distance. Although there was a variety of embodied and dis-embodied experiences of one's body, female bodies were overwhelmingly seen as inherently dirty – and as a consequence were, in Douglas' terms, bodies 'out of place'. Menstrual blood was particularly defiling and polluting and, as I discuss in Chapter Five, anorexia had a fundamental role to play in the erasure and purification of a polluted body. I was amazed at the number of women who talked of periods in sheer horror – they winced as they described how they felt when they bled, as if having periods was a cruel joke or torture that they had to endure. Menstrual blood signalled not only their associated disgust with a sticky and messy fluid, but more importantly, it signalled an axis of relatedness (of being desired rather than desiring, danger, the capacity to have children, child rearing, sexual relationships, cooking, nurturing, hygiene) that operates through women. It was this axis of relatedness that did not sit comfortably with many participants.

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<sup>8</sup> Alienation is undeniably disempowering, as Peters (1987) writes:

Most A.N's [anorexics] claim feeling powerless ... This can be linked to feeling alienated from the body. Berger and Luckman (1966) explain that most humans hover in the balance between being and having a body. All my informants claimed they felt marginal, alienated and powerless. They associated this to their experience of their bodies. This feeling of alienation extends beyond the family; its locus is cultural and it affects all women in varying degrees.

While participants in my research also recounted similar feelings of displacement, they also spoke at length about the incredible power that alienation from their bodies gave them. Exclusion and alienation can create different forms of power.

<sup>9</sup> Several participants displayed a hatred for their own flesh by cutting or burning their skin (as detailed in Chapter Six), thereby allowing the emotive properties contained in blood to drain away.

Being out of place in terms of sexuality was characterised by transformation – either to become child-like and asexual, or masculine. Several women talked about being “tomboys” and “anti-girl”, despising the expectations of friends and family that they enjoy shopping, cooking or learning how to apply make up. Amanda, who made a point of saying that her parents “hoped she would be a boy”, excelled in her employment as an overseer in the male dominated building industry. This fulfilled her childhood dream to be “more of a boy instead of a girl ... I’ve always been a bit blokey anyway — my friends say ‘you’re one of the guys’”.<sup>10</sup> The three men involved in this project were also ‘out of place’ with stereotypical gender roles – two were gay and the third, Robert, ‘feared’ that he was. Robert said that rather than deal with being gay he made himself “skinny and ugly” so that he wouldn’t be attractive and therefore wouldn’t have to deal with his sexuality.<sup>11</sup>

What is central to all these narratives is a profound discomfort with relatedness; with those relationships “seemingly given by biology and/or produced by social interaction” (Stafford 2000: 37). Participants were pointing to experiences and places where relatedness (and its assumptions) were central yet problematic: to families (feeling adopted, alienated), to commensality (sharing food, being nurtured with food as a child), to social rites of passage that connected and transformed people (school formals), to heterosexual and homosexual relationships, and to a sense of relating to their own bodies. These concerns encompassed the wide net that is relatedness, and crossed a continuum from the most formal kind of relations (relations of kin) to the least formal (sharing food in a playground). Neither was valued over the other, and at

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<sup>10</sup> Other authors have also commented on the desire of those with anorexia to become androgynous or male-like (cf. Malson 1998: 114). Bruch, cited in Bordo, reports “that many anorexics, when children, dreamt and fantasised about growing up to be boys” (Bordo 1988: 102). Bordo similarly notes another woman who commented: “If only [I] could stay thin ... I would never have to deal with having a woman’s body; like Peter Pan I could stay a child forever”. The choice of Peter Pan, Bordo suggests, is telling: “what she means is, stay a *boy* forever” (Bordo 1988: 102).

<sup>11</sup> It is interesting, and I have Margie Ripper to thank for pointing this out to me, that Robert does not think of sexuality as *his* desire, but as being desired (or not), i.e. unattractive to others.

times it was the informal ties of relatedness that were highlighted as the most significant. The effect of all these experiences was that they had the capacity to generate new meanings and experiences of being related, and it is these new forms of relatedness (through desire and secrecy) that are explored in the remainder of this chapter.

### **Desiring to become ‘anorexic’**

Diagnosis with an illness or disorder often encourages ‘sufferers’ and relatives to form support groups and connections they might otherwise not have made. Illness can be a powerful connection of social support. In the so-called ‘HIV/AIDS community’ there is a strong sense of belonging that is not predicated on a discrete spatial location — it is an identity that has its own powerful sense of connection and relationships through a shared identity. And although that shared identity might be predicated on a medical diagnosis, there are a bevy of practices and bodily markers that signal belonging to the group. For example, the T cell count is used by people with HIV to mark significant events in the course of the illness — a low count can indicate decline in immune status, and the opportunity for the appearance of later stages of the disease process such as Kaposi’s sarcoma (a purple skin lesion) or pneumocystis carinii pneumonia (PCP) (Graham 1997: 61). The comparison of T cell counts between HIV positive people can be part of the process whereby they “come to a communal understanding of their illness ... the count thereby accrue[s] a socially shared set of meanings” (ibid: 61). Similarly, beyond the obvious markers of weight loss in anorexia there are the ‘invisible’ indicators of metabolic imbalances and cessation of bodily processes (such as menstruation), results and effects that are compared between people to reveal the seriousness of disorder.

There is however, a fundamental difference between the ‘HIV/Aids community’ and people with anorexia — a puzzling desire to belong. One would only join a HIV/AIDS support group after a confirmed diagnosis — no one would actively seek this potentially life threatening condition in order to belong and have an identity. People with anorexia, though, often talked of the initial seduction towards anorexia, and their ensuing desire to be a ‘better’ anorexic. There were some who were called “anorexic wannabes” — these were the people who wanted to be anorexic, and actively pursued what they called “the coveted title”.<sup>12</sup> No other illness or disorder carries such attraction.

This sense of belonging was dependent on context. For instance, being in a ward with a group of other people with anorexia engendered a different sense of belonging to, say, a group of women with eating disorders conversing in a chat room on the net — a virtual sense of belonging. Place was of fundamental importance to belonging. If one is exploring the social relations that express attachment between people you cannot ignore or treat as passive (as Cohen has done) the settings in which these attachments occur (cf. Gray 1999: 441-2). Geographers and anthropologists have recently pointed to the importance of ‘sense of place’: of how spaces are created, imagined, remembered, lived in, and invested with meaning (Feld & Basso 1996; Hirsch & O’Hanlon 1995). It is these attachments, struggles, and embodiment of spaces that interweave to create differing senses of placement and belonging.

It was when people came together, often in treatment settings or support groups, that the sense of belonging was most evident.<sup>13</sup> As described in the introduction of this

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<sup>12</sup> The desire to have anorexia is replicated in a wider everyday context. When some people (mainly women) learnt that my research was concerned with anorexia they would joke or “wish” to have anorexia for a week in order to lose weight. Similarly, the book *Good girls do swallow* (Oakes-Ash 2000) has a chapter entitled ‘so you want to be anorexic – join the queue’.

<sup>13</sup> Hornbacher (1999: 106) also describes the connections that occurred in treatment settings: “at first there is a religious fervour, a cultist sort of behaviour, a pact. I made a pact with a tall, thin girl who offered to help me lose weight”. A psychiatrist at a ward round I attended commented on ‘the pact’

thesis, one of my fieldwork sites was a live-in community treatment setting. Here the eight young women had already had significant contact with a variety of psychiatric services and were well versed with the medical criteria for anorexia as defined in the *DSM-IV* (APA 1994). This inventory emphasises physiological and psychological aspects of anorexia, such as reduced body weight, lack of menstruation and distorted body image. But none of the residents relied on this inventory when describing anorexia (in fact no-one did during my fieldwork). Rather they outlined a specific sense of relatedness — of belonging to an identity that encompassed its own particularities of secrecy, allegiance, hierarchy, distinction, language and practices. These dimensions, as Edwards and Strathern (2000) suggest, go beyond the traditional notions of relatedness as *either* biological or social and examines connections that are made, in this case, through the shared predicament and desires of those with anorexia.

Within this residential setting some people were trying desperately to belong, to become the best anorexic, to walk into a room, sweep it with their eyes and know immediately that they were the thinnest in that room. Others were trying desperately to not belong — to recover, and leave and have no contact with any person with an eating disorder ever again. Many, though, were caught in a space of ‘outside belonging’ where they were trying to do both, to rid themselves of what they described as the “hell of anorexia” — the shame, the guilt and the depression — but were not willing to give up what it afforded them. Staff repeatedly joked about the number of times they had heard this inherent contradiction from patients: “they want to get rid of anorexia but they don’t want to put on any weight”. The people with anorexia put it another way — “I want to get rid of anorexia but I don’t know who I’d be”. They were fearful about leaving the belonging — the identity, the power, the security and the relationships, that the umbrella of anorexia provided.

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that had developed between a young woman and her male friend prior to her hospitalisation. This relationship he reported, revolved around shared cooking, bingeing and purging.

The safety that anorexia gave people often meant that it was difficult to seek treatment, as this narrative therapist outlines:

Anorexic individuals rarely seek treatment voluntarily. Even if they do show up in our offices of their own accord, they are virtually never asking for assistance in gaining weight, but rather for help in coping with side effects or other issues they do recognise as problematic ... Anorexic individuals may deny that they are ill, deny that they are thin, deny that they want to be thin, and deny that they are afraid of gaining weight. They may also refuse to acknowledge that they are distressed, that they are fatigued, or that they are engaging in specific behaviours such as dietary rituals, vomiting, or laxative abuse. (Bemis-Vitousek 1997: 4)

It may have been clear to the clinician (through visible thinness) that the patient had anorexia, but, as many participants told me, they initially denied any sickness, some spending whole sessions in silence, refusing to talk. What participants were playing with I argue, is agency, a set of actions that shifted according to where they were and who they were with. Agency, as Desjarlais notes in his ethnography of language and agency in a shelter for ‘the homeless and mentally ill’, “emerges out of a context and a set of practicalities; it is not ontologically prior to them” (1996b: 894). The shelter residents he spent time with “had to act in terms of negation and opportunism. This orientation prompted a form of performative agency characterised by reactivity, indirection, deviation, contradiction, spontaneity and impermanence” (ibid: 893). This was a political tactic, a strategy “in which people acted in certain ways in order to achieve or gain something” (ibid).

This strategy, or what Battaglia refers to as “agency play” (1997: 507), was similarly happening in my fieldwork. Jackson (1998), whose concept of play is strikingly similar to Bourdieu’s notion of strategy and struggle in the field, further explores this notion of play, suggesting:

The existential imperative to exercise choice and control over one’s life is grounded in play. If life is conceived as a game, then it slips and slides between a slavish adherence to the rules and a desire to play fast and loose with them. Play enables us to renegotiate the given, experiment with alternatives, imagine how things might be otherwise, and so resolve obliquely and artificially that

which cannot be resolved directly in the ‘real’ world. What we call freedom is founded in our ability to gainsay and invent, to countermand in our actions and imagination the situations that appear to circumscribe, rule and define us. (Jackson 1998: 28-9)

What these three authors are all drawn to are the key concepts of play, agency, strategy and struggle. It is through these concepts that people as agents (not actors) continually negotiate their daily lives.

One of the main ways in which participants ‘renegotiated the given’, was through a reformulation of desire. As already mentioned, anorexia was certainly viewed as a ‘desirable’ positioning by many of the people who had the diagnosis. It was a goal they often strove towards. A number who knew that they were being admitted to a psychiatric unit for assessment tried desperately to lose as much weight as they could before admission so they wouldn’t be laughed off as a fraud or a joke. One woman told the staff that she couldn’t be admitted for three weeks because of work commitments while admitting to me that she really wanted the time to reduce her weight to 35 kilograms and so be justifiably treated as ‘an anorexic’. Another who usually planned to lose weight before going to hospital explained that this practice was “a bit like cleaning your house before the cleaner comes”. People wanted to clearly show by their bodies that they deserved to be called ‘anorexic’.

The desire to be the best anorexic was exemplified by Amanda, a thirty year old woman who had lived with anorexia, depression and self abuse since her teenage years.

Despite multiple admissions to private and public hospitals over the last 16 years, Amanda told me of her continuing desire to be a “better anorexic”. From her hospital bed — a place where she was supposedly recovering — she compared herself with two of the most widely publicised women with anorexia:

I wanted to be noticed. I wanted to be different. And I still want to be different and that’s one of the reasons I don’t want to put on the weight because I don’t want to look normal, I don’t want to look like everyone else ... You’re always trying to be the best anorexic so you always try to out compete anyone that you know and meet. I guess you read about those twins in England and you think

wow, they were really good at this, I wish I could be as good as them - I wanted to be as strong as them and as good as them ... they looked disgusting but it was like 'why do I even think I'm sick? It's a joke to think I'm sick because I'm just so much healthier than everyone else - look at them - they're so thin' and it's like I'm just not even sick because I'm not as thin as them and until I can be thinner or sicker than other people I can't prove it to myself. I still don't think that I've been sick enough and that's the problem.

Amanda was referring to the identical twins Samantha and Michaela Kendall from Birmingham in England, whose 'battle' with anorexia was highly publicised in the media throughout the 90s. Graphic pictures appeared regularly in popular Australian women's magazines (*New Idea* July 2nd and November 19<sup>th</sup> 1994; *Woman's Day* March 25<sup>th</sup> 1996 and May 26<sup>th</sup> 1997, to name a few), and interviews were recorded when the women were at extremely low weights (on American daytime chat shows such as *The Oprah Winfrey Show*). Michaela died in 1994 and Samantha the following year.

To be seriously ill was not a deterrent. On the contrary, serious medical conditions related to complications of low weight simply gave more credibility to the distinction of anorexia; of playing on that fine line between life and death. To gain access to anorexia Sonya recounted, "you have to be really thin and you have to be really sick — the sickest they've ever seen' ... see if you're 90 pounds that's not good enough to be in the cult ..." To have a heart attack due to low levels of potassium, for example, was a legitimate entry card.

Participants said that the hardest question for others to deal with was why *young* people (mainly women) would desire to literally starve themselves to death. "Just eat, what's wrong with you, just eat", implored families and friends. Desiring death is the ultimate negation of relatedness and was seen as a lack of reason, for in desiring anorexia and moving towards death participants were confounding an underpinning philosophy that privileged rationality and progress. 'Western' medicine, as Foucault and others have argued, is founded on a bedrock of rationality and progress, in which bodies and



diseases are categorised, ordered and treated (with the aim to assist and/or cure). The flouting of this philosophy may be partly responsible for the negative attitudes towards people with eating disorders by some health professionals. In their study concerning professional attitudes to people with eating disorders, Cameron *et al.* (1997) reported a high level of frustration, fear, anxiety and helplessness: “it’s like beating your head against a brick wall ...they [the patients] are not prepared to follow the path you are laying open for them ...nothing seems to get through to them” (Cameron *et al.* 1997: 28). The two participants who perhaps most graphically exemplified this attitude were Danielle and Charlotte, both of whom struggled with their ensuing desire to have anorexia despite repeated warnings that they could irreparably damage their health. Both had insulin-dependent diabetes, and omitted doses of insulin in order to rapidly lose weight. They told me that the desire to be empty and pure outweighed the complications of diabetes (risks such as reduced blood circulation to the peripheral circulation of the body). During the course of my research both women lost their eyesight as a result of these actions, made even more poignant by that fact that Charlotte was a visual artist and Danielle was the single mother of a young child.<sup>14</sup>

The ways in which desire moves the body is antithetical to the Western philosophical tradition that has, as Nietzsche points out, tended to fear “appearance, change, pain, death, the corporeal, the senses, fate and bondage, the aimless” (Nietzsche, cited in Dollimore 1998: 245). And this, for Nietzsche, is the underlying problem: “we remain”, he argues, “entangled in error, necessitated to error, to precisely the extent that our prejudice in favour of reason compels us to posit unity, identity, duration, substance, cause, materiality and being” (*ibid*) in a search for the immutable.

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<sup>14</sup> See Crow *et al.* (1998) for a review of the literature regarding eating disorders and insulin-dependent diabetes.

Desiring anorexia was not simply a negative process. Rather than being a lack or an absent negative (as Kristeva and psychoanalysis more generally has positioned it), desire was also experienced as a series of practices that produced, connected, separated and constituted social relations (Grosz 1994: 165).<sup>15</sup> Desire was an important dimension of participants' social lives, for as Probyn argues:

It is through and with desire that we figure relations of proximity to others and other forms of sociality. It is what remakes the social as a dynamic proposition, for if we live within a grid or network of different points, we live through desire to make them connect differently. (Probyn 1996: 13)

One of the most recent illustrations of the building of social relations through the desire to have or be 'a better anorexic' is evidenced by the ever increasing number of 'pro-anorexic' websites that have appeared since my fieldwork. These websites (*Starving for Perfection*, *Wasting Away on the Web*, *Dying to be Thin*, *Anorexic with Pride* and *Goddess Ana*) are constructed by people with anorexia and offer advice such as "how to improve your eating disorder, and how to deceive your family and friends". *Beautiful by Bones* describes itself as a club for sharing tips, being pro-anorexic and "being beautiful by having your bones show loud and proud". Photographs of emaciated women (such as Karen Carpenter) and men are posted as "thinspiration", as desired states of being. E-mail groups such as *Puking Pals* also promote anorexia, summing up its philosophy as "how to have your cake and puke it".

While there has been a public outrage about the ethical and moral responsibilities of these authors and the internet site providers (and in July 2001 Yahoo agreed to take some down), these websites demonstrate a very particular playing with agency. Cyberspace offers a space to simultaneously reveal and conceal information. People were able to project incredibly intimate and mundane aspects of their daily lives into

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<sup>15</sup> Bray and Colebrook (1998) note how Deleuze in *Dialogues*, "refers to anorexia as a phenomenon that has been subjected to misinterpretation precisely to the degree that it has been organised according to a theory of lack" (Deleuze 1987: 90, 111, cited in Bray and Colebrook 1998: 63).

such a public arena precisely because of the anonymity it provided. They described experiences and practices that, in a different context, would be pathologised, admonished or censured. This was a strategic use of technology, in which agency was strategically revealed, yet concealed.

It was this playing with agency that caused public outrage. It was, for example, no longer medical practitioners or health professionals who were the ‘experts’, but the people with anorexia themselves, as this warning from the anonymous ‘eating disordered’ ‘Sammy’ details:

If you are using Syrup of Ipecac or Laxatives as a means of weight loss, or are considering using either of these methods, then you **NEED** to read this page. Syrup of Ipecac is meant for **EMERGENCY ROOMS** or **HOUSEHOLD EMERGENCIES ONLY!** It’s purpose is to save the life of someone who has ingested poison, and induces vomiting [sic] to rid the victim of the poison. This is it’s purpose, and should be it’s only purpose. I know some of you are curious about Ipecac, are considering using it as a means of purging, or are actually using it at present. What I would say to you, is **DONT**. For your own sake, **DONT**. I have been through years of bulimia. I know how desperate you get, just to rid yourself of the food which is ‘raping’ you and contaminating ur [sic] stomach. Ipecac is not the answer. If you must, use your fingers or a toothbrush, etc.

This playing, Battaglia argues, “is useful to people not so much for controlling or determining a site of authorship or authority as for *ambiguating* authorship or authority” (Battaglia 1997: 506). As a form of play, agency is thus “a vehicle or site for problematising sociality” (ibid). The authors of these websites knew that they were problematising sociality, and warned visitors that the information would only be of interest to those who desired to be or maintain anorexia, not to family members, friends or those recovering from eating disorders. These sites graphically illustrate the ways in which people with anorexia re-negotiate the taken-for-granted nature of illness, agency, desire and relatedness.

## CREATING RELATEDNESS THROUGH CONCEALING AND REVEALING

Estelle explained the reconfiguration of desire, power and belonging through her exposure to the social relations of secrecy in eating disorders. She was amazed when she was first admitted to an in-patient program and met with other “anorexic patients”:

I found that there was a whole culture behind anorexia - once I got in there - there was this whole culture thing - they all seem to stick together and they have their laxative abuse and stuff like that but it's almost like a trade secret - like it was really bizarre for me. Because I'd never really known anyone with eating disorders while I'd had it but I knew about this whole thing because I'd been warned about getting sucked in to the whole anorexia culture and the girls that didn't want to get better.

Estelle's experience of hospital highlights the tensions of allegiance, of wanting to recover and conform to her program, but being maligned by other patients for doing so: “I wanted to fit into that culture when I went to the hospital because I wanted to fit in with everyone and they all saw me as this freak that wants to get better and at first I felt really rejected by them ... I was leaving the thing [anorexia] so they didn't like me that much”. Even though Estelle's non-conformity puzzled the group, they took great delight in introducing her to the “collective ways of anorexia”. When they discovered she hadn't used laxatives to lose weight they explained the practice to her, tempering their information with anonymity — “we haven't really told you about this, okay?”

I had already gleaned from health professionals that there was an element of concealment surrounding anorexia. During ward rounds at one major hospital the dietitian would report on each patient's weight status. It was not unusual for some patients who were on weight gain programs to register an initial weight loss — this was due to fluid loss. Continued weight loss, however, was viewed with much suspicion. There were cries of “cheating and lying”, and it was immediately assumed that the patients must be hiding food and secretly exercising. Measures were put in place to counteract the sabotage of cheating. A total of three “warnings” were given to patients

who were contravening their contracts, with the common offending behaviours being hiding or secretly disposing of food or surreptitiously exercising. Rooms and belongings could be searched to find hidden items, such as laxatives or unwanted food.

Outside of treatment settings people with anorexia were reluctant to reveal practices of weight loss or food refusal to those around them. Family and friends were often not aware of the extent to which someone had gone to reduce their weight. Rita recalled the strain of having to live “like a criminal — you have to constantly hide and lie and cheat”. She explained that being anorexic:

... was like having a full time job ... because there’s deception involved. Not only do you have to make your environment exactly how it should be and control what you put in your mouth but you also have to deceive other people and especially now they know what I do ... In the early days, certainly in my 20s when I went to parties or dinners, I used to feel enormously proud if I could get through the evening without eating anything. If I was driving home or going home and I could say to myself - phew, I got out of eating and no one noticed.

*How could you do that?*

Oh there are lots of ways. You pretend to eat for a start. You put your fork in something - you hold it like this (she holds the fork in her hand near her face), then it goes on around you and then you put it down again. You blend in - it’s like part of a movie.

*But nothing’s changing on your plate - you’re moving food around but it’s still there.*

You can make it look as though you’ve made a dent - and you do it as inconspicuously as you can and then you take your plate back into the kitchen and scrape it into the bin. It’s a strain because you constantly have to be assessing and playing the room like some bloody entertainer so as not to be - sort of like the reverse because you don’t want to be noticed and so you play the room in such a way as not to be noticed that you’re cheating - it’s a lie, it’s a cheat, it’s a hustle - it’s a strain. But then at the end of it, if you succeed, you feel good.

These tactics of concealment are well known to health professionals and are commonly referred to as “anorexic tricks”. Tricks enable a person with anorexia to conceal and cloak their real intention of losing weight. Their purpose is to convince observers that nothing is untoward and they are “fine”. The art of “pulling tricks”, as de Certeau reminds us, is deployed by those in subordinate positions of power, takes advantage of

opportunities and mobilises itself “in the service of deception” (1984: 37). Trickery operates “within the enemy’s field of vision” [the enemy in this case being the staff], or the terrain imposed on it – it vigilantly makes use of cracks and is a guileful ruse (ibid).<sup>16</sup> One therapist noted the variety of tricks that they as caregivers are presented with:

Well, I don’t eat meat for ethical reasons ... I don’t eat butter because it’s bad for your health ... I don’t use vegetable oil because I don’t like its slimy texture ... I don’t eat sugar because I’m allergic to it ... I don’t eat much at any one time because I hate to feel stuffed ... I exercise three hours a day because it relieves tension. You are asking me why I lost 30 pounds? - I didn’t mean to, it just happened. (Bemis-Vitousek 1997: 5)<sup>17</sup>

Other tricks include drinking litres of water or hiding bars of soap in underwear before being weighed, always taking the stairs instead of a lift, or refusing to wear warm clothes in winter so as to burn more calories. These common tactics do not surprise professionals, but when an unusual trick comes to light it will be commented on as ingenious, creative or quite bizarre. During a ward round a young woman who was spitting her food out after chewing it was described by a clinician as “rather unusual” – despite a number of my participants telling me that they did this routinely.

The language of concealment was extended in one eating disorder unit where the psychiatrists described the thinking that becomes engrained amongst ‘anorexics’ as “magical or superstitious thinking”. This concept became a therapeutic device, where it

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<sup>16</sup> This description of “pulling tricks” could equally be applied to the tactics of shoplifting, a phenomenon that has been reported as significantly higher amongst women with eating disorders (Baum & Goldner 1995; Goldner *et al.* 2000). Goldner *et al.* (2000) suggest that the association of shoplifting with eating disorder severity may be due to “mental dysfunction associated with the starvation and metabolic compromise that often accompany severe eating disorders” (2000: 474). I would argue that there are other important dimensions at play, such as the effects of cheating a powerful capitalist driven system. At ward rounds during my fieldwork there were several references to women who had been caught stealing laxatives and were awaiting criminal prosecution. Goldner *et al.* (2000) similarly note that those women in their study who were using laxatives reported stealing them, suggesting that this was “motivated in part by a desire to maintain the secrecy of their purgative methods” (ibid).

<sup>17</sup> In her book *The Secret Language of Eating Disorders* (1997), Claude-Pierre similarly notes the excuses and ‘tricks’ that patients have to avoid foods:

‘I can’t eat this bread because it bothers my gums’  
 ‘I’m diabetic, so I can’t have sugar’  
 ‘I’m lactose intolerant, so I can’t have milk’  
 ‘I’m hypoglycaemic, so I can’t have fat’ (Claude-Pierre 1997: 102)

was suggested to patients that anorexia was magical, for it “masked” the person’s thinking and actions. As a magical disorder, anorexia created the illusion of a distorted body image through trickery and deception. Anorexia, and by extension, the people with this diagnosis, could not be trusted (cf. Coopman 1995: 1).

### **The distinction of secrecy**

As my fieldwork relationships with people deepened over time, I became aware of the importance of concealment and secrecy to the ‘logic of practice’ that underpinned anorexia. This importance was much more than simply trying to hide practices from staff, friends and family. The power of secrecy is not only in what it conceals, but also in what it reveals and creates. Strathern and Herdt both argue that what is missing from the comparative study of secrecy is an understanding of how secret collectives, in the creation of social hierarchy, are systems which *produce cultural meaning* (Herdt 1990: 368, my emphasis; Strathern 1988: 115). Strathern highlights the ways in which secrecy in Gimi cultures enabled the actors to play the parts they allocated themselves, being thus in control of their meaning (Strathern 1988: 204). Secrecy thus establishes an exclusive domain in which only certain sets of meanings have value; others were suppressed or rendered irrelevant for the event (ibid).

The fact that staff knew about ‘tricks’ or secrets was in many ways immaterial, because it was the creation of meaning — what Estelle described as “the whole culture behind anorexia” — that gave people with anorexia exclusive relationships of power, knowledge and practice. It was the *performance* of secrecy, rather than its content, that was productive.

As stated in the introduction to this chapter, secrecy was a distinctive feature of anorexia, and, as Taussig notes, where there is secrecy there is power (and vice versa) (Taussig 1999: 7). The performance of secrecy enabled participants to hide ‘anorexic

practices' and vehemently state that they "were fine" (cf. Peters 1995: 44); it distinguished them from those with other 'illnesses' (both medical and psychiatric); and when people came together in treatment settings it had the potential to establish a collective and new relationships through common diagnosis and experiences. Some suggested that there was a "secret language of eating disorders", a language that was articulated through a range of bodily practices that were known and shared amongst those with anorexia. Although some participants chose not to engage with the collective secrecy, all knew of its existence and power from their own day-to-day strategies of concealment. These secret knowledges and practices were most clearly displayed when people participated in treatment programs, for it was here that the sense of belonging to the 'anorexic' identity was most important and yet most at risk (from the threat of anorexia being exposed and thus disempowered). It was in these spaces that 'anorexic practices' were challenged and confronted, yet these were the places where the internal and vertical hierarchy of anorexia was most evident, as some competed to be the best anorexic within the group.

Secrecy thus operated to mark differences between people — both within and outside anorexia — and in doing so created status and prestige for those who practised it. Those who maintained anorexia described feeling a sense of superiority over everybody else they encountered. Anorexia was, most particularly in the early phases of the experience, a productive and empowering state of distinction. It was not experienced as a debilitating illness, but as a state that was "unique", "heroic", "an achievement", "a thrill", "a high" in which people felt "indestructible" and "superhuman". Rita summed up the pride associated with anorexia: "When I was diagnosed with anorexia I was secretly proud. One of the features of when you're extremely thin is bloody pride, you're bloody proud of yourself for getting down to skeletal proportions — 'oh, I'm strong, I did it, just a bit more' ... it was my special secret".



This power of anorexia came from people's immersion in a *habitus* that promotes a particular representation of the 'female body' as desirable and valuable. Lynch (1987: 128) argues that "in the weight-conscious West the human body is now the ultimate commodity", inextricably interwoven with the emphasis on thinness and success. The body has thus become a source of "symbolic power based on the possession of symbolic capital" (Bourdieu 1990: 138). In standing out above the crowd by excelling at its own rules, participant's publically and viscerally attested to the embodied distinction of symbolic power.

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Unpacking secrecy is an important first step in understanding the logic of anorexia, for it points to the ways in which secrecy operates to create exclusion, difference and power for its keepers. Secrecy has many guises: its primary function is to conceal and hide, but "concepts of sacredness, intimacy, privacy, silence, desire, danger and deception all influence the way we think about secrecy" (Bok 1982: 26). These guises intertwine and sometimes conflict, but are all fundamental to the ways in which belonging is expressed; that is, to the ways in which the power of secret knowledges and practices are possessed and made use of.

Bok's book, simply titled *Secrets* (1982) explores how secrets have come to be known through language (of stories, myths and literature) and experience. Of secrecy she writes:

From earliest childhood we feel its mystery and attraction. We know both the power it confers and the burden it imposes. We learn how it can delight, give breathing space, and protect. But we come to understand its dangers, too: how it is used to oppress and exclude; what can befall those who come too close to secrets they were not meant to share; and the price of betrayal. (Bok 1982: xv)

Bok examines the evolution of the word 'secret' through several languages to trace what she calls its "different shadings ... whether of something sacred, intimate, private,

unspoken, silent, prohibited, shameful, stealthy, or deceitful” (Bok 1982: 7). The Latin *secretum*, for example, carries the meaning of something hidden, set apart. It derives from *secernere*, “which originally meant to sift apart, to separate as with a sieve” (ibid: 6). Another Latin word for secret, *arcanum*, denotes the sacred, the uncanny and the mysterious. Otto refers to this connection of the sacred and the secret as “numinous consciousness” — a “feeling” that combines the daunting and the fascinating, dread and allure (Otto 1928: 31). The uncanny quality is similar to Kristeva’s notion of abject which, as described in Chapter Four, encapsulates the simultaneous operations of desire and horror.

Intimacy and privacy represent another aspect of secrecy — the German word *heimlich* originally pertained to the home, the hearth, the intimate, but later, it took on the added meaning of something kept from view of strangers and finally also that of a secret (Bok 1982: 7). As Bok notes: “the private constitutes, along with the sacred, that portion of human experience for which secrecy is regarded as most indispensable” (ibid: 7). The point of tracing the European etymology of secrecy, Bok suggests, is to highlight those certain features that have come to be taken for granted in the ways it is conceptualised and practiced.

The associations of privacy and intimacy are particularly important as they serve to compound many of the practices associated with anorexia. People vomit, for example, when they are sick, and it is usually done in private and seen as disgusting when not. The act of vomiting and purging intentionally, rather than the consequence of a sickness, meant that it was mandatory to keep such practices secret. To be exposed ran the risk of being publicly shamed and ridiculed. In a similar way, the once public and communal activities of eating and exercising enter the private and intimate world. Both are done ‘in secret’; people with anorexia “often disguise the fact that they are eating at

all, going to the refrigerator at night when no-one else can see them” (Claude-Pierre 1997: 183). This was the reason why Natalia shopped for food kilometres away from where she lived, in order to maintain secrecy and anonymity. Again, to be exposed could run the risk of shame, embarrassment and guilt.

Along with Bok’s analysis of secrecy, other major contributors (Wedgewood 1930; Simmel 1950; Shils 1956; Bellman 1984) have also argued that being secretive operates to set one group off from another and changes the nature of the social whole (Luhmann 1989a: 161). Secrecy thus differentiates as well as unites: “a secret society is dependent for its existence upon its non-members as it is upon its members” (Wedgewood 1930: 135).

More recent interpretive ethnographic work has re-examined the meanings associated with secrecy. Authors like Herdt (1990) and Luhmann (1989a, 1989b) start by recognizing the important findings of the above earlier accounts and similarly define secrecy as “an intentional process of differentiating included persons and entities from those excluded, while simultaneously building solidarity among secret sharers” (Herdt 1990: 360). They have however, criticised these early analyses for their positioning within a structuralist/functionalist divide in which ‘society’ is opposed to ‘the individual’, and pushed the analysis further in a number of ways.

The major critique of earlier works, and Simmel’s (1950) classic study in particular, concerns the autonomy of a ‘secret society’. The secret society for Simmel is a singular social order that leaves no room for an alternative understanding of the shifting, heterogenous and contested nature of secrecy (or societies). Moreover, within this schema, there is no understanding of the ontological processes for the people involved, they simply merge into the secret society. Simmel spoke of the “de-individuation of the person, [thus implying] a loss of self/personhood through a complete merging and

commitment of the person into the collective” (Herdt 1990: 363). Herdt argues to the contrary, suggesting that Simmel’s “clouded understanding” on this point is motivated by a “Western ontology regarding the rational and magical in secrecy” (ibid: 364). Herdt cites Young’s (1983) critical examination of myth in Malinowski, Leenhardt and Levy-Bruhl as a useful parallel argument. In conceptualising myth as a social experience, Young states that, “mythic thought is affective rather than intellectual, a matter of moods rather than ideas”, an experience that sees “mythic participation as unity” (Young 1983: 14). Similarly, as an embodied social experience, secrecy constitutes and transforms the person into new social arenas. As Luhrmann argues in her ethnography of the occult in contemporary England: “the most compelling aspect of secrecy in modern magic is the impact it can have upon an individual’s experience” (Luhrmann 1989a: 161). Secrecy thus operates not simply in a ‘secret society’, but in the transformative relationships in which individuals participate.

The second criticism of previous analyses stems from the above argument, and recognises the multiple layers of hierarchy that can occur within secret collectives. Internal or vertical hierarchy has been identified: “... secret collectives [not only] assemble hierarchies between outsiders and insiders, [but also] between members of the collective itself.<sup>18</sup> Power and resources are at issue” (Herdt 1990: 360).

And lastly, the ways in which secrecy has tended to be moralised have also been criticised. The secret, for Simmel, is the moral badness of the person. To avoid censure or punishment, the person conceals information (Herdt 1990: 365) — they must be lying, cheating, deceiving or manipulating. Hiding, subterfuge and concealment have been seen as a ‘negative’ dimension of a dynamic process of cultural production

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<sup>18</sup> Barth’s study of the secretive men’s initiation cult among the New Guinea Baktaman describes the accumulation of status with the learning of more in-depth knowledge. The differing ascending stages of concealment and revelation each carry greater status: “Each level is organised so as to obscure the next level ... he [the initiate] realises the existence of veil behind veil” (Barth 1975: 219-20).

(ibid: 364). As Rita pointed out, anorexic practices made her feel like a criminal, hiding in the closet for 20 years. Hiding made her feel guilty, shameful and deceitful — all compounding her sense of herself as a “bad person”. To conceal, though, as my earlier discussion of Strathern and Herdt outlines, is simultaneously to construct or fabricate a parallel, and possibly entirely different system, of signs (ibid). For all the time that Rita was concealing practices, managing to hide the fact that she hadn’t eaten, she was constructing a space where she felt “good” — superior to those who did eat. There is always an obverse side to the negative, and it is the production of meaning “in the closet” that is of importance.

The following sections explore the complex dynamics of secrecy, describing the ways in which relationships were transformed through the secret collectives of anorexia, the internal hierarchy of groups and the difficulty of leaving the intimate connections of anorexia. Secrecy is not divided between individual and the collective. Rather, the data highlights the dynamic interrelationships of concealing and revealing that occurred with and between people who had a diagnosis of anorexia.

### **The secret collective**

As discussed in Chapter Two, I knew that I could not always gain access to people’s private and secret experiences. Monica, who used her own experiences of eating disorders in her therapy, suggested that whether or not I had experienced anorexia would greatly affect my research: “you sit with a group of people with eating disorders and they have their own language — if you haven’t been there you don’t understand it”. I certainly did not plan to mimic or ‘go native’ with participants, and I was aware that there were aspects of people’s lives that I would be excluded from (as in any research project). People were, however, clear about when they were telling me a secret or ‘letting me in’ to an area of privileged knowledge.

Being ‘let in’ denotes a spatial separation. The insider/outsider dynamic was often characterised in spatial terms — those who were in, or out of “the club”. Sonya explained the almost suburban and mundane inclusion:

I suppose I sort of see it as like an anorexic club - it’s just like everyone is pretty accepting of you if you are sick, everyone’s friends and stuff like that and there’s a bit of competition going on - it’s sort of like you put in your membership and it’s really hard to get out.

*How do you get into the club - what’s your membership?*

It’s sort of like a coffee club - you meet, you discuss the illness ... you have these friends - you’re suddenly in this group and people understand you ... for me it was like my life had just been nothing for such a long time - that was all I knew, it was all I did and I didn’t have any outside life and so suddenly I’m meeting all these people who don’t have any sort of life either so it was just perfect - what else do we have to talk about - nothing but anorexia.

Engaging with others who had the same diagnosis opened up new doors of relatedness. People characterised anorexia as if belonging to a persuasive and powerful group — “a religion”, “a competitive sporting team”, or part of “a game”. Sonya explained that she was able to tell me things because she had “been a traitor and left the cult of anorexia”.

She stopped to explore her use of the word “cult”:

I consider anorexia to be a secretive cult ... It’s very much like a cult - you have to belong and there are certain things you don’t share with the so-called normal people but you can share with each other ... It’s a cult because anorexia brainwashes you, and if you don’t cut the cord, it will kill you.

People with eating disorders do group together and mark themselves as distinct from others. In hospital wards they formed cliques, they sat together in the dining rooms, sat on each other’s beds to swap stories, and maintained connections after their admissions. They separated themselves from those with other psychiatric disorders like schizophrenia:

In many ways we’re very normal. Like anorexia - okay it is a mental disorder but it’s not as debilitating as some of the others. For example, when I was under observation for two weeks I was in a room with four beds and the girl next to me was - she was crazy - I don’t mean that in a derogatory sense but she’d have hallucinations and she had a tendency towards violence ... it was really scary ... myself and the other eating disorder patients tried to avoid these people and you

felt a bit sort of like ‘I’m not like these people, why have you put me in here?’ - I have a problem with food but that’s it - I’m not crazy.

Amanda was reiterating a common understanding amongst those with anorexia, in which they saw themselves as *extraordinary* rather than ‘abnormal’.

Distinctions, or what people called “battle lines”, were also drawn against those who wanted to help them. “People [with anorexia] build such a wall around themselves”, said Rita, “such a safety net of anorexia that anyone who comes along and tries to threaten that has got to be viewed as an enemy”. The “enemy”<sup>19</sup> included the doctors and nurses who were seen as taking away the relationship people had with anorexia. The kitchen staff were called the “kitchen witches” — pictured to be spreading lashings of butter onto sandwiches with the sole intention of fattening up the patients.

As previously discussed, undercover practices of resistance were in place — either solitary resistances or collective, organized attempts. These strategies of “trickery” were a form of *la perruque* – tactics of resistance that blend in with their surroundings, camouflaged so as not to draw attention to themselves, liable to disappear into their colonising organization (de Certeau 1984: 31). Although de Certeau characterises *la perruque* as operating in the workplace, it is by no means the only space in which this tactic occurs:

... *la perruque* is infiltrating itself everywhere and becoming more and more common. It is only one case among all the practices which introduce *artistic* tricks and competitions of *accomplices* ... sly as a fox and twice as quick: there are countless ways of ‘making do’. (ibid: 29, emphasis in original)

Lacking their own space, people ‘made do’ within “a network of already established forces and representations” (de Certeau 1984: 18). Means of vomiting and hiding food were difficult in patients’ rooms because toilet and shower ensembles were locked, and hand basins had the underneath plumbing removed so nothing could be disposed of or

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<sup>19</sup> In explaining *la perruque* de Certeau uses military language (such as enemies, battle lines, soldiers and struggles) as an analogy. The same military language is utilised by those with anorexia.

flushed away. People had to be ingenious in getting rid of food and vomit, and the more creative disposal schemes were “trade secrets” that were joked and laughed about — to *perruque* the system was to outwit the staff and to win. The staff knew about the common stashes of butter in people’s shower bags or bins, but the butter scraped into duvet covers, under the metal lip of the side locker, or in between the pages of a newspaper to be unwittingly taken home by a caring relative was divulged with excited and hushed tones. When people were ‘sprung’ by staff they vehemently denied these practices, desperate to keep their secrets safe. There is, however, a simple glucose test that determines if the yellow fluid in a bedpan is in fact urine, or apple juice.

Sometimes people just gave in and admitted defeat, unable to provide excuses for the vomit squeezed into cosmetic containers or orange juice poured into flower vases.

Depending on what type of treatment program people were on, some spent lengthy periods of their admission in single rooms. Here activity was reduced to moving on the bed and the only time you could leave the room was to be escorted and wheeled to the shower under a privilege system. Interaction with other patients was curtailed, but handwritten letters were secretly passed from one door to another, swapping stories of how to exercise without being noticed. And those who were allowed the freedom of the ward sometimes established groups of cheating<sup>20</sup>, banding together like a relay team.

Rita described how she was included in a network of food avoidance without any warning — the fact that she had an eating disorder automatically meant she was an accomplice in a “network of deception”:

We’re a secretive lot ... this young girl tried to set up a little network of accomplices - like a support system to help her cheat. She even shoved a bag of nuts into my hand that was her supper. We were just walking past each other in the corridor and she shoved a bag of nuts in my hand and kept walking and ... so I was actually aiding and abetting her by doing that ... I wasn’t going to dob her

<sup>20</sup> One therapist told me how a former group of residents at *Vista* had developed “underground behaviours”. Collectively they had agreed not to use oil when cooking the evening meals and to hide this decision (and practice) from staff. Another participant recalled how she had once co-opted another patient on the psychiatric ward (who did not have an eating disorder) to buy laxatives for her at the hospital shop. He had freedoms that she, as a bed program patient, did not.



in - I really should have, but I don't know why I didn't. I guess because you can see both sides and being older I can see the nurses and doctors perspective but on the other hand I know how desperate she was to lose those nuts. She didn't want to put them in her body.

The secrecy that operated within the clinical setting not only propelled people with anorexia together, but also encouraged intimacy between them. The closeness of relationships was reinforced in some therapeutic treatments. For example, support groups were seen by people as spaces where they could feel safe in speaking openly and not be attacked for their views. Some professionals recognised the double-edged nature of establishing and/or maintaining eating disorder therapy groups, arguing that it provided a forum to fuel levels of competition and secrecy amongst those who already had strong bonds of intimacy. Several major hospitals had stopped running support groups altogether because they had the unintended effect of perpetuating eating disorder practices.

Let me illustrate this point ethnographically by describing the sessions that occurred during a single day in a treatment program. As described in Chapter One, the residents at *Vista* travelled by bus to the hospital to participate in a daily intensive therapy program. There were many facets to this program, but the main focus was the encouragement of talking — talking about emotions, relationships and about how 'things' made you feel. Talking was seen as therapeutically valuable, as it was felt that people with eating disorders needed to become comfortable with 'externalising' their emotions, a skill which they were deemed to be 'lacking'.

The mornings would start with "open talk", a one to two hour session where the eight residents came together in a private room in the eating disorder unit. The idea of this session was that it allowed each person in turn to speak about their weekends and how they were feeling, and then for the young women to ask each other questions or comments in relation to what was said. The doors were shut, chairs moved into a circle

and silence prevailed. Eyes looked downward and bodies shifted in seats. After a long five minutes Michelle eventually broke the silence and brought up an incident that had happened last week at the residence. In a quiet voice she asked the group to remember the movie they had all been watching together on the television. She had made a comment about not understanding some connections in the plot and another resident off-handedly chided her for her inability to follow the story. This dismissal, she felt, was unwarranted. Catherine, whom the comment was directed at, explained her actions by saying that her father does this to her, and she was unwittingly reproducing his behaviour. Tears ensued, apologies were made and the conversation turned to another person.

In the break, the staff attending this group met to discuss and document the effectiveness of the session. The fact that two participants had excused themselves on separate occasions to leave the room and go to the toilet was not viewed favourably. Going to the toilet was seen as an excuse to not confront emotional issues, as well as contributing to the break down of the cohesiveness and intimacy of the group.

Following a communal lunch and an afternoon session of body image drawing, the young women returned to *Vista* for family therapy and the evening meal. Family therapy was facilitated by one staff member (a trained family therapist), and parents and/or friends were invited to come and talk and 'share' as a group. Again the forum was intended as a safe and supportive environment to voice concerns. Catherine used the space to raise an incident with her mother (who was sitting next to her on the lounge), who had asked her on the weekend if she "was over her fat phobia yet". Catherine cried at what she saw as the insensitiveness of such a glib remark, and pleaded with her mother to understand that comments like that did not help in her recovery.

Before dinner, to which guests were invited on this night, parents and friends were asked to leave the room to give the young women space to talk about what they were having for dinner. Francine, who has was on the roster to cook that night<sup>21</sup>, announced (with a folded napkin over her bent arm) that for the main meal they were having tortillas, which included some ‘challenge’ foods like cream cheese, sour cream, meat and sweet sauces. Dessert was frozen chocolate yogurt, a specifically chosen ‘challenge’ food for all. Francine had also chosen the accompanying music for the evening meal: her favourite band *Spirit of the Wind*. Each girl then publicly declared which food she was going to challenge before calling out to her guest to come and join them at the table.

After the meal the guests were again asked to vacate the room for 30 minutes to allow each person to talk about how they felt after eating dinner, how they went with their challenges, and any other general comments about their day. Everybody was asked what their ‘victory’ for the day was — anything from challenging ‘negative thoughts’ about eating a particular food to warding off thoughts about wanting to exercise. This was designed to end the day on a positive note. Again this was a closed group, and the phone, which rang several times, was left unanswered as it would disturb the gathering.

The intimacy and openness that was encouraged in the group was intended to provide a protective and therapeutic environment. As a therapeutic device, it was a forum where people could gain confidence in speaking about how they felt and communicating concerns that might otherwise be dealt with through coping mechanisms of starving or purging. Confidence was at a premium — the group could only work through trust and the fact that it was closed from family and friends. Although I have been critical of Simmel’s understanding of ‘the secret society’, the workings of the therapeutic group

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<sup>21</sup> Residents always prepared and cooked the evening meals in pairs.

had a remarkable similarity to his account. Luhmann makes the same point when discussing the therapeutic value of openness within “magic circles” (1989a: 158), and draws on the “applicable elements of his theory”:

... the secret society encourages members to trust one another, to treat each other as equals, and to develop affective bonds; the secret society tends to be highly self-conscious of its social life; and the secret society tends to present itself as a counterimage of the ordinary world, clearly set apart from it and organized along different lines. (Luhmann 1989a: 158)

As a collective (rather than a ‘society’), the residents at *Vista* relied on each other not to reveal what was discussed in confidential group sessions. Simmel describes this reciprocal confidence as moral solidarity: “in the confidence of one man [sic] in another lies as high a moral value as in the fact that the trusted person shows himself worthy of it” (1950: 348). Bok similarly points out that secrecy creates a sense of shared privacy and trust because of the group’s explicit acceptance of its members. Secrecy, she argues, “offers the freedom to trust and to be creative, and the excitement of transcending ordinary limitations” (Bok 1982: 49).

Although sharing of knowledge and stories was premised on recovery and a positive therapeutic environment, the revealing of personal and secret information in a confidential setting reproduced the workings of secrecy that people with eating disorders were already familiar. Staff who facilitated these groups and the community live-in program were well aware of the strong relationships that pivoted around anorexia, and tried to encourage independence outside of the safety and supports of ‘illness’.

Beyond *Vista* and all other treatment settings, people with anorexia continued friendships, with some even choosing to share apartments — a move that was firmly discouraged by staff. Those who went their separate ways often kept in touch by letter, e-mail or phone, their relationships refracted through the commonality of eating disorders. Estelle, for example, kept in touch with a friend she made in hospital, whom

she called “bulimia Ben”. A group of nine women who had met whilst in treatment at a private hospital had formed a competitive netball team that played on a weekly basis, naming their team “Chicken Legs”. In my local community when people in the project spoke about their friends it was often the case that I already knew them because they had also participated in this research project. Several people’s ‘stories’ had been circulated amongst staff and patients almost to mythic proportions. Jacqui, for example, was well known within eating disorder ‘circles’. She had had an eating disorder for most of her life and now in her 40s was facing life-threatening complications as a result. During her multiple hospital admissions she had befriended many younger women, and warned them of the future dangers of their practices. Her ‘struggle’ with anorexia was often evoked in ward rounds or in conversations I had with informants.

Secrecy was not only defined by treatment settings — those with anorexia were aware of a sense of possession and of cohesiveness that was not defined by a coming together. Simmel argues that secret societies tend to be conscious of themselves as a group (1950: 363). They have a shared predicament that binds them. This was certainly the case in public spaces (such as gyms or shopping malls) where people would point out others who had anorexia. They were strangers, but they “just knew” who was “in” by their distinct bodily comportment — “the dead look” in their eyes, the sallowness of their upper arms and the heaviness of their gait. These bodily signs meant that people could easily distinguish between those who were “naturally thin” and those who were anorexic, as Beth commented:

The first thing that always gets my attention is the arms – (the tops of people’s arms) because they look disproportionately thin ... and in the face – there’s a look in the eyes. People used to say it about me and I could never see it in myself but I can recognise it in other people - their eyes are dead and if you’ve known someone it’s particularly noticeable and then you see them - like there’s no life behind them, it’s just emptiness. So I find the face and the eyes the biggest give away but in terms of the body the arms. It’s something you recognise - like the haggard look, the dead eyes and just a weariness and I don’t

know whether it was having been through it - it touched something in me and I recognised it.

Recognition of another ‘anorexic’ was an invitation to form a relationship. It initiated an exchange of comforting words at a bus stop or across the plaza on the university campus, and at other times it allowed for comparisons and exchange of purging techniques. Other recognition cues related to food practices – the “trade secrets” of avoiding food and purging — and the more common ways of avoiding eating such as claiming to be vegetarian for moral reasons, saying that you’d already eaten, excusing yourself to the toilet once too often, or pushing the food on your plate around to make it look less like a full serve. Anorexia was in itself a vehicle of communication and connection.

### **Climbing up the ladder**

As argued in the previous section, one function of secrecy was to distinguish members from outsiders. Within the group however, equality was not the only effect of boundary marking. As already indicated, anorexia involved competition with oneself and/or others, and the game was very seductive. This competition was played out when the extremely underweight Josie came to stay with the *Vista* residents (as described at the beginning of this thesis), where the seduction to compete was a risk to the slow process of recovery.

Many other participants spoke about the insidious levels of competition in anorexia,

Sonya likening anorexia to a highly competitive sporting event:

... It’s like the Olympics - whoever is the thinnest has won the gold medal. The ultimate goal is to be the sickest, and the ultimate victory is death. Everybody wants to be the Olympic winner - the worst case - the one who survived three heart attacks and a stroke and was in a coma for five weeks ... It’s just like attaining that religious level in a cult of self-sacrifice. It’s very rewarding in a sick way.

“The best”, Amanda reiterated, “is dead — that’s when you win — the best you can be being anorexic is when you die”. Malson and Ussher (1997), in their paper exploring death and constructions of femininity, similarly describe the perilous competition, quoting one of their interviewees : “I always wanted to be the perfect anorexic, but I know the perfect anorexic’s a dead one basically” (1997: 57).

The path of the “best” anorexic was the “purest”. People referred to “pure” or “true” anorexia: weight loss by total control through almost total abstinence of food and drink. Unlike the binge/purge anorexics, purists did not need the aid of laxatives or vomiting; their path had “no crutches”. “Pure anorexia” was not only an important part of distinguishing them from other people, but also from other eating disorders, which were seen as lower down the scale. Those who binged and vomited fell into the bulimic category and were disparaged for their messiness and weakness: their loss of control, their falling prey to the desire of appetite. “People with bulimia are totally out of control and disgusting because they binge and purge. They cheat — they don’t go the hard slog like [we] do”, said Briony. Compulsive eaters don’t come anywhere near the mark and were disparaged for their outright gluttony.

In *Wasted* (1999) Hornbacher vividly captures the competitive aspirations of those with anorexia and I quote her at length to illustrate the point:

When I got to treatment the first time, I was not one of the emaciated ones. I was definitely slim, far thinner than is normal or attractive, but because I was not visibly sick, the very picture of sick, because I did not warrant the coveted title of Anorexic, I was embarrassed. Ignore the fact that my diastolic pressure had a habit of falling through the floor every time I stood up, putting me on watch for sudden cardiac arrest, or the fact that my heart pattered along, slow and uneven as an old man taking a solitary walk through the park. Ignore the fact that I had a perforated oesophagus and a nasty habit of coughing blood all over my shirt. In treatment, as in the rest of the world, bulimia is seen as a step down from anorexia, both in terms of medical seriousness and in terms of admirability. Bulimia, of course, gives in to the temptations of the flesh, while anorexia is anointed, is a complete removal of the bearer from the material realm. Bulimia harkens back to the hedonistic Roman days of pleasure and feast, anorexia to the medieval age of bodily mortification and voluntary famine.

In truth, bulimics do not usually bear the hallowed stigmata of a skeletal body. Their self torture is private, far more secret and guilty than is the visible statement of anorexics, whose whittled bodies are admired as the epitome of feminine beauty. There is nothing feminine, delicate, acclaimed, about sticking your fingers down your throat and spewing puke. (Hornbacher 1999: 153)

This hierarchy of eating disorders was unwittingly replicated by health professionals who commonly refer to the “ABC” of eating disorders — anorexia, bulimia and compulsive eating respectively (Melville 1983; Grieves 1997: 78). Some participants who were initially categorised as bulimic were told by their psychiatrist that they were “failed anorexics”. They did not fulfil the requirements for a diagnosis of anorexia (their weight loss was not significant and they purged their bodies rather than abstaining from food) and were thus seen as unsuccessful in their goals. Rather than ‘give the game away’ (as such a comment would hope to encourage), it only served to compound a sense of disgust at their own failure and spurred them on to greater heights of abstinence.<sup>22</sup>

### **Cutting the cord**

Leaving anorexia was not a straightforward process. Because it offered much support, both individually and collectively, it was difficult “to cut the cord”. Those who left were not considered well or healthy, but as “outside anorexics”, traitors and frauds. It meant, as Hornbacher writes, losing the communication and connectedness that practices of anorexia form between women:

... when you decide to throw down your cards, push back from your chair, and leave the game, it’s a very lonely moment. Women use their obsession with weight and food as a point of connection with one another, a commonality even between strangers. Instead of talking about why we use food and weight control as a means of handling emotional stress, we talk ad nauseam about the fact that we don’t like our bodies. (Hornbacher 1999: 283)

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<sup>22</sup> Once diagnosed with ‘the wasting disease’ people felt that they had to uphold the stereotype of being thin, otherwise they would be deemed a fraud. Maintaining the stereotype people told me, made it difficult to recover.



Leaving anorexia also meant severing an intimate connection with a friend, a friend that was part of, and in some instances central to, who people considered themselves to be. Elise, for example, started to call herself Ana (a common name amongst participants for anorexia) for not only did she have her family and doctors telling her she was anorexic, but she also felt that it was pivotal to her sense of identity – “I became Ana, not Elise”. Whether people experienced Ana as part of, or representative of who they were, it was always described as a most difficult relationship to cut. Sitting in our usual seat in the park one day, Rita described the difficulty of “letting the eating disorder go”. She had “a powerful dream” in which an image of a little girl “was walking away from me (she paused) — it was leaving”. Rita started to cry, describing the intense loss and sadness at the thought of having to say goodbye to her “little friend” [the eating disorder]. She returned to this dream later in the afternoon and told me why it “moved” her so much:

It was like I was losing someone - but in a way I think that little kid was not the little me but the little matey that I was attempting at that point in time to kick out. But there was an infinite sadness in seeing - the little girl was actually the binge and she was leaving (she started to cry again) - it sounds like bloody Hollywood crap but the child image was looking over the shoulder and the eyes looking so terribly sad. Loss. That wasn't an image of me it was something that I was losing - it would be good if I did lose that part of myself but I was infinitely saddened to be losing it and as it happened I didn't. The little comfort mates are still there ... you don't want to lose them, they become like your little mates. You need them and you almost embrace them and they're the things that you hug and cuddle rather than people because they're always there for you and to lose them would be to lose everything.

Anorexia was more than symptomatology for Rita. It was experienced not as alien or unwelcome (as many psychiatric disorders can be), but as part of her self, as a person with whom she had a relationship.<sup>23</sup> Even though Rita had attempted suicide on several occasions and had been close to death with low weights, she equated the loss of anorexia with her own death:

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<sup>23</sup> Unlike Harris (1989) and Carrithers *et al.* (1985) I do not understand the concepts of ‘self’ and ‘other’ to be in opposition. The assumed dichotomy of self/person, which is premised on a biological/social ontology, suggests that the self is “a locus of individual [and universal] experience, through its counterposition to the person as a being formed within the moral framework of society and its relationships” (Ingold 1991: 365). People, as Ingold argues, do not come into being as ‘selves’ prior to their entry into social relationships; “selves *become*, and they do so within a matrix of relations with others” (ibid: 367).

It's like if you leave me I'll die ... it's the little faithful, loyal matey that's always there when I need them and will never let me down but it's not a mean little friend - it's not a demon friend although sometimes I feel pretty clawed up inside and quite - on a visceral level you know that sort of gut-wrenching agony - but it's there and it's always been there. I'll die if I lose it - either I'll die if my little mate isn't there or I'll have nothing.

The strength of this bond was described by a male psychiatrist at the Scottish Eating Disorders Interest Group meeting when addressing other clinicians, researchers and family members. To emphasise the power and emotive relationship that people have with anorexia, he asked which audience members had children. Choosing one woman, he then engaged in a role play with her where she acted as herself (the mother) and he an inspector for the child and adolescent youth services. In an authoritative manner, he proclaimed that she was not fulfilling her duties as a mother and that he had come to take her children away where they could be cared for 'properly'. He acknowledged that while she might love her children, she was obviously not coping as she was constantly exhausted, tired and often angry, and on several occasions seen to be physically harming them. He had come to take her children away, right then and there. This scenario, the psychiatrist argued, was what people with anorexia are often confronted with when they attend treatment. This bond of kin is now being used as an analogy in the training of some therapists (cf. Bemis-Vitousek 1997:11)

As Rita suggested though, there is much ambiguity to the relationship one has with anorexia. Many characterised anorexia as a best friend but also an enemy; as being in an abusive relationship from which it seemed impossible to walk away. In their article *Anorexia Nervosa: Friend or Foe?*, Serpell *et al.* (1999) asked patients with a diagnosis of anorexia to write two letters to 'their anorexia nervosa', one addressing it as a friend, and the other addressing it as the enemy. While their discussion highlights the positive reinforcements that anorexia as 'a friend' maintains, the authors overlook the

ambiguous nature of this ‘disorder’. Anorexia offers an ambiguous relationship of *both* friend and foe. Rita encapsulated the contradictory nature of her experiences:

It’s empowering but also enslaving. You’re an absolute bloody slave to it ... it’s your friend and your enemy, you bet. Yes, it’s like the devil with a smile – “come here, I’m going to help you, I’ve got a good way for you to cope” and then he<sup>24</sup> sticks the fork in.

Others described anorexia as like a marriage which began with “a honeymoon phase” but then transformed over time into a destructive relationship.<sup>25</sup> The only way to escape was to divorce themselves from what they termed their “abusive lover”.

\* \* \*

This chapter has examined experiences of belonging in a variety of contexts – in participants’ homes, in treatment settings, public spaces and even via the internet. In all these spaces issues of relatedness were central: of feeling alienated and disconnected from families, friends and bodies; longing to have a diagnosis of anorexia; anorexia ‘acting’ as a secret friend and abusive lover; the sharing of ‘anorexic’ practices that engendered belonging in hospital settings; being an “outside anorexic”; and leaving the group and friendship(s) of anorexia behind. Through these varying contexts I have described not only the processual nature of anorexia, but its positioning as a focus of agency and experience within a field of relatedness.

Anorexia was not just a clinical entity, but was co-produced and mobilised by a variety of people, knowledges and representations. On the one hand it was authored by others (by psychiatrists and health care workers as described in Chapter One) and on the other hand it was displaced by the actions of those who were given the diagnosis. As Strathern has shown in exploring the phenomenon for Melanesian culture, the agent, or

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<sup>24</sup> I often asked those participants who had personified anorexia what gender it was. There was no definitive answer, as it was sometimes female and sometimes male. As an abusive lover, the devil and a father it was male, and as a friend it was often female.

<sup>25</sup> Bemis-Vitousek (1997) similarly describes “the honeymoon phase of eating disorders” as like “the romance of a new marriage” (1997: 9).

acting subject, may thus be less a locus for relationships than a “pivot of relationships ... one who *from his or her own vantage point acts with another’s in mind.*” (Strathern 1988: 272, emphasis in original). In this view “the object or outcome is their relationship, the effect of their interaction” (ibid) to be transformed or replicated.

Anorexia was a central pivot of relatedness as well as a vehicle for relatedness itself. By entering into a relationship with anorexia people had the capacity to own it and disown it, conceal and reveal it, and in the process, create different types of relatedness that confounded taken-for-granted avenues of connection. Participants were thus constantly struggling and strategising within and inbetween sets of social relations.

Participants described anorexia as a friend *and* an enemy, a source of support, and in Rita’s experience, it replaced intimate, physical contact. Concealing this relationship from those who would not understand the desires and motivations of anorexia was mandatory, and people went to great lengths to hide and/or deny ‘anorexic practices’. The shame of being exposed (due to the associated disgust that accompanied purging and bingeing), and the desire to continue a relationship with anorexia ensured secrecy. By avoiding social engagements of intimacy and commensality, participants radically altered social relations with those around them.

When participants entered treatment programs and met others with similar diagnoses they learned of the secret collective surrounding anorexia. This collective, however, was not bounded or pristine as Simmel’s argument would suggest, but rather dynamic and changing, and its boundaries were always moving. Although practices were often revealed to other ‘members’ of the group and close ties of affection and allegiance developed, there were those like Estelle and Rita who wanted to disconnect from this group and move away.

No matter where people were positioned, they were aware of the relationships that anorexia provided and excluded. In following this theme of relatedness, the next chapter investigates the very specific relationships that participants had with foods.

## CHAPTER 4

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### ABJECT RELATIONS WITH FOOD

*Loathing an item of food, a piece of filth, waste or dung. The spasms and vomiting that protect me. The repugnance, the retching that thrusts me to the side and turns me away from defilement, sewage, muck. The shame of the compromise, of being in the middle of treachery.*

*(Kristeva 1982: 2)*

Building on the themes of relatedness from the previous chapters, this discussion moves into a different field of relatedness, that between participants and food. The relationships that those diagnosed as ‘anorexic’ have with food are often assumed to be an extension of taken-for-granted concepts around nutrition, concepts that are transformed into idiosyncratic routines aimed at weight loss. My research challenges this common assumption, exploring the different meanings that participants attributed to particular foods, and the practices involved. I reveal how food practices were central to the relationships that people with anorexia had with each other, their own bodies and other people.

This chapter is divided into three sections. The first begins by discussing the genealogy of nutrition, for ‘nutrition’ is far more than the discovery of ‘scientific facts’ about dietary practices. It is, in the Foucauldian sense, a ‘regime of truth’, a discourse that produces subjects through relations of power and knowledge. As Coveney (2000) has recently highlighted, nutritional discourses in western cultures have a long history that are interwoven with a variety of concerns: ethics, morality, notions of the body, care of the self, changing concepts of health and illness, pleasures and spirituality. The point of tracing this genealogy is to show the ways in which nutrition has emerged in a variety

of fields that then circulate in people's everyday experiences and practices surrounding food. Nutrition, as many have argued before me, did not appear out of thin air.

While people with anorexia clearly drew on the current nutrition discourse in their everyday practices, characterising different foods as 'good and bad', 'healthy and unhealthy' and 'indulgent or sinful', they also highlighted a completely different schema that centred on the contaminating aspects of foods. The second section introduces Douglas' typology of dirt, pollution and danger, for on the surface it appeared that participants used a similar classificatory scheme when discussing foods. Oils, for example, were anomalous and dirty because of their marginality within the classification of foods. It was, however, the embodied responses to foods that pointed my analysis away from Douglas and towards Kristeva's visceral model of abjection. When people spoke, ate, thought about, touched, came near or even dreamed about food it was an embodied act, one that was filled with emotions of fear, desire, pleasure, repugnance, disgust and utter abhorrence.

The final section critically assesses and extends Kristeva's psychoanalytic/literary concept of abjection. Rather than limiting abjection to the formation of individual subjectivity (as Kristeva does), this chapter argues that abjection is located in everyday practices and relationships. Tasting, touching and smelling certain foods, for example, evoked horror and disgust, and ensured practices that reduced the transmission of contagious substances between people and objects. Hands were protected, certain foods, people and spaces avoided, and, as Chapters Five and Six describe, bodies were meticulously cleansed to remove the dirt and disgust associated with foods. As abject, contaminating foods blurred the usually clearly marked spaces within and between relations.

## **“YOU ARE WHAT YOU EAT” — NUTRITIONAL PEDAGOGY**

Each field that I encountered shared a common currency of language about food and nutrition. In the medical realm, for example, food practices and habits were framed by biomedical explanations: anorexia was refracted through a discourse that took the disorder to be an extreme conformity to contemporary dietary regimes. Within this framework the physiological effects of not eating (effects of malnutrition such as osteoporosis or infertility) were of prime importance.

Dietitians were integral to redressing this imbalance and restoring a person’s nutritional status. All medical teams had a dietitian ‘on board’, measuring people’s weight and body mass index and calculating caloric diets that worked towards a target weight goal. They ‘prescribed’ what foods a person should eat, and at what times, and in what quantities. Khare similarly discusses how the nutritionist is interested in “prescription as well as description, gathering data to construct universals of the human diet and to pronounce on the appropriate foods, evincing a ‘utopian’ idea of the ‘perfect human diet’ to achieve perfect health” (Khare 1980: 526-7, cited in Lupton 1996: 7).

Even though my fieldwork traversed a number of different treatment settings, I found that the authority of nutritional information was taken for granted in each. At a private hospital I sat on Olivia’s bed while she showed me how she planned her daily meals. Rather than counting calories the meal plan was categorised according to portions, where a “protein/carbohydrate exchange” system was used to monitor intake. This form of treatment, while promoted as a radical alternative to mainstream services, works within a nutritional framework that uses the language and assumptions of that discourse.

To understand the privileged status of nutritional discourse it is necessary to trace the histories of nutritional science, as the relationship between nutritional practices and



wider discourses are integrally connected. Although the concept of dietary regimens can be traced back to Hippocrates (based on a humoral system of health), nutrition as a science did not receive popular circulation until the late eighteenth century (Lupton 1996: 69). It is this period and onwards that is of interest, for it here that the nutritional value of food (based on its chemical composition) emerged to combine with doctrines of good health, hygiene and manners.

The history of nutrition, like all histories, is a contested one. In reviewing this contestation, Coveney (1999, 2000) argues that the debates have not allowed for a full appreciation of the heritage of ideas that are part of nutrition discourse. In particular, he points to the false separation of moral asceticism and scientific discoveries, as argued by Turner (1982) and Aronson (1982) respectively. Turner suggests that the eighteenth century English physician Cheyne, who wrote widely about the importance of dietary asceticism for health, was central to the development of western discourses on diet (Coveney 1999: 23). Cheyne drew on a mechanical metaphor of the body, constructing it as “a complex series of pumps, pipes and canals [that could only be] maintained by the correct input of food and liquid, appropriate exercise and careful evacuation” (Turner 1982: 260). In a series of popular books published between 1724 and 1742 Cheyne theorised a rich diet — “the rarest delicacies, the richest foods, and the most generous wines” — caused illness amongst “the Rich, the Lazy, the Luxurious, and the Unactive, those who fare daintily and live voluptuously” (Cheyne 1733: 28, cited in Lupton 1996: 70).

Cheyne’s work had affinities with other areas of asceticism, and most particularly religious asceticism. Turner believes that John Wesley, the founder of Methodism, was directly influenced by the dietary asceticism promoted by Cheyne, not a surprising link

considering the familiar spiritual practice of disciplining the body and purifying the soul through strict dietary practices.<sup>1</sup>

In contrast to Turner's rendering of nutritional history, Aronson argues that nutrition emerged in the late eighteenth and early nineteenth centuries through scientific knowledge of organic chemistry and its application to physiology (Coveney 1999: 23-4). She suggests that the origins of rationalisation of the modern diet were located not in Cheyne's ascetic dietary regimes but in calculations about the food needs of different groups of people, of how the body converted food into energy (Aronson 1982: 54). In this discourse, the body was seen as "a thermodynamic system in which food constituents provided energy for caloric output as work" (Coveney 1999: 24). Institutional populations in jails, armies and workhouses were researched in order to provide evidence about differing manual labours, occupations and lifestyles and the corresponding dietary requirements.

Despite the cogency of each argument, Coveney suggests that these positions are actually two sides of the same system of thought: "the concern with the moral order has been, and indeed continues to be, central to and intimately bound with scientific enterprise" (1999: 24-5). The false separation of asceticism and science, he goes on to argue, has come about by locating the discovery of nutrition in the hands of bright physicians or scientists, as Turner and Aronson have done. Rather, nutritional science was "produced at a time when a range of population sciences such as social statistics, social sciences and population medicine informed the regulation of the law, poverty, health, life and conduct of individuals through the normalisation of mundane activities" (Coveney 2000: xi). Within his Foucauldian analysis, nutrition developed amidst a number of historical developments and social procedures, rather than individual lives.

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<sup>1</sup> This connection between Christian asceticism and the rise of science was also clearly made in Weber's *The Protestant Ethic and the Spirit of Capitalism* (1930).

These developments, which came to fruition in the nineteenth century, were “part of a panoply of technologies and strategies designed to better manage populations” (ibid).<sup>2</sup>

Coveney notes how dietary guidelines for populations, initially developed in the United States in the 1970s, have now been developed for nearly all countries in the industrialised world:

Although differing slightly in content, these guidelines spell out dietary goals for each country’s population, for example, “eat less fat”, “eat more fruit and vegetables”, “eat less sugar”, “eat less salt” and so on. (Coveney 1999: 23)

It is clear from this very brief overview of the history of nutritional science that there has been an increasing concern for the governmentality of people’s diets. This regimentation, in Foucault’s terms, has meant an increased surveillance, rationalisation and regulation of what people eat, all supported and authenticated by scientific claims and knowledge of the medical field. ‘Diet’ has become a highly visible aspect of people’s lives that should be regulated in the interests of good health.<sup>3</sup> It has also become a moral question, “involving issues of an individual’s capacity for self-control and work and the avoidance of waste and excess” (Lupton 1996: 73). Coveney sums up this convergence of institutional structure and everyday practice:

On the one hand there was a government of others [populations] through the development of food classifications, registers and recommended allowances against which food habits could be scientifically assessed, complete with the survey as an instrument of ‘the panopticon’ (Foucault’s ‘technologies of power’). On the other hand, through the imperative to eat ‘properly’, nutrition was constructed as a moral choice where individuals were required to be ethical; to problematise their food choices, consider their actions, thoughts and desires

<sup>2</sup> While agreeing with this argument, it is located within a particular historical (and cultural) period. Mennell (1991: 138) notes how medicalisation had little impact on the dietary regimes of those who were not ill prior to the ‘modern era’. Rather, he argues (along the lines of Norbert Elias) that it was “the progressive move towards the ‘civilising’ of appetite, with its emphasis on refinement, delicacy and self-control as a sign of courtly manners, rather than explicitly medical reasons that began to change dietary habits in Europe in the sixteenth and seventeenth centuries” (Mennell 1985, cited in Lupton 1996: 68). And of course, prior to these times were the early Hippocratic injunctions concerning personal hygiene and maintaining a balance in one’s diet for good health. For a comprehensive overview of attitudes to food in late antiquity see Grimm (1996).

<sup>3</sup> Coveney (1998, 1999, 2000) uses Foucault’s insights to characterise the ways in which ‘people’, ‘populations’, ‘the public’ and ‘individuals’ are disciplined by nutritional discourses. While such analysis contributes significantly to the history of nutrition, Coveney’s argument, like Foucault’s, fails to account for the gendered nature of the disciplined body.

in hopes of becoming ‘good’, rational, healthy subjects (Foucault’s ‘technologies of the self’). (Coveney 1999: 33)

The salience of these nutritional ideas, of scientific evidence and moral imperatives, is readily available in the public domain. It is taken for granted that most people have had some level of engagement with these nutritional ideas, either through schools, family environments, public health campaigns, children’s centres, local health practitioners, the media, and even from packets of supermarket food. One participant learned of the moral values and dangers of cholesterol and fats through her mother’s work at the Heart Foundation. Maddy had ready access to the health promotional literature that outlined the ‘good and bad fats’, including the suggested daily intake and the effects of too much fat on one’s body and overall health.<sup>4</sup> Armed with this knowledge, she limited herself to 3000 kilojoules a day (fats were ‘blacklisted’) and in a scientifically rigorous manner she meticulously measured and recorded her daily oral intake.

Conforming with orthodox nutritional advice, people seek to control their diet to achieve ‘good health’, rather than eating foods which they may prefer because of taste. The very notion of ‘nutrition’, Lupton (1996) suggests: “is a functionally orientated one: food is for nourishing, for fuelling the body, for building bones, teeth and muscle, a means to an end. Food preferences, tastes and habits are considered secondary to what food does biologically to the body” (Lupton 1996: 7). This stripping of the sociocultural context of nutrition was promoted by some health professionals in my fieldwork. A psychiatric nurse, for example, responded to Angela’s anxiety and fear of foods that she was presented with on a weight gain program by suggesting that she think of food as: “just a fuel. It’s just a fuel to keep the body running, nothing more”.

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<sup>4</sup> Austin (1999) argues that public health promoters have unwittingly served to fuel “obsessive concerns with food, fat and diet” (1999: 263).

The relationship between nutritional status, health and food consumption is one that can be reproduced with ease. In her analysis of the relationship between food, embodiment and subjectivity, Lupton (1996) asked participants in her focus groups and interviews to describe ‘unhealthy foods’ and found that:

... almost all of them nominated fatty or ‘greasy’ foods, junk or fast food, salty foods, fatty red meat, chocolate, soft drinks and other sugary foods. Foods described as ‘healthy’ were typically vegetables and fruit (particularly if ‘fresh’), salads, whole grains, lean meat, chicken and fish. (Lupton 1996: 81)

Again, these guidelines of healthy and non-healthy foods were clearly used by participants in this project. Beth showed me her lists of bad foods and good foods.<sup>5</sup> The bad food list, which was more than twice the length of the other, had ‘fried’ as the first listed food: this included fried bacon, egg, chips and rice. After this, foods high in fat content were marked (cheeses, pizza, biscuits and red meats), followed by processed foods and those high in sugars and complex carbohydrates. The good food list included most vegetables and fruits (excluding pears and potatoes), low fat yoghurts, high calcium/low fat milk and skinless chicken.

Any of the public spaces mentioned above, from child care services to a general practice waiting area, will have a poster exhibiting the “Five food groups pyramid” – a hierarchical arrangement with the ‘bad’ foods at the top (fats and oils) and the ‘good’ foods at the bottom (vegetables and cereals). Participants were conversant with this model, often telling me about the pyramid in conversations about food. When Elise left the hospital program she confided in me that she had reverted to eating only from the bottom of the pyramid: fruit, vegetables, rice, cereal, low fat milk and diet yoghurt.

As the historical outline of nutritional discourse reveals, the ideas of healthy food are constantly changing. The most recent change to nutritional education (which occurred

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<sup>5</sup> Santich (1995) describes the way “nutrition encourages a ‘good’/‘bad’ dichotomy by producing a food hierarchy based on what is considered nutritious” (Santich 1995: 146, cited in Coveney 2000: 28).

during my fieldwork) has been in the replacement of the triangular model with a circular one (See Plate 2). It was via the ABNA newsletter that I learned of this change and saw the new representation of ‘healthy eating’. Although the visual hierarchy has gone, five food groups remain, yet the once included unhealthy category of fats and oils is relegated to the corner of the image – “choose these sometimes in small amounts”. In many ways, fats and oils have been marginalised even further from daily consumption. Fat is no longer considered to be a valuable component of food consumption in this diagram. Despite the distinction of ‘good and bad fats’ (of polyunsaturated and saturated), contemporary nutritional, medical and popular discourse continue to represent fat as ‘unhealthy’, ‘bad’ and ‘unnecessary’.

Why have fats been further marginalised from daily food consumption? At the most basic level, it is the literal translation of the word ‘fat’. If one consumes fatty foods, then one will become fat. As the moralistic dietary message reminds us: “we are what we eat”. Dietary messages constantly tell readers to reduce their fat intake, and if one consumes more than the daily requirement of fat then you will become fat.<sup>6</sup> For people with a diagnosis of anorexia fat literally translates into a physical and emotional feeling, as Estelle explained: “we don’t say – ‘oh I feel a bit sugary today’, but will often say ‘I feel fat’ or ‘I am fat’”. Estelle further explained why she able to eat sugar, but not fat:

I guess it’s because sugar dissolves - it’s not such a solid thing - do you know what I mean? You get sugar in a soft drink or something and it doesn’t leave the same sort of greasy or heavy feeling either, and you can see fat whereas sugar - I suppose I got the image of sugar dissolving into my system and going into my muscles and being burnt off like that whereas I had the image of the fat sort of just sitting in my stomach. You think of this stuff here (she pinches her stomach) and you think of that as fat, not sugar ... like everyone says ‘you’re fat’, not sugar ... I feel fat because I ate fat ... I could almost imagine it just going straight onto my thighs, or my bum, or my tummy whereas the sugar I imagine diluting through my system.

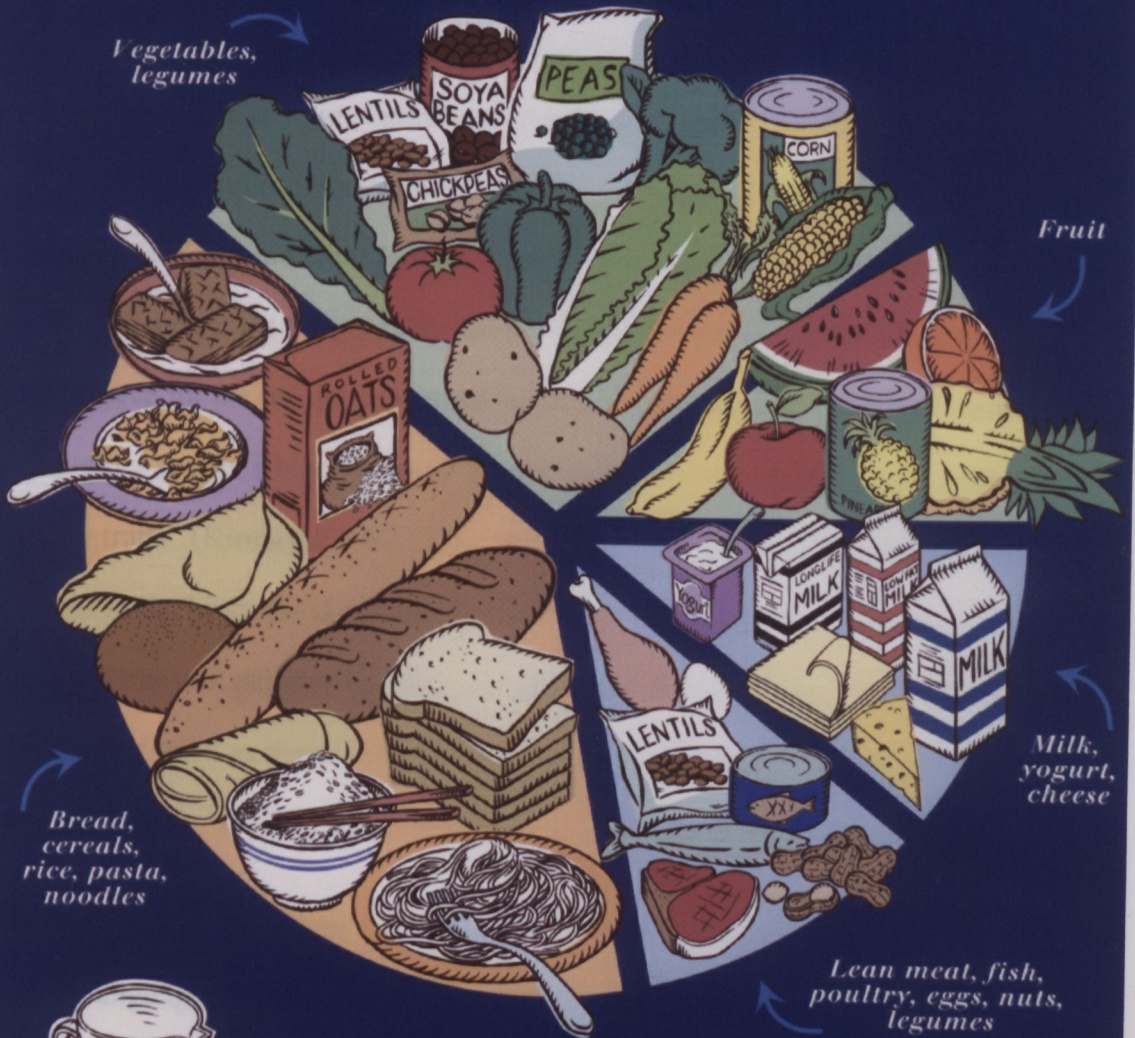
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<sup>6</sup> This dietary message is manifest in the brand name advertising of foods such as *Lean Cuisine*, *Lite*, and *Healthy Choice*.

WHEN FAT IS NOT 'FAT'

THE AUSTRALIAN GUIDE TO HEALTHY EATING

# Enjoy a variety of foods every day



Bread, cereals, rice, pasta, noodles

Vegetables, legumes

Fruit

Milk, yogurt, cheese

Lean meat, fish, poultry, eggs, nuts, legumes



Drink plenty of water

Choose these sometimes or in small amounts



Plate 2. Food Circle

concepts of food and the... distributing... to an eating disorder... a person's... manual

## WHEN FAT IS NOT 'FAT'

People with anorexia clearly used the rhetorical devices of 'fear of fat' that are current in popular and nutritional discourses. But the meanings associated with the language were not always the same. I found that there were additional meanings of food and fat that were unavailable to those who did not belong to anorexia.

In his discussion on the role of embodied metaphor, Kirmayer (1992) highlights the ways in which people attribute entirely different meanings to the same, seemingly neutral 'facts'. He outlines the 'case' of 'Mr Y', a 35 year old businessman receiving haemodialysis for chronic renal failure. The doctors wanted Mr Y to have a blood transfusion to correct his dangerously low haemoglobin levels, but he refused. The reasons he gave for his refusal concerned ideas of contamination, as he was "terrified of receiving other people's blood because it may contain genetic material that carries their personality traits" (Kirmayer 1992: 325). The doctors considered this rationale absurd, as blood — in the biomedical domain — does not "contain genetic material ... and genes do not transmit personality from one adult to another" (ibid). Mr. Y understood the blood transfusion as threatening his bodily boundaries, of transgressing and polluting his body. 'Blood' for the patient was not 'blood' for the physician.

Kirmayer is drawing the reader's attention to the assumed universality of the meanings of medical language. Within biomedicine, the 'facts' of biology are a given, and patients who hold differing beliefs are, in the case of Mr. Y, referred to a psychiatrist. Differing viewpoints are seen as false beliefs, misapprehensions, or "some hidden perversity of the patient's mind" (ibid: 326).

I found a similar assumption at work amongst health professionals in relation to concepts of food and fat. During ward rounds it was assumed that factors contributing to an eating disorder were generally located in a person's upbringing — their sexual



history, family relationships — and their inability to cope with these. Very little space was given to people’s experiences of their bodies and relatedness outside of this framework. There was, for example, no investigation of a young Jewish girl’s beliefs surrounding the dietary law of her religion.<sup>7</sup> When I asked the treating psychiatrist if her beliefs might have a connection to the way she experienced anorexia, he replied: “it has nothing to do with her anorexia”. Another woman had travelled extensively and lived in Japan, where she consulted a Japanese herbalist about her dietary concerns. Her “mystical ideas about food”, and the belief that “her internal organs were twisted, sick and out of place” were pathologised as a somatic illness or schizophrenia. She was described in the ward round as “quite mad”, “not run of the mill”, and “quite an unusual one”.

How people with eating disorders view food is not central or problematic for health professionals. It is assumed that they take everyday, common sense, dietary guidelines to the extreme, to the point where they are no longer common sense and hence “manifestations of individual pathology, of dysfunctional beliefs or faulty cognitions” (Malson 1998: 128). Yet as Geertz (1973) and more recently Herzfeld (2001) have highlighted, ‘common sense’ is in and of itself a cultural system: “If common sense is as much an interpretation of the immediacies of experience, a gloss on them, as are myth, painting, epistemology, or whatever, then it is, like them, historically constructed and, like them, subjected to historically defined standards of judgement” (Geertz 1973: 76).

Anorexia is commonly referred to as ‘the slimmer’s disease’, a diet that has just gone ‘too far’. The current diagnostic definition, either from the American Psychiatric Association 1994/2000 or the World Health Organisation 1992, assumes that people

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<sup>7</sup> Eckermann claims that “research continues to show a relationship between ‘eating disorders’ and religious affiliation” (1994: 94). One such study, Sykes *et al.* (1986) reported a strong correlation between Catholic and Jewish women and eating disorders.

with eating disorders are afraid of becoming fat, and as a consequence, actively avoid fatty food. Although there are slightly different criteria in each definition<sup>8</sup>, each includes references to the “fear of gaining weight or becoming fat”, “feeling fat” and “the avoidance of fattening foods”.<sup>9</sup>

But like Mr. Y, people with anorexia can have quite different beliefs about the nature of food and fat. ‘Food’, like ‘blood’, is not always ‘food’ for the patient. It was not until I was four months into my fieldwork that I became aware of the differing meanings associated with foods. I too had assumed that people with anorexia have a fear of fat and high calorie foods and therefore avoid them. This was certainly how many people (including those diagnosed and health professionals) talked about anorexia, but there were a number of other meanings also at play. For a large number of participants, food was not life giving, it was *life threatening*. It was characterised as disgusting, polluting, contaminating, evil, poisonous, dirty, defiling and harmful. Fats (butter, margarine and oils), in particular, were the most dangerous, and not simply because of their ‘fat’ content, but because of their form, their ability to move and seep into the ‘cracks’ of one’s body. It was these properties of food and fat that were intensely feared by people, a fear that extended far beyond the concern of weight gain *per se*.

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<sup>8</sup> Malson (1998) notes the variations in percentage weight loss considered necessary for diagnosis: Whereas *IDC-10* (WHO 1992) and *DSM-III-R* (APA 1987) [and *DSM-IV* (APA 1994)] state that weight loss (or lack of expected weight gain) should be at least 15 per cent, *DSM-III* (APA 1980) states 25 per cent and others (e.g. Meskey 1980) state 20 per cent. Precisely how much weight a woman has to lose before she is pathologised seems to vary, and to some extent the decision is arbitrary. (Malson 1998: 3)

<sup>9</sup> Although fear of fat or fat phobia is central to the ‘western’ diagnosis of anorexia, a number of commentators argue that it is not a universal feature. In reviewing the literature, Katzman and Lee (1997) highlight those studies that do not support the taken-for-granted diagnostic assumption of fat phobia. Lee *et al.* (1993), for example, report no fear of becoming fat amongst anorexic patients in Hong Kong. Kok and Tian (1994) similarly report no fat phobia in large scale surveys amongst those with anorexia in Singapore.

## FOOD AS ‘MATTER OUT OF PLACE’

Throughout my fieldwork I had been asking people how they experienced food, and what different foods meant to them. Common sense dietary laws were easily articulated and there were times when I thought there was perhaps no other meanings of food in operation, until a casual response highlighted a new way of understanding and experiencing food. Rita alerted me to a different framework around foods, one which drew on current nutritional advice, but also had its own language, meanings and practices. She assured me that these beliefs were part of the “manual of eating disorders” and that most members of “the club” would share the same understanding. She was surprised that she was the first to explain this to me, suggesting that it was central to many people’s experiences of anorexia.

On reflection, part of the hesitancy in describing the ‘hidden meanings’ of food and fats was related to the overall secrecy of some anorexic practices. The perception amongst those with anorexia was that these beliefs (and what was done to counter them), were perceived by others to be “very unusual”, “weird” and “strange”. These beliefs were described to me only when relationships were well established, often through casual remarks or practices, and almost exclusively couched in terms of embarrassment and irrationality.

In many ways, though, I should not be surprised at the time it took for people to share this with me. Stoller (1997) describes any fieldwork situation as like an apprenticeship, where people choose to invite the ethnographer at different times to learn new meanings and understandings about certain events or practices. As described in Chapter Two, when I entered the field I was at the ready for that which was unfamiliar to me.

Ironically, though, it was by attending to what was most familiar that provided me with an entrée into a whole new belief system around food. It was through embodiment — the sensory, the visceral and the unspoken — that I began to learn of different levels of

meaning. What initially obscured my understanding of how people with anorexia experienced food was my own assumption that we were sharing the same meanings of language and visceral responses to food.

Rita and I would often meet in the afternoons at a public park not far from her house. We'd meet in the car park, and then walk to a nearby wooden seat that overlooked a large pond and the grounds of the park. Being an animal lover, Rita once brought a loaf of white bread to feed the ducks as we sat and chatted. We both broke the bread into small pieces and threw it to the ever-increasing number of expectant ducks. When it looked as if the ducks were losing interest, Rita closed the opening to the plastic bag of bread, turned on the seat and looked earnestly around the park. I asked her what she was looking for and she replied: "I'm looking for a tap or a toilet block to wash my hands ... 'Why do you need to wash your hands?' I asked ... 'oh', she said quite matter of factly, 'because they're dirty, I've touched food'". This was the first time I had 'twigged' to the correlation between food and dirt and I could not overlook this response to food. Rita told me that she always washes her hands after she touches food, most particularly foods that are greasy and slimy, such as oils, butters and uncooked meat. She also described a hierarchy of foods that was not necessarily predicated on the food pyramid or calorie or fat content. It was a hierarchy of clean and dirty foods:

Vegetables are okay to touch - they are 'clean' and 'pure' - whereas other foods, and the greasy ones in particular are 'defiling', 'disgusting' ... 'polluting' and 'contaminating' ... You pollute your body by ingesting this stuff called food ... I find putting food in my mouth repugnant.

I returned to my field sites with a new focus. Many nodded knowingly and enthusiastically when I asked about 'dirty foods', one woman telling me that I had now come a long way in my understanding of eating disorders. In reflecting on her experiences Trudy sent me an e-mail:

Much of my anorexia was about being ‘clean’ versus ‘dirty’. Not eating was clean. Eating was dirty, contaminating. It was not about being fat or thin. Nor was it about weight.

Looking back over my earlier fieldnotes I could now see these themes of purity and dirt circulating in people’s narratives. My first informant Sonya similarly described her wish to not eat in order to be “empty and clean ... I felt dirty when I ate. I still do sometimes, sort of grimy”. Despite some idiosyncratic changes to lists (some, unlike Rita, viewed bread as clean), fats, oils, butters and meat (particularly red meat) all came under the rubric of ‘dirty’.

Surprisingly, there are few authors (including those writing autobiographical works) who explore at any length the ways in which food is talked about and experienced by people with anorexia. Even though Malson, for example, reported that her informants viewed food as “dangerous, dirty, and disgusting” (Malson 1998: 126), food is explained within a broader discourse of mind/body control. She suggests that food has become an object in dualist discourse, where “body management becomes central to the maintenance of self-integrity, and eating becomes an occasion when the body, something that is “not me, ‘takes over’ and triumphs in the discursively produced conflict between mind/self and body ...” (ibid: 125).

Bordo similarly describes the triumph of the will over the body in the following example: “One woman describes how after eating sugar she felt “polluted, disgusting, sticky through the arms, as if something bad had gotten inside me”” (Bordo 1988: 95). Rather than exploring the particularities of language and embodiment, Bordo draws on a religious framework to explain this “tainting of the flesh” (ibid).

The foods that Malson, Bordo and others (Hepworth 1999) talk about are almost a generic label: either a gloss for all foods, or an extension of nutritional education, good and bad foods, indulgent and dietary foods. There is no discussion of the distinction

between foods.<sup>10</sup> When, on occasion, the embodied sensations of food are mentioned, they are overlooked or subsumed into disembodied discourses. What is lacking from the literature is an exploration of which foods in particular are defiling, and why some foods are more polluting than others. How do certain foods become dirty?<sup>11</sup>

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In *Powers of Horror: An Essay On Abjection* (1982) Kristeva suggests that “the logic of prohibition, which founds the abject, has been outlined and made explicit by a number of anthropologists concerned with defilement and its sacred function in so-called primitive societies” (1982: 64). Of these anthropologists it is Mary Douglas to whom Kristeva is most indebted, in particular her concepts of ‘dirt’ and ‘classification’. Although criticised by Kristeva, Douglas’ classificatory schemes have much in common with Kristeva’s own psychoanalytic theory of abjection and emergent subjectivity, and cannot be described without this acknowledgment. The following section briefly explores the value of Douglas’s ideas, examining the critiques and the subsequent departure that Kristeva takes.

Participants’ use of the words dirty and clean was akin to Douglas’s formulation of these terms. In *Purity and Danger* (1966) and *Implicit Meanings: Essays in Anthropology* (1975), Douglas describes how the concept of dirt emerges from a culture’s classificatory system of order. It is at the margins or boundaries of these systems though, that categories are most threatened and vulnerable. Some people, materials, events or behaviours do not fit easily into these bounded categories and may

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<sup>10</sup> One exception is MacSween (1993) who investigated what foods women with anorexia eat, why they chose particular foods, their favourite foods and what they would never eat. She concluded that food in anorexia is separated into two distinct categories: food as safe (low calorie and non-fattening) and dangerous (pleasurable and fattening). “Food that gives pleasure is dangerous food; the aim is to eliminate the pleasure, and eventually the food itself” (1993: 215). While MacSween introduces Douglas’ (1966/84) concept of ‘matter out of place’, it is ritual rather than pollution that she focuses on: “For the anorexic woman all eating is dangerous and transitional, and ritualisation is an attempt to make it progressively safer by divesting it as far as possible of spontaneity and response to desire” (MacSween 1993: 207).

<sup>11</sup> I am aware of my own exclusion of fluids in this discussion.

be entirely ambiguous in their positioning. Those things that “blur, smudge, contradict, or otherwise confuse classifications” (Douglas 1975: 51) are considered out of place. And what is out of place, Douglas argues, is threatening to the social order and labeled as dirty, dangerous and polluting (cf. Wood 1997: 28-29).

One of Douglas’ classic examples of purity and danger relates to Jewish dietary law and the prohibition of certain foods laid down in the Old Testament book of Leviticus. In her chapter *The Abominations of Leviticus* Douglas asks:

Why should the camel, the hare and the rock badger be unclean? Why should some locusts, but not all, be unclean? Why should the frog be clean and the mouse and the hippopotamus unclean? What have chameleons, moles and crocodiles got in common that they should be listed together? (Douglas 1966/1984: 41)

She answers these questions by applying her theory of dirt, marginality and pollution. Only those animals who “fully conform to their class” (Douglas 1966/1984: 55), such as birds that fly, fish that have fins and scales, and animals that walk on all four feet, chew their cud and have cloven hooves are considered clean (ibid: 54-7; cf. Grosz 1989: 75). Pigs were forbidden to Hebrews because they were creatures considered to be anomalous under this given system of classification based upon chewing the cud and cloven-footedness. Pigs (and camels) are cloven footed but are not ruminant and this, Douglas argues, is the only reason given in the Old Testament for avoiding them (Douglas 1966/1984: 55). Their positioning was ambiguous and therefore impure or polluting (Caplan 1994: 7).

Similarly, those creatures that cross the boundaries of habitat (through indeterminate forms of movement such as creeping, crawling or swarming) are “explicitly contrary to holiness” (Douglas 1966/1984: 56). The snake, for example, which *slithers* indeterminately on land or in the water, does not adhere to rigid categories and is therefore unclean, dangerous and not fit for consumption.

Douglas applies this classification of boundaries to the body. The body, she argues, is a model that can stand for any bounded system:

Its boundaries can represent any boundaries which are threatened or precarious. The body is a complex structure. The functions of its different parts and their relation afford a source of symbols for other complex structures. We cannot possibly interpret rituals concerning excreta, breast milk, saliva and the rest unless we are prepared to see in the body a symbol of society, and to see the powers and dangers credited to social structure reproduced in small on the human body. (Douglas 1966/1984: 115)

The body thus becomes a metaphor that is used “in different ways to reflect and enhance each person’s experience of society” (Douglas 1973: 16).

As with any bounded system, the body is most vulnerable at its margins (the skin) and external openings/orifices (for example, the mouth, nose or vagina):

... all margins are dangerous ... any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolise its specially vulnerable points. Matter issuing from them [the orifices of the body] is marginal stuff of the most obvious kind. Spittle, blood milk, urine, faeces or tears by simply issuing forth have traversed the boundary of the body. (Douglas 1966/1984: 121).

Sexual fluids, like food, have a liminal status in terms of attesting to the permeability of the human body for they cross its boundaries. Of the bodily fluids, Douglas argues, the ones that are related to bodily functions of digestion and procreation (for Douglas and Kristeva this is menstrual blood rather than semen) are the most defiling (Douglas 1966/1984: 125).

Dirt or filth in Douglas’ terms is not an inherent quality, but applies to a boundary and, more particularly, “represents the object being jettisoned out of that boundary, its other side, a margin” (Kristeva 1982: 69). Danger arises “from failure to control the quality of what [the body] absorbs through the orifices; fear of poisoning, protection of boundaries, aversion to bodily waste products ...” (Douglas 1973: 16).

Douglas’ concepts of dirt, danger and pollution are particularly apt when exploring participant’s fear of certain foods. Coming into contact with food was described by



participants as a dangerous liaison, as it was a polluting substance that crossed bodily boundaries. Several attributed food with the properties of a contagious disease; it was “out of bounds” and to be avoided “like the plague”. For many, the very act of eating — of food passing into the interiors of the body— was described as contaminating and polluting. Rita described bringing food to her lips and into her mouth as “utterly repugnant”, as it marked the passing of a pollutant (food) into her body:<sup>12</sup>

I don't like anything on my lips. It's a sensation which I really don't like ... I've never worn lipstick for that reason. You see, when you eat you actually try to make as little contact with your mouth as possible. You actually put the food directly in without touching the lips – that's the aim – chew and swallow and the whole operation needs to be awfully quick.

Lips were the gatekeepers to her mouth, “an interesting piece of facial equipment” that Rita described as “a soft, moist and sensitive area”. Once inside the mouth, food had contaminated her body. It had crossed from “the external into the internal world ... it's inside you, it has been imbibed, and internalised and there is a sense of feeling dirty, and impregnated with something ...”.

Skin contact with food was also problematic, as Rita's earlier account of touching bread demonstrated. Beth said that the only way she could explain the abhorrence of touching food was by describing something to me that “would make your body wretch”:

I felt dirty in regards to all food I ate. I felt contaminated for want of a better word. I only felt pure when I was empty ...

*When you say contaminated, what do you mean?*

Like (pause) impure and sort of sullied ... I'll try and describe it. You know how, just say if you're sitting on the grass outside and you turn around and put your hand in dog poo, it's that sort of feeling, that sort of contamination ... so you don't want to prepare food – well I wouldn't anyway, but you don't touch anything.

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<sup>12</sup> When I went to visit Rita with my baby daughter she exclaimed how pleased she was that Freya was being breast fed and had not yet been contaminated by food. In Rita's eyes, Freya was 'pure'.

Beth's equation of food with excreta was similarly expressed by other participants. Food, and fats in particular were described as "dirt", "filth", "junk", "rubbish" and "shit".<sup>13</sup>

Foods that move (like fats and oils) are potentially dangerous and polluting because of their ambiguity within Douglas' classificatory system. Moreover, in this schema food is doubly defiling because it passes through the oral boundary of the mouth, thereby transgressing the boundaries and margins of bodily order. Once inside the body, food mixes with saliva and travels through the alimentary system, and is transformed into an unrecognisable substance through digestion. Rita captures this horror of digestive transformation:

*You know this idea of food as polluting or contaminating - how would you describe the polluting or contamination - how does it work?*

It's like injecting or introducing - you might as well be drinking thick, gunky, sticky<sup>14</sup> glue - that's the image of ingestion - sticky, and gunky, and slidy and slimy - it turns into all of that as it goes through - it turns into gunk ... because I'm bulimic now and I'm bingeing. I see food as not only in and of itself junk and gunk and rubbish that I'm imbibing and therefore becomes even worse - it makes me fat and it's like I'm loaded up with - it's like I'm a balloon of glue or something - an ugly bag of gunk ... and it's so much better to not eat - it's much better to abstain.

Digestion and decomposition move food from one category to another, from food to waste.

While Douglas provides many insights into participants' experiences of food, this research also highlights the limitations of her theory. This is not to say that Douglas is outmoded or irrelevant; far from it. My critique of her work, which is in line with numerous others, has made possible a trajectory of ideas concerned with embodiment,

<sup>13</sup> In Shute's novel *Life-size* (1992) there are similar equations of food with bodily waste products. In writing from her hospital bed about her experiences of anorexia, Josie described food as like excrement, mucous and urine.

<sup>14</sup> Two participants found the stickiness (rather than the caloric content) of jam and honey to be most problematic. Douglas (1966/1984), quoting Sartre from *Being and Nothingness* (1943), notes the horror and ambiguity of things which are sticky: "the viscous is a state half-way between solid and liquid ... it is unstable ... it attacks the boundary between myself and it ... to touch stickiness is to risk diluting myself into viscosity" (Douglas 1966/1984).

and as I outlined in the introduction, most particularly with the relational and sentient aspects of embodiment.

The main critiques of Douglas' work lie within a broader critique of the structuralist genre of anthropological theory. Her work is clearly informed by the intellectual legacies of sociological and anthropological theorists, of Durkheim, Mauss and Levi-Strauss. The general theme of Douglas' work is the relationship between the social and physical body, in that the social body constrains how the physical body is perceived and experienced (Shilling 1993: 73). Thus, as she argues in *Natural Symbols* (1973), the human body is the most readily available image of a social system; it is a metaphor of society as a whole. These theories are "sociocentric", in that Douglas "has her eyes uncompromisingly fixed on society as such" (Strathern 1996: 15).<sup>15</sup>

Emphasis on a 'social body' results in a body that is profoundly disembodied, far removed from the phenomenological worlds of lived experience and practice. In Douglas' formulation (and Malson and Bordo's above accounts), lived bodies are reduced to positions and categories made available by the broader social body. Moreover, her two bodies – the social and physical – reiterate the distinctions between mind and body, culture and biology. Within this formulation the 'individual' body continues to reproduce these Cartesian binaries, of a contained, rational 'unit' that has distinct boundaries of inside/outside. The ontology that is at the very heart of

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<sup>15</sup> Counihan (1999) reproduces this metaphoric transposition of body to society in her brief analysis of eating disorders. She cites Douglas' argument in order to explain fasting:

Mary Douglas asserts that the 'human body is always treated as an image of society' and that the passage of food in and out of the body can stand for social boundaries and their transgression (1973: 70). Most important for our concerns here is her claim that 'bodily control is an expression of social control' (ibid). Western women's strong concern to control their food intake is a metaphor for their efforts to control their own bodies and destinies in a culture that makes self control a moral imperative. (1999: 99-100)

Garrett (1992) similarly draws on Douglas' themes in her analysis of anorexia as a purity ritual. She argues that 'the body' of anorexia is used as "a diagram of a social situation", as "a personal ritual that is an attempted solution to social problems" (1992: 14). Moreover, while she critiques Chernin's (1986) problematic distinction between nature/culture, she reproduces a number of dichotomies (of individual/society and nature/culture) in her own work. She characterises anorexia for example, as "a ritual which represents rejection of life and connection with nature ... the fear of connection between the individual and the outer world" (Garrett 1992: 14).

structuralist thinking has been heavily critiqued, for it configures the body as representational: as fixed, ahistorical, prescriptive and universal (cf. Leder 1990; Csordas 1994).<sup>16</sup>

## UNDERSTANDING ABJECTION

Although relying heavily on Douglas' concepts of dirt and pollution, Kristeva similarly distanced herself from what she called the "structural-functional X-ray of defilement" (Kristeva 1982:69):

As a matter of fact, the explanation she [Douglas] gives of defilement assigns in different statuses to the human body: as ultimate cause of the socio-economic causality, or simply as metaphor of that socio-symbolic being constituted by the human universe always present in itself. In so doing, however, Mary Douglas introduces willy-nilly the possibility of a subjective dimension within anthropological thought on religions. Where then lies the subjective value of these demarcations, exclusions, and prohibitions that establish the social organism as a "symbolic system"? (Kristeva 1982: 66)

In *Powers of Horror* (1982), Kristeva shifted Douglas' focus from the social body to the lived experience of gendered bodies (in this case female), and redirected the analyses from structuralism to psychoanalysis, from semantics to subjectivity. It was, as I argue below, a shift from one extreme to another.

Abjection is a somewhat slippery concept to define, for it has multiple dimensions and is capable of different interpretations. As stated in the introduction to this thesis, the word 'abject' literally means to cast off, to exclude or prohibit, yet abjection is defined by its relationship to desire — "like an inescapable boomerang, [it is a] vortex of

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<sup>16</sup> Jackson similarly critiques this representational bias in the anthropology of the body, using the disembodied nature of Douglas' work as example:

... the human body [in these writings] is simply an object of understanding or an instrument of the rational mind, a kind of vehicle for the expression of a reified social rationality ... subjugation of the bodily to the semantic is empirically untenable ... meaning should not be reduced to a sign which, as it were, lies on a separate plane outside the immediate domain of the act. (Jackson 1989: 122-3, cited in Csordas 1994: 10)

In exploring bodily experiences, Jackson calls for evocation rather than representation, a task that should be phenomenological in nature (ibid: 205-8).

summons and repulsion[s]” (Kristeva 1982: 1).<sup>17</sup> Even so, it seems impossible to name abjection, for, as Kristeva writes:

When I am beset by abjection, the twisted braid of affects and thoughts I call by such a name does not have, properly speaking, a definable *object*. The abject is not an ob-ject facing me, which I name or imagine ... The abject has only one quality of the object — that of being opposed to *I*. (ibid: 1, emphasis in original)

Abjection thus *refer* not only to a “sensation and attitude” (Grosz 1990: 87), but to that which is expelled “as well as to the act of throwing it away” (Ellman 1990: 181). Abjection also refers to a space between the pre-oedipal and oedipal, a space of simultaneous pleasure and danger, of repulsion and attraction. As neither subject or object, abjection is “an unnamable, pre-oppositional, permeable barrier that requires some mode of control or exclusion to keep it at a safe distance from the symbolic and its orderly proceedings” (Grosz 1990: 93).

Kristeva’s psychoanalytic theory of abjection is concerned with an individual’s process of self-identification. She claims that this process occurs in the early years of life when a child gains identity and a place within the symbolic order by separating from its mother. Abjection thus testifies to a break in the mother-child dynamic where the territorialisation of space is enacted. It is the space of struggle against the mother, the “earliest attempts to release the hold of *maternal* entity even before ex-isting outside of her ... It is a violent, clumsy breaking away, with the constant risk of falling back under the sway of a power as securing as it is stifling” (Kristeva 1982: 13, emphasis in original).

Symbolic language, Kristeva argues, is central to this break, for subjectivity has its genesis in the delimitation of the ‘clean and proper body’, a process that constitutes an awareness of corporeality and bodily boundaries. This awareness centres on the child’s

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<sup>17</sup> Although desire is central to Kristeva’s concept of abjection it is linked to a psychoanalytic (Lacanian) legacy of negativity. While an analysis of the theoretical debates concerning desire is outside the scope and direction of this thesis, the ethnography clearly demonstrates the ways in which desire is experienced as both lack *and* a productive force. I thank Melissa Iocco and Ingrid Hofmann for making this clear for me.

acquisition of language, for it is when the child learns the language associated with ‘proper’ sociality that subjectivity is possible. Through expulsion and exclusion of the improper, the unclean and the disorderly elements of corporeality, the child can take up a symbolic position as a social and speaking subject. For Kristeva, the processes of subjectivity are “intertextual practices ... subjectivity is enacted by way of language” (Kristeva 1990:175, cited in Reineke 1997: 19).<sup>18</sup>

Although abjection is predicated on the polarisations of inside/outside and subject/object, abjection is not reducible to these oppositions. What is excluded from the body can never be fully obliterated but hovers at the borders of existence. “We may call it a border”, Kristeva writes,

... [but] abjection is above all ambiguity. Because, while releasing a hold, it does not radically cut off the subject from what threatens it — on the contrary, abjection acknowledges it to be in perpetual danger. But also, abjection itself is a compromise of judgement and affect, of condemnation and yearning, of signs and drives. (Kristeva 1982: 9-10)

Abjection, as Grosz writes, “cannot be readily classified, for it is necessarily ambiguous, undecidably inside and outside (like the skin of milk), dead and alive (like the corpse), autonomous and engulfing (like infection and pollution)” (Grosz 1989: 74). It is not either one thing or another (as structuralism would have it), but it is both these states. Abjection, therefore, is fundamentally “what disturbs identity, system, order ... [it] does not respect borders, positions, rules ... [it is] the in-between, the ambiguous, the composite” (Kristeva 1982: 4).

The three broad categories of abjection that Kristeva identified—food and thus bodily incorporation; waste; and the signs of sexual difference — are all located in the

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<sup>18</sup> Kristeva’s interests in the maternal, food, death and the text are strikingly similar to Bakhtin’s concept of grotesque. Kristeva wrote about Bakhtin’s intertextuality and dialogism in her essay ‘Word, dialogue and Novel’ (1966), a year after *Rabelais and his World* was published. In that essay, and in *Powers of Horror*, Kristeva only mentions Bakhtin’s use of carnival in passing. Her concept of abjection could be seen, as Vice states (1997):

... as a psychoanalytically inflected development of Bakhtin’s grotesque. Even if the link between the two concepts is not that of Kristeva’s debt to Bakhtin, Kristeva’s model offers a different and more modern way of viewing the same phenomena Bakhtin discusses. Rather than contradicting Bakhtin’s theory, hers can be seen as an extension of his. (1997: 163)

existential immediacy of bodily experience. I briefly outline these three key areas below as they are central to the following discussion and remaining chapters of this thesis in that they provide the theoretical tools to examine the ethnographic data.

Reactions to abjection are visceral, for it is via the emotions and bodily sensations of desire and disgust: retching, vomiting, shame, weeping and sweating that this concept exists. Of eating and drinking Kristeva observes that:

Food loathing is perhaps the most elementary and most archaic form of abjection. When the eyes see or the lips touch that skin on the surface of the milk — harmless, thin as a sheet of cigarette paper, pitiful as a nail paring — I experience a gagging sensation and, still farther down, spasms in the stomach, the belly; and all the organs shrivel up the body, provoke tears and bile, increase heartbeat, cause forehead and hands to perspire. Along with sight-clouding dizziness, *nausea* makes me balk at that milk cream, separates me from my mother and father who proffer it. “I” want none of that element, sign of their desire; “I” do not want to listen, “I” do not assimilate it, “I” expel it. But since the food is not an “other” for “me”, who am only in their desire, I expel *myself*, I spit *myself* out, I abject myself within the same motion through which “I” claim to establish *myself*. That detail, perhaps an insignificant one, but one that they ferret out, emphasise, evaluate, that trifle turns me inside out, guts sprawling; it is thus that *they* see that “I” am in the process of becoming an other at the expense of my own death. (Kristeva 1982: 2-3, emphasis in original)

Unlike Douglas’ writings, Kristeva’s abjection is not only located on the *margins* of bodies, but in the visceral and pulsating movements of her body.

During my fieldwork I found that people with a diagnosis of anorexia had remarkably similar embodied reactions to certain foods. Some shuddered at the very thought of eating, they drew their bodies inwards and closed their lips, put their hands over their noses and mouths, closed their eyes, and often said they felt nauseous at the very mention of certain foods. By drawing inward — closing and protecting — participants were evoking disgust and revulsion, an emotive ‘casting out’ of abject horror.<sup>19</sup> At the

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<sup>19</sup> Malson notes in her study that some people could not even say the word ‘food’, as one of her female interviewees described:

You’ll find that I never say f-double-o-d – uh. There are certain words that are just taboo such as e-a-t-i-n-g as well. I wouldn’t say that to save my life ... I look at these things as being poison and I don’t want poison in my body and I want to be cleansed inside ... (Malson 1998: 128)

same time, many felt the searing pull of hunger, of being engulfed by desire, as Jane described:

Sometimes I think ‘I’m not anorexic, I’m just not hungry’ - but I am - I’m always hungry. I’m hungry all the time and I’m so scared that if I give in to my hunger I will never stop eating, that I’ll just keep eating and eating and eating and never be satisfied ...

The second category of abjection, the embodied reaction to waste, is also a horror towards that which transgresses borders and boundaries and merges with the self.

“What goes out of the body” Kristeva argues, “out of its pores and openings, points to the infinitude of the body proper and gives rise to abjection” (Kristeva 1982: 108).

Grosz, in paraphrasing Kristeva states:

Bodily fluids, wastes, refuse — faeces, spit, blood, sperm, etc. — are examples of corporeal byproducts provoking horror at the subject’s mortality. The subject is unable to accept that its body is a material organism, one that feeds off other organisms and, in its turn, sustains them ... For example, faeces signifies an opposition between the clean and unclean which continually draws on the opposition between the body’s interior and exterior. As internal, it is the condition of bodily existence and of its capacities for regeneration; but as expelled and externalised, it signals the unclean, the filthy. Each subject is implicated in waste, for it is not external to the subject; it *is* the subject. It cannot be completely externalised. (Grosz 1989: 75)

Arising from the horror of corporeal waste is the third category of abjection, the signs of sexual difference. Like Douglas, Kristeva argues that not all bodily wastes have polluting value. Tears, for example, although they belong to the borders of the body, are not dirty. Menstrual blood however, does signify horror, for it:

... stands for the danger issuing from within the identity (social or sexual); it threatens the relationship between the sexes within a social aggregate and, through internalisation, the identity of each sex in the face of sexual difference (Kristeva 1982: 71)

Menstruation does not only signify sexual difference between men and women, but it marks the differences between men and the maternal (*ibid*).



## Constituting abjection ethnographically

While Kristeva argues that she approaches and surveys the concept of abjection phenomenologically (Kristeva 1982: 31), her ‘writing’ of this concept remains firmly embedded in texts and the language of psychoanalytic theory. As Reineke observes, “the abject typifies the unconscious” (1997: 22); it is uncovered “at the point of cleavage between the Imaginary and the Symbolic” (ibid: 21). To illustrate this space Kristeva draws on mythic, poetic, religious, and avante-garde representations in literature and art to evoke the sensations of abjection. “Outside of the sacred” Kristeva writes, “the abject is written ... Great modern literature unfolds over the terrain [of the abject]: Dostoyevsky, Lautreamont, Proust, Artaud, Kafka, [and above all] Celine” (Kristeva 1982: 17-8). Like Douglas, her concept of ‘sacred’ draws explicitly on the texts of the Old Testament. Biblical abominations (both semiotic and spoken through confession) construct “the logic that sets up the symbolic order” (ibid: 110).

In many ways, the illustrations that Kristeva gives to abjection demonstrate the limitations of psychoanalysis for this thesis. As a genre that deals with problematic terms such as ‘pre-cultural’, ‘ahistorical’, and ‘pre-oedipal’, psychoanalysis, I believe, cannot be constituted ethnographically. To assume such a universalist psychological ordering is untenable, and Kristeva (similarly to Douglas) has been widely criticised for making unfounded generalisations (Spivak 1981; Grosz 1990; Tsing 1993; Butler 1990, 1993 and Reineke 1997).

I do not use Kristeva’s psychoanalytic framework.<sup>20</sup> I remain, however, drawn to her concept of abjection for it has striking resonances with my fieldwork. Experiences of

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<sup>20</sup> For anthropology, there are a number of profound (and distasteful) problems with Kristeva’s theories. Her reading of anthropology, for example, is one in which it and its ‘subjects’ are equated with ‘the primitive’. She refers to ‘primitives’ as those people who have a lot in common with European children, poets and psychotics. Moreover, as Tsing also notes:

*Powers of Horror* follows an insulting evolutionary track [a biologized scheme of pan-human development] from Africans and Indians to Judaism, Christianity, and, at last, to French poets. In addition, she assumes an epistemological dichotomy between European “theory” and global “empirical” variation in which, by definition, the Third World can never be a source of theoretical insight. (Tsing 1993: 180-1)

anorexia, like abjection, are fundamentally embodied, ambiguous and transformative. While these terms — embodiment, ambiguity and transformation — are in and of themselves not abject, they are rendered abject in anorexia. Anorexia, as described in the previous chapter, plays with, and makes ambiguous, the relationships of self and other, both through self-identification and in wider relationships. Experiences of anorexia pivot around ambiguous relationships with food, bodily (and other) wastes, and sexual difference. Participants experienced the simultaneous pull of desire and disgust, and the horror associated with foods and bodily fluids as they transgressed boundaries. Although clearly not one and the same, both anorexia and abjection “demonstrate the impossibility of clear-cut borders, lines of demarcation, divisions between the clean and the unclean, the proper and the improper, order and disgust” (Grosz 1990: 89).

The remainder of this thesis extends Kristeva’s concept of abjection by constituting it ethnographically through the everyday practices of anorexia. Abjection played a central role in people’s experiences of anorexia. This role was not simply deployed through language, but practised through gendered bodies; the simultaneous hungering for and ‘spitting out’ of foods<sup>21</sup>; the physical retching of vomiting and purging; the erasure of sexual difference; the protection of bodies from contamination; of elaborate cleansing routines (both internally and on the margins of bodies); and the desire to be clean, empty and pure.

Moreover, this ethnography demonstrates how abjection is fundamentally concerned with relatedness. If, as Kristeva outlines, abjection is concerned with that which is

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Tsing continues to provide a powerful critique of Kristeva’s singular and universalised treatment of gender, and the ways in which she sees gender difference as prior to culture (the maternal is the ground from which all phallic culture emerges) (1993: 186).

<sup>21</sup> It was not only foods that were hungered, but also relationships and intimacy. Natalia had written in her diaries about ‘skin hunger’, a term that she used to describe the strong desires that some people with eating disorders have to be touched. Natalia craves physical intimacy but shies away from it because of her past experiences of sexual abuse.

desired and expelled then it is equally concerned with relations of connection and disconnection. What is desired or expelled (for example, food, wastes, spaces, memories and people) stands in relationship to the 'self'. This self is not a unified, stable self, but one that is 'in-process' and recognises the dynamic relations of self and other on a number of levels. These are relationships that participants had with their 'selves' (with an otherness within the subject), with other people, with anorexia, and with objects in their worlds. Abjection is thus not solely about 'individual identity', but concerned with intersubjectivity: "the ways in which selfhood emerges and is negotiated in *a field of interpersonal relations*, as a mode of being in the world" (Jackson 1998: 28, my emphasis).

Before extending abjection ethnographically a number of caveats are needed. The first is to distance this research from the potentially misleading reproduction of the child-mother (and in this case daughter) relationship that has been well examined in the literature on anorexia. Some early feminist analyses of anorexia have drawn on Klein's object relations theory, pointing to the mother-daughter bond as instrumental in the development of eating disorders (see, for example, Chernin 1986; Orbach 1986). While several participants did discuss relationships with their mothers in terms of their development of anorexia (some mothers had eating disorders themselves), these were not the only relationships to be singled out. Sometimes fathers, brothers, sisters and aunts were also pointed to as significant in providing familial and familiar contexts for eating disorder practice. Moreover, as I argue throughout this thesis, relatedness is not confined to relationships within the family, and my use of abjection does not fall back on the 'maternal matrix' that Kristeva outlines. Rather it is concerned with the broad-ranging possibilities, conflicts and experiences that any number of relationships provide.

And secondly, my use of the word ‘practice’ is distinct from Kristeva, who, as Oliver notes, suggests that “poetic language is text as practice” (Kristeva 1984: 181, cited in Oliver 1993: 3). My use of practice, which is informed by Bourdieu’s *habitus*, focuses on the everyday practices of ordinary living. As Ortner suggests, practice is, for Bourdieu, concerned with the “routines that people enact [and reproduce and transform] ... in working, eating, sleeping, and relaxing, as well as the little scenarios of etiquette they play out again and again in social interaction” (Ortner 1984: 154). It is thus through the enactment of everyday, temporo-spatial and gendered practices that abjection is found.

The remainder of this chapter provides the first of the ethnographic contexts for abjection. In moving Kristeva’s location of abjection beyond the symbolic, imaginary, psyche and language, I demonstrate how the anticipation of particular foods generated abjection, that is, the specific qualities of calories, fats and oils and their embodied responses. While it is essential to outline the properties of foods that people treated as abject, (for example, those that continually moved between the categories of solid and liquid), it is equally important to explore how these foods moved in and out of the body and the responses to this movement. I argue that it is the interplay of senses that is central to this embodied abjection, for it is through “the medley of senses bleeding into each other’s zone of operation” (Taussig 1993: 57) that we come to experience the world.

### **“ARE YOU A FATS OR CALORIE GIRL”?**

Like Douglas and Kristeva, I too was interested in the nature of dirty and clean foods. Why in Beth’s food list was red capsicum clean? The answer lay not in the linguistic or structural classifications of types of foods. Rather it was the properties of the foods themselves *and* their embodied effects. Capsicum was ‘clean’ for Beth for several

reasons. First, she had “read somewhere” that capsicum contains “negative calories ... as in the amount of energy you need to digest it is more than the food itself gives you”. And secondly, red and green capsicums were clean because their surfaces/textures were not slimy and greasy. Capsicums were “squeaky clean”. In contrast were those foods that glistened (such as melted cheese on top of a pizza), or those that left remnants of oil behind. Beth suggested, for example, that if she had to eat foods high in fat she would much rather eat avocado than fried chips, as the nature of greasiness was different. Seeping, greasy foods were considered dangerous, fatty, and dirty.

It was thus the indeterminacy, the ambiguity of foods that was at stake. Food continually transforms itself, through the varied processes of digestion; when heated or cooled; when mixed with other foods; and when left to rot. Food, as Lupton similarly notes, is “therefore a source of great ambivalence: it forever threatens contamination and bodily impurity, but is necessary for survival and is the source of great pleasure and contentment” (Lupton 1996: 3).

Interestingly, it was the practices of food avoidance that marked differences and established alliances between people with anorexia. In the previous chapter I described the relationships that people with anorexia develop with each other. As an example of the “special language that people with eating disorders share”, Tamara explained that when people meet in a treatment setting one of the first questions they might ask each other is:

“Are you a fats or a calorie girl?” You’re usually concerned about both, but one more so than the other, and if you share the same fear of fats there are immediate likenesses. Calorie girls are worried about airborne contagion whereas the fats and oil girls are concerned with touch.

Fats and calories were described as contagious because they had the ability to move and transgress boundaries. They had the potential to engulf, contaminate, and merge.

Kristeva notes that while all food is liable to defile it “becomes abject only if it

[crosses] a border between two distinct entities or territories” (Kristeva 1982: 75). The concern with contagion was related to the intertwining aspects of abjection; of the threat and incorporation of harmful substances, the ambiguous form of particular foods and the potential for that which is indeterminable to transform.

### **Miasmatic calories**

The fear of airborne contagion was related primarily to the ability of calories to diffuse out of food and into the air. Calories were attributed an insidious nature because of their perceived smallness, invisibility and potential to move. In a chapter entitled “The forgetting and remembering of the air”, Abram (1997) reminds the reader of the simultaneous pervasiveness and invisibility of air:

On the one hand, the air is the most pervasive presence I can name, enveloping, embracing and caressing me both inside and out, moving in ripples along my skin, flowing between my fingers, swirling around my arms and thighs, rolling in eddies along the roof of my mouth, slipping ceaselessly through [my] throat and trachea to fill the lungs, to feed my blood, my heart, my self. I cannot act, cannot speak, cannot think a single thought without the participation of this fluid element. I am immersed in its depths as surely as fish are immersed in the sea. Yet the air, on the other hand, is the most outrageous absence known to this body. For it is utterly invisible. (1997: 225)

While Abram (in a Heideggerian tradition)<sup>22</sup> “illuminates” that which is hidden in the everyday, these two features of air — its pervasiveness and simultaneous invisibility — were paramount to several people’s fear of air.

A number of participants told me about a young Australian woman named Bronte who exemplified this fear of “flying calories”. Bronte’s “struggle with severe anorexia” had been closely followed in the press (both television and newspapers) over several years in the late 1990s. A popular Australian women’s magazine, which ran “exclusive” updates on Bronte, quoted some of the “worst times” of her “nightmare”:

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<sup>22</sup> In *The Forgetting of Air* (1999), Irigaray critiques the metaphysical tradition that the work of Heidegger (and other philosophers) is founded upon — that is, the solid earth. She argues that there can be no presence, or Being, without air, yet its fluid, invisible, transparent nature renders it forgotten.

One thing I remember is that when I first came in here [for treatment] I couldn't walk past anyone who was eating because ... I felt the calories had gone into me somehow. I'd roll up towels and push them under my door so the calories from outside couldn't come through and go into my body". (*New Idea* 1998: 15)

For Bronte and others with similar fears the most threatening point for calories was via the sense of smell. Smelling meant inhaling an essence of food, an essence that carried calories. What was even more distressing was that smells moved and they knew no boundaries. They circulated through the air, hung in kitchens, or travelled through the house (under doors and through open windows), permeating different rooms. Rita recounted her fear of smelling food in her family home:

Very early in the piece when I smelt cooking in the house - I would have been about 15, a teenager - I used to wonder - I used to hope against hope that those molecules of food smells getting into your nose and into your body didn't actually carry any substance - like calories - I was terrified that it may be fattening to actually smell food - like almost the smell of food is in and of itself intrusive - not just the physical plunging of stuff in ... it's another hole that it gets in.

*Did you ever protect yourself?*

Yeah - or I left the vicinity.

*Did you ever walk into the kitchen or cover your face?*

I don't remember.

*Or hold your breath in the kitchen?*

Yes, yes ...

These fears of flying calories affected relationships within the family/household, and strategies of aversion and avoidance became paramount. Tamara, for example, who enjoyed cooking and preparing meals for other people (with ingredients with which she felt safe) couldn't go near the kitchen when someone else was cooking: "if mum was cooking whenever I was home I couldn't be in the kitchen ... I felt like if I even went near it I was going to catch calories ... too many calories flying around here ...".

Howes' phenomenology of smell explores why the characteristics of this sense are ideally suited to expressing the notion of contagion and danger. Citing Gell he argues that smells are distinguished by their "formlessness, indefinability and lack of clear

articulation” (Gell 1977:27, cited in Howes 1991: 140) and as a consequence “are always ‘out of place’, forever emerging from things [and merging with things], that is, crossing boundaries” (Howes 1991: 140). Renee Devisch, in his ethnography of emotions amongst the Yaka of Zaire (1990), similarly points to the liminality of smell:

... since it evokes and crosses boundaries between different realms of experience. This primal sensory or emotive experience instigates transitions between persons and categories. Smell may evoke strong moods or provoke emotional changes in the individual ... Bad smell from decay or smell that mixes bodily functions can no longer mediate between persons, but evokes repugnance. (Devisch 1990: 119-20)

The fear of food smells might explain their absence in my own experience of fieldwork. Although fieldwork sites can be saturated with smells (cf. Stoller 1997; Seremetakis 1994; Howes 1991), the spaces I encountered in the field were noticeably devoid of such aromas. Only once in someone’s home did I enter to the ‘warm’ smell of biscuits baking in the oven. Vicki, who said that she could only bake now that she was ‘recovering’, was making a batch of biscuits for her father who was about to go on his annual Easter fishing holiday. More commonly, I found that the only smells in people’s homes were those of antiseptic cleaning fluids, swabbed over surfaces to sanitise and erase odours.

This fear of airborne contagion has resonance with the miasma theory of disease common throughout the Middle Ages and up to the emergence of the scientific model of medicine (Lupton 1994: 33; Corbin 1996). The large numbers of epidemics and plagues during this time led to an understanding of the body as permeable and highly susceptible to invasion and attack by disease. Disease was likely to be most prevalent where the noxious vapours of miasma were present, for example, the foul, stagnating smells from marshes, bogs or sewerage works were dangerous and believed to cause disease if inhaled. The most dangerous vapours were related to the heat of decomposition, to rotting vegetables, animal or human waste, where decomposition



created “putrid emanations” and “harmful effluvia” (Wood 1997: 28). It was when substances were transforming into waste that they were seen as most dirty, dangerous and potentially harming.<sup>23</sup>

Miasma, like Kristeva’s proliferating corpses, signify “the utmost of abjection ... because [it] represents ‘a border that has encroached upon everything’: an outside that irrupts into the inside, eroding the parameters of life” (Ellman 1990: 181-2). Miasma represents disintegrating boundaries and inbetweenness, threatening to contaminate by connecting separate entities.

### **‘The snake that slithers’: the ambiguity of fats**

If the concern with calories is related to their invisibility and invasion through smell, the concern with fats is related to their visibility, their slimy, greasy feel and their ability to seep and sneak into the body through a variety of means. Fats are, to borrow Douglas’ terminology, the snake that slithers. Like snakes, they have a mode of locomotion that enables them to cross the boundaries of their habitat and move out of their ‘proper place’. And like the airborne contagion of calories, fats could move and infiltrate. They were, however, more threatening than calories because once in the body they would stick and solidify “like cement”. Recall the earlier ethnographic example in which Estelle explained how she could eat sugar but not fat:

Sugar disappears, it can be burnt off, whereas fat does not dissolve, it sticks and stays with the body, it can be seen. You think of this stuff here (she pinches her stomach) and you think of that as fat, not sugar ... I could almost imagine it just going straight onto my thighs, or my bum, or my tummy whereas the sugar I imagine diluting through my system.

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<sup>23</sup> The two factors that aided the rise and fear of miasma were air and heat. In his history of odour and the French social imagination, Corbin (1996) notes how, before the advance in what was called pneumatic chemistry in 1750, air was thought to act as a passive carrier, transporting an accumulation of foreign particles (Corbin 1996: 11-2). Air was believed to act on the living body in multiple ways: by simple contact with the skin or pulmonary membranes, by exchanges through the pores, and by direct ingestion. The temperature and humidity of air was central to its effects on the body. This combined fear of temperature and air was often talked about by participants with reference to cooking food. Barbecues in particular, were the worst offenders. The sound of sizzling fat and the smell of cooking meat ‘turned people’s stomachs’ and many could not be in the vicinity of such smells for fear of inhaling the polluting vapours. The heat of cooking generated potency to the food.

Estelle is highlighting the properties — the ambiguous texture and form — which mark fat as being polluting. Fat is indeterminate in form, it is difficult to get rid of, it seeps, infiltrates and congeals. It is liminal in the sense that it can be either solid or fluid; it is inbetween. Fat is like the skin on the milk that Kristeva described, it is revolting “because it forms the boundary between two elements and two different forms: liquid and solid” (Vice 1997: 165). It connects.

Fat has the power to effect embodied visceral responses. The smell, sight and tactility of oil not only evokes disgust, repugnance and nausea for Estelle, but also death. The embodied sensations of fats and oils transport Estelle, as the poet Baudelaire (1975: 42) would say, “back to the event with which it is originally associated”, back to the fish and chip shop in which she worked:

I can remember that smell very vividly - it's a foul smell and we emptied out the deep fryers into buckets out the back and the next day I came back and it was like this layer of fat sealed over the top - solid fat - oooh that's gross (she shakes her head and screws up her mouth) and it smelt gross - I can remember a pig getting cut up after it had been shot (on the farm) and just that sort of smell - I don't know - the smell of fat burning - it's hard to describe ... there's something dead ... I don't know - when I think about it, it makes me feel sick - just the smell and the look of it - you can imagine it - the way it settled on top of the bucket - I can imagine it settling on the top of my stomach and it never getting out. Just the way it coagulates like that ... it would just stay in you for ever and ever and never get out. When you get that layer of grease and you can feel it on your teeth and the inside of your mouth - uugggh - some girls reckon they can feel it in their stomachs and stuff - I never had that - I can never really feel the food in my stomach but I can feel the fat and the residue in my mouth or on my lips and it's really greasy.

In her body, fat coagulated like the fat in the bucket. It was ‘matter out of place’:

Fat was very much like something under the skin that I didn't want there - like sort of something invading my body and getting in the way of what good muscle could be there - it was just something that shouldn't be there (laughs) - an alien sort of presence.

The ‘clogging’ effect of fat has resonance with current concepts of health. Before her diagnosis of anorexia Karen had been visiting a naturopath who had prescribed a

number of tablets to “cleanse her digestive system”. Part of the cleansing routine involved a very detailed attention to food consumption, where ‘cleaning foods’ such as vegetables and tofu were encouraged. The naturopath had advised Karen that eating these foods would cleanse her liver, arteries and digestive system, which were ‘clogged’ with fats and hence sluggish. The naturopath told her that she should not have fatty deposits in her liver, and fat in the blood stream was dangerous because it could be the precursor to a heart attack or stroke. Fats were characterised as ‘out of place’ (by both Karen and the naturopath), potentially dangerous to the flow of blood and bodily fluids, and hence dirty.

## **PROTECTION FROM TRANSFORMATION**

The measures that were put in place to protect oneself from the polluting nature of fats was far more extensive than those associated with smell. Protection from smell meant covering the nose or mouth, whereas protection from fats initiated an elaborate surveillance of the entire body. Because of their seeping and sticking nature, fats were regarded as more insidious than calories – they could enter through any part of the skin, cling under finger nails or be transferred unwittingly from hand or object to mouth. “They’re so slimy and pervasive”, recounted Angela, “like they can just sneak into places where they shouldn’t be and you just feel that you would never get it out of you. It was going to sit there like a lump spreading its grease all through your body”.

One fifteen year old who was undergoing a ‘bed program’ in a psychiatric unit at a major public hospital told me in hushed whispers from her hospital bed that she did something “really weird”, so unusual Elise said, that she hadn’t told the psychiatrists for fear of what they would make of her:

I’d prepare food for my brother and sister all the time and towards the end, like just before I came in here, the last four weeks or so I’d wear gloves or wrap my hands in Glad Wrap (plastic cling wrap) because I couldn’t stand the thought of

fat seeping into me (she laughs to emphasise the ‘weirdness’). It just seems so silly.<sup>24</sup>

Elise’s concern with the amorphous nature of fat tempered the very relationship she had with both food and her family. In hospital, where she was expected to eat all meals presented to her, she would firstly ‘check’ the oiliness of the food by touching it with her fingers (like a piece of blotting paper soaking up a fluid). Elise knew, for example, that a piece of cake would contain butter, but she didn’t know how much. She would touch it to feel how much residue it left on her fingers in order to gauge the fat content. This initial assessment of food was far more important to her than the senses of smell or sight, for the amount of oil was the mitigating factor in her response. What Elise called “obvious fat” — the butter in small, plastic containers or margarine spread on bread — did not have to be gauged in this way. She once apologised for scraping the butter off her sandwiches and onto the side of her plate as we sat together eating lunch in the patient dining room, and exclaimed: “I know this looks pretty irrational and silly, but it’s a must”.

Elise hated the oily feel of butter – “it’s oily, it’s greasy”, she said as she made a rolling gesture with her fingers, reproducing the slippery sensation. “It’s a dirty feeling. I hate the feeling of when my hands are greasy because you feel so dirty”. Avoiding contact with greasy and oily substances was not only limited to foods, but extended to a range of other objects. She was so concerned about oily substances being absorbed through her skin and congealing in her body that she stopped using hand creams, wouldn’t wash her hair with shampoo or use lip balm to moisten her lips. Her rationale at the time was: “well where does it go? It disappears into your body and then what?” A media story about Bronte similarly highlighted the fear of greasy cosmetics: “[the nurses recalled how Bronte] wouldn’t even allow us to put moisturising cream on her hands

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<sup>24</sup> A recent Australian advertisement for a plastic food wrap depicts a male surgeon in an operating theatre (supposedly one of the most sterile environments) wrapping food in antibacterial wrap.

because she thought the oil might have some nutritional quality and would be absorbed into her skin” (*New Idea* 1998: 16). Skin was no longer ‘the first line of defence’.

Tanya’s avoidance of fats was remarkably similar to Elise’s. Instead of wearing gloves when handling food, Tanya would have to immediately wash her hands with soap and water:

If I’m making a sandwich for my brother and sister I don’t even like to get butter on my fingers. I can’t even touch it. It’s like there’s a really irrational piece of me that says ‘you’d better not get it on your fingers just in case it’s possible that – this is going to sound really stupid – but just in case it’s possible that the fat could somehow seep in through your skin’.<sup>25</sup> Even saying it out aloud is embarrassing because logically I know that it is so far from the truth but you can’t stop yourself thinking things like that and it’s weird.

Avoiding fats proved to be a difficult challenge to those who worked in the food/catering industry.<sup>26</sup> Tamara waitressed in a pub that prided itself on serving German style foods (thick steaks and rich sauces) in the style of smorgasbords and counter meals. Initially she said that her repulsion of the fatty foods was due to their high calorie count, but she later ‘admitted’ that it was also because she was frightened that these substances would “somehow seep through [her] skin”. Working behind the closed doors of the kitchen Tamara would “never go without” the recommended disposable gloves when handling food, and resorted to wearing them even when it was not required.

I wouldn’t even pick up a bottle of oil or a tub of margarine, I couldn’t go near it, the fear was just immense. It was like if I picked it up it would somehow get onto me and into me. It was just this incredible fear that it was going to ‘get’ me.

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<sup>25</sup> In reflecting on the ways in which her room mate takes all aspects of food for granted, Hornbacher describes her friend as having ‘no idea’ about her own intense fears and desires surrounding butter :

... the idea of buying butter in a store, the idea of touching butter without fear that the oils would seep through the skin of your fingers and make a little lipidy beeline for your butt, the idea of eating food that you knew, you knew had butter in it, of having butter in your possession that did not haunt your waking and sleeping hours, that did not wear a little invisible sign that only you saw: EAT ME, ALL OF ME. NOW. (1999: 265)

<sup>26</sup> It is widely acknowledged that despite their abhorrence of food, people with anorexia often work in restaurants or catering industries. For those in this research who worked around food and prepared it for others they explained that the proximity visually satiated their desires of hunger. They simultaneously maintained a distance through the use of plastic gloves, tongs or frequent hand washing.

Like Elise, Tamara reiterated how illogical this was, but the imperative to do these things overrode the irrationality. Rozin, Millman and Nemeroff (1986), who tested Frazer and Mauss' laws of sympathetic magic in contemporary settings, suggest that the laws of magic operate even though people 'know better'. The power of metonym and metaphor transcends the dictates of logic and reason. Another young woman remembers being absolutely vigilant around anyone who was eating in her house. At the dining room table Vicki refused to let her father pass anything across to her if he had touched butter with his hands, for fear of it transferring to her: "I would flip, I would lose it if dad touched butter and then went to touch a glass or something I was using. I would make him wash it". To prevent the spread of contamination, Vicki had her own crockery: a specific bowl, spoon, glass and cup that only she would wash and use.

Others were fearful that 'clean' foods would become contaminated by 'dirty' foods through close association on plates or by being mixed in recipes. At the family dining table Catherine would separate all the food on her plate, as she believed that greasy foods (such as mashed potatoes) would contaminate the clean foods (such as zucchini and tomatoes). She still separates what she eats "into little parcels - so the flavours and parts of the food don't mix".

My mum used to think it was weird - everything wasn't allowed to touch each other on the plate. You'd have your vegetables there and something there - the different kinds of foods couldn't touch - all separate and all in their little portions ...

*And what was the reason for separating the food?*

I liked to have them separate - this word pops into my head - and so it wouldn't contaminate the other food (laughs) - I still do that today ... if I had something on my plate which I didn't like or that was very fatty it couldn't touch the other vegetables because of the fat might get onto them - you know - so the flavour or whatever was in that food would spread to the other things. Things like the butter and the meat - the meat could *never* touch the vegetables - agghh -

The food that Catherine had the most trouble with was mashed potatoes. Potatoes on their own were ‘clean’, but if milk or butter was added to make mash potato then it was contaminated. It transformed from a “good food” to a “bad food”, from edible to poison:

I used to use the contamination thing on the plate (laughs and looks away) or in cooking things - you can contaminate things when you cook things ... like adding things in ... eating (the mashed potato) I used to think I’m going to die ... and I know I had a few arguments with my mum and she’d make mashed potato and put butter in there and I’d crack up at her ‘you’ve destroyed it, you’ve contaminated it - I’m not going to eat it’.

## FEAR OF TRANSFORMATION

Fear of transformation was not solely located within the realm of greasy foods. Other foods that had the potential to move and be abject were also experienced as problematic. Becky, for example, was terrified of the colour of some foods. Howes (1991) suggests that “a colour always remains the prisoner of an enclosing form” (1991: 140), yet several participants clearly demonstrated that this was not always the case.

Becky was the first to explain this fear to me:

When I was anorexic I believed that if I ate something red it would contaminate my entire insides. For example, if I drank red punch I had some fear that it would dye my insides red - my stomach, intestines, liver etc. And because I associated red with dirty, then my insides would be dirty too. Do you see the connection? However it goes one step further. There were some red things that I could eat: tomatoes, catsup and strawberries. Those red things don’t dye things. For example, if you drop a red jellybean in some water, the jellybean will run and cause the water to turn red, right? But if you drop a tomato in the water it doesn’t “run” or cause the water to turn red. The things I could not eat were the ones that would “run” and thus dye my insides. Does that make sense to you?

Why the colour red?<sup>27</sup> There are two ambiguous characteristics of red that intertwine.

The first is the symbolism of the colour and the second is the ability of that colour to

<sup>27</sup> In a Freudian analysis on Ndembu colour symbolism, Turner suggests that ‘we’ understand the basic colour triad (black, white and red) preconceptually in terms of universal human bodily and visceral experience. The three colours “stand for basic human experiences of the body (associated with gratification of libido, hunger, aggressive and excretory drives, and with fear, anxiety, and submissiveness)” (Turner 1970, cited in Jackson 1998: 82-3). Such a universalised, decontextualised

move. Although the importance of the colour red is expanded in the next chapter (in relation to a particular context of bodily fluids, gender and sexuality), Becky associated the colour red with the fluidity and danger of blood. It was the inbetweenness — the potential for multiple meanings — that invested it with ambiguous properties. “Red is the worst colour to me. In my anorexia, I could not eat anything that was red. Red is a contaminant. Red is dirty. Red is all consuming”.

Red was also dangerous because of its capacity to move and transform. Dyeing involves a merger of properties and an overlapping of domains. The process fundamentally changes the nature of that with which it merges. The colour which Becky ingests seeps out into her body and transforms her. She in turn becomes that which she equates with red: dirt, danger and pollution.

### **Becoming like another**

The transformative properties of food, their ability to move and merge with the body through sensory perception and experience, are strikingly similar to Frazer (1890/1959) and Mauss’ (1902) descriptions of magical belief systems. According to Frazer there are two laws of sympathetic magic: the law of similarity and the law of contact or contagion. Contagion, he suggests, rests on the principle that “things which have once been in contact continue ever afterwards to act on each other” (1890/1959: 7). In magical practices, contagion occurs through a variety of means: direct contact with the contaminated source, indirect contact with bodily products (such as hair, fingernail parings or spittle), or through touching an intermediary object. Influence of contagion has the potential to be permanent (hence, “once in contact, always in contact”) (Rozin, Millman & Nemeroff 1986: 703).



Frazer's laws of magic describe embodied states of transformation. The whole purpose of magic is of course to effect a change in the condition of the person on whom it is practised (Howes 1991: 130). This change is effected through the senses. The connection between senses and transformation has been well documented, especially in the case of magic. In the Trobriand Islands, "the sense of smell is the most important factor in the laying of [love or sorcery] spells on people; magic, in order to achieve its greatest potency, must enter through the nose" (Malinowski 1929: 449, cited in Howes 1991: 130).

It was through sensory connection and transformation that fear was evoked amongst participants: fear of touch; drawing in another's breath; or looking at others. Danielle wouldn't follow in what she called "a fat person's" footsteps for fear of becoming like them, becoming obese. Like the game that children play avoiding the cracks on the pavement, Danielle could not step on the shadows of others lest she 'absorb' their 'fatness'. Breathing in another's odour also had the potential to transform her into that person. As an example, Danielle described how she doesn't like to stand next to someone who may have a cold or smells of garlic, as she feels by breathing in their smells she will be contaminated. She will either turn away so as not to "share air" with them, or take shallow breaths. Similarly, when she travels on a bus and she wants to shut her eyes she ensures that no-one else is in her vision before she closes them, as if by shutting her eyes she is incorporating some of their presence.

Mimesis, as Taussig (1993: 36) writes in his elaboration of Frazer's laws of magic, involves a playing with, or blurring of, different kinds of bodily boundaries: "One becomes something else, or becomes Other". Bettina was constantly worried about becoming other. Again, it was through the senses that these transformations were most likely. When eating she tried not to think of other people, for she feared that the food would take on their properties, which in turn would transform her. She could not stand

too close to people for fear of merging with them. For many years she had to eat “flawless” food:

...everything has to be perfect - especially with food. For example, this morning I had a piece of bread with a crease in it. I was unsure of whether to eat it or not, but there was no other bread, so I ate it. Then I became worried if I should have eaten it or not ... sometimes I don't know what normal is. Sometimes I can't decide who I am, or where I start or finish. I'm worried that people or objects can influence me, that I can turn into them ... I just want to become perfect again ... and that's how the food is involved - I know that you are what you eat, and that's why what I eat has to be perfect.

\* \* \*

As an ethnographic reworking of Kristeva's concept of abjection, this chapter has explored the relationships that people with anorexia had with particular foods.

Extending beyond descriptions that rely on taken-for-granted discourses of nutrition, or 'mind/body' control, the analysis has highlighted a different level of understanding about food. For many participants, food was experienced as abject: as a 'dirty', disgusting substance that was equated with bodily waste. It was however, not simply the oral ingestion of food that was threatening to participants, but also the possibility of connecting with dirt and contagion through other sensory modes such as touching and smelling.

It was thus those foods that had the potential to move and transgress that were most problematic. Oils and fats, for example, were defiling because they moved between categories of solid and liquid. They were the most threatening of all foods, for they had the ability to transgress bodily boundaries through touch, seeping through the skin into participants' bodies and sticking and clogging “like mud”. Smelling foods was similarly problematic, for air was a carrier of food smells, a carrier of calories and of contagion.

Having established abjection as an ethnographic focus, the next two chapters explore how that which was considered abject was 'cast out' from the body. They centre on the erasure of disgust and how people cleansed their bodies of dirty, polluting food through purging. There was however, another level of cleansing that also took place, and that was related to the erasure of the female body itself. Women described and experienced their bodies, and in particular their reproductive, digestive and sexual bodies, in the same ways that they described food, as polluting, dangerous and dirty. Anorexia was a practice that removed the threat of abjection.

## CHAPTER 5

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### “ME AND MY DISGUSTING BODY”

*In sixth grade I used to take days off from eating, to cleanse my system.*

*(Hornbacher 1999: 56)*

Despite being referred to me whilst an in-patient on an eating disorder ward, Julia disagreed with the diagnosis of anorexia. “It’s not anorexia” she told me, “it’s an ambivalence to food”. Ambivalence was a recurring theme throughout her narrative, and it was the dominant motif around which her relationships pivoted. At 38 years of age, Julia was the fourth child in what she described as “a really bright, high achieving family ... it’s very hard coming fourth in line to smart, bright women. I’m not suggesting that I’m stupid but they put unbelievable expectations on me and at the same time treated me like the baby all the time”. Her upbringing was at times like “a civil war ... we’ve all got dreadful tempers and we’re all very strong willed and obnoxious but we really do love each other”.

As an example of the family volatility, Julia spoke of a typical Sunday family lunch: “they were horrendous”, she said as she rolled her eyes and shook her head in exasperation. She hinted at the abuse of alcohol and drug taking by other family members, and her disgust at that “kind of behaviour”. She wanted to distance herself from what she saw as their “complete lack of control”, a distancing that she effected by choosing not to share in the commensality of family gatherings. She withdrew into “a safe place”, a place where she did not have to engage or partake in intimate relationships. This space was what she called ‘anorexia’; her “protest against the status quo, against everything”.

In keeping with the family luncheon theme, Julia talked of tablecloths, the white, laundered spread at the centre of family dynamics that has food passed over it and spilled on it, arms lent upon it, drunken laughter and angry dialogue thrown across it. Tablecloths continually transform: during a meal they become dirty, and are later soaked and bleached to return to their original state. As Visser notes, “a good deal of its prestige rests upon the trouble such a tablecloth entails: it must be washed and pressed every time it is used, and a single stain ruins it” (Visser 1992: 156). Julia described the different types of tablecloths — the “everyday and the special occasion” — and it was the special occasion tablecloth that she likened herself to:

I guess [anorexia] is like having a really clean, beautiful, embroidered or cross cut white table cloth that you would never use because if you did - even though it's there to be used and it's beautiful and tablecloths always get things spilled on them, something is ruined. It's stained, it's spoiled, it's been ruined ... I'm like the tablecloth that's wrapped up in tissue paper in the draw or wrapped in plastic and kept safely away nice and clean but is never used and never admired - I'm not prepared to go so far as to have things spilt on me and the spilling - the spillage is all the stuff that made me and my family miserable.

I begin this chapter with Julia's story as it illustrates a number of continuing and interwoven themes that unfold in this and the next chapter: the relationships between dirt, disgust and cleanliness. In likening herself to a tablecloth, Julia echoed the concerns of many other participants: that food has the potential to defile, to pollute and stain. Wrapped in tissue paper, safely away in the drawer, Julia not only avoided the spillage of wine and foods, but also the ‘spillage’ of relationships, in her case the turbulent emotions of family life. Through restricting her food intake, she refused to share the cloth of commensality and attempted to remain pristine and clean like the white embroidered linen.

Julia's metaphorical rendering of anorexia is an example of one of the ways in which people avoided defilement. Avoiding food (restricting intake) and purging (most commonly vomiting and/or laxative use) were the two main ways in which participants

protected and cleansed themselves. These practices were clearly positioned in a number of differing discourses. In the medical field they were viewed as markers of diagnosis and/or severity of illness, as symptoms of a disorder, as a means to weight loss. Historical and feminist analyses, on the other hand, look beyond the signs and symptoms to the wider meanings of purging, exploring the ascetic experiences of fasting saints and other religious groups. These discourses, as I will describe in the first section of this chapter, are quite separate in their endeavours; one looks at the physiological ramifications of food refusal and purging (such as weight loss and electrolyte imbalance), and the other at the ascetic separation of the mind from the body in an attempt to reach purity and salvation.

Rather than reproducing these separate discourses in my own analysis, this chapter seeks to explore the connections between and beyond them. When people talked about purging and restricting they rarely spoke solely about weight loss or spiritual salvation. Their language was far more secular, and consistently returned to a desire to be clean, pure and empty. Restricting and purging cleansed people’s bodies of that which disgusted them: ‘dirty and polluting food. The logic seems straightforward: food that comes into contact with the body has the potential to become part of the body— to be absorbed —and must be removed. To touch it, smell it, taste it or eat it is to embody dirt and disgust. There were however, other levels of embodied disgust that had to be cleansed from the body, experiences that related directly to gendered bodies.

As I have argued throughout this thesis, bodies and food are inseparable, and in the case of anorexia it is the experiences of the female body and food that are inseparable. Women described their bodies, and in particular their medically fragmented bodies — reproductive, digestive and sexual<sup>1</sup> — in the same ways that they described food: as

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<sup>1</sup> This research did not assume a premise of ‘fragmented bodies’. In *Ngarrindjeri Wurruwarrin : A World That Is, Was, and Will Be* (1998) Bell critiques the ways in which early research concerning women’s reproductive lives was flawed:

abject. Although participants described the potential for desires, hungers and pleasures, they overwhelmingly experienced their bodies as dirty, polluting and dangerous. The second half of this chapter describes how female participants came to feel this disgust: through unwanted sexual experiences, by their own bodily processes (menstruation, digestion), and fear of sexuality. Participants not only wanted to rid their bodies of defiling food, but in the process, erase and cleanse their own ‘dirty and disgusting’ bodies.

## EXPLAINING PURGING

### Signs of disease

In the early months of fieldwork preparation, whilst speaking to clinical directors and health professionals, I often encountered blank faces when I asked about the meanings of bodily fluids. The ways in which people purge — self induced vomiting, laxative and diuretic use — were viewed as straightforward, self-evident measures to lose weight. As one psychiatrist was signing an ethics approval for my project, he replied in answer to my question: “that’s simple, they do it to lose weight”. The *DSM-III-R* (APA 1987) classification echoes this understanding, describing these practices as “abuse so as to achieve weight loss and maintain a low body weight”.<sup>2</sup> These practices are thus rendered instrumentally as the signs and symptoms of anorexia nervosa.

Signs and symptoms are the ‘bread and butter’ of diagnosis in medicine. Hippocratic medicine emphasised the careful observation and registration of every symptom, forming the basis for establishing precise ‘histories’ of each disease, even if that disease

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... if the organising device of research is the physicality of women’s bodily functions, of puberty, menstruation, conception, and birth, then each may be studied as separate phenomenon, documented, and fragmented. In these analyses women become just so many body parts or functions. A researcher could extract information about each function, but little attempt was made to locate these moments in a woman’s life within the context of the reproduction of Ngarrindjeri culture. (1998: 527)

<sup>2</sup> The most recent diagnostic manual *DSM-IV* (APA 1994) changes the word ‘abuse’ to ‘misuse’.

was itself unknown at the time (Honkasalo 1991: 251). With the appearance of medicine as the ‘natural science of the body’ in the 18<sup>th</sup> century, symptoms lost their central place in diagnostic practices, for they could only *infer* the disease causally. Symptoms came to be seen as subjective evidence or assessment of a disease, such as a complaint or pain. A sign, by contrast, was seen as objective evidence of the disease, observed, interpreted and tested ‘independently’ by the physician rather than the patient.

Foucault refers to this shift in medicine as a “syntactical reorganisation of disease”, a reorganisation that treats signs and symptoms differently and expects them to cohere into a rationale explanation.

The symptoms allow the invariable form of the disease — set back somewhat, visible and invisible — to *show through*. The sign announces: the prognostic sign, what will happen; the anamnestic sign, what has happened; the diagnostic sign, what is now taking place. (Foucault 1973: 90, emphasis in original)

Purging is a symptom that has observable and detectable signs to a clinically trained eye; it can be seen by enlargement of the submandibular and parotid glands or measured by a number of specific laboratory tests (routine blood chemistry studies or non-routine assessments such as serum amylase levels) (APA 2000: 13). As a symptom, vomiting or diuresis allows the clinician to observe the physical signs of malnutrition, to listen to abnormal bowel sounds or measure a low body temperature.

Purging is an important diagnostic marker as it also infers further classifications into specific types of anorexia. The *DSM-IV* (APA 1994) outlines two subtypes of anorexia nervosa: restricting and binge/purging. Someone who restricts their food and fluid intake but does not take laxatives, diuretics or vomit, would be classified as having the restricting subtype of anorexia nervosa. This group, as discussed in Chapter Three, are known as the “pure anorexics” amongst in-patients. To use Julia’s metaphor, they are the “special occasion tablecloths” who revere purity. Within these subtypes there is



recognition of swinging between purging and restricting: “Patients with anorexia can alternate between bulimic and restricting subtypes at different periods of their illness. Among the binge-eating/purging subtype of patients with anorexia nervosa, further distinctions can be made between those who both binge and purge and those who purge but do not objectively binge” (APA 2000: 19).

From ward rounds and other participants, I too learned of the ‘tell tale signs’ of anorexia, the signs that ‘called one’s bluff’ or ‘gave the game away’. Beth and I would sit on the back verandah of her share house in the late summer mornings, drinking glasses of water and adding cigarette butts to the already overflowing ashtray. She was a pale, thin woman in her late 20s, and often dressed in dark coloured t-shirts, baggy pants and black sandals. At times her voice was faint, and she often looked contemplatively out onto the sparse, dry garden, collecting her thoughts and delivering them in serious and measured responses. During conversations Beth would always tuck her long legs under her body and place her hands in her lap, playing with them as we talked, ‘picking’ at her fingers and nails. In her moments of contemplation my attention was drawn to her hands, and the small sores that were concentrated over the knuckles of the first two fingers on both hands. My first thought was that these marks may have been cigarette burns, as several other women had shown me scars on their legs and hands from self inflicted razor blade and glass cuts. I later discovered that this was ‘Russell’s sign’ (Daluisi *et al.* 1997), a medical term for skin lesions consisting of abrasions, small lacerations, and callouses on the joints of hands. These nondescript lesions are caused by repeated contact of teeth to the skin of the hand as it enters the mouth during self induced vomiting (Zerbe 1993, cited in Hornbacher 1999: 61).<sup>3</sup>

When I asked Beth about these marks she said that the observable signs of anorexia —

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<sup>3</sup> When participants arrived at one of the psychiatric wards they were given a pamphlet entitled *Living With the Culture of Control* (Women’s Health Project: 1992), which noted that one of the physical problems associated with vomiting was “calluses over knuckles if hands are used to induce vomiting” (1992: 7).

her lacerated knuckles along with obvious weight loss — were not indicative of her *experiences*: “they are only medical signs, it’s not what it’s really about”. When I moved out of the medical domain, away from a domain of semiology that was mediated by the medical gaze and its language, I began to learn about the ways in which purging was experienced as a polysemous and often contradictory practice. Purging was a means to lose weight, but more significantly it was also a means to rid the body of defiling food and erase feelings of disgust. This thesis extends taken-for-granted understandings of purging and argues that it was a transformative process, one that temporarily eviscerated emotional states (of disgust, shame and guilt) and senses of embodiment (of emptiness and purity).

When I asked participants about purging practices I received a mixed response. Some rolled their eyes, looked away in embarrassment or asked me why on earth I was asking. Self-induced vomiting, Nadia said, was not “like throwing up”. It was intentional, hidden and many believed it did not signal an illness:

I’m so ashamed of what happened through all those years ... it’s not like vomiting normally - sorry tape (she apologises to my tape recorder) ... I think it is such a private thing - I wouldn’t divulge everything anyway - simply because it’s too hard for me to verbally admit, but you do some amazing things.

*But what’s ‘normal’ throwing up?*

When your body makes you do it - most of the food’s digested and it’s bile and it really smells whereas I think throwing up after having eaten a lot - and I was really regimented and had to throw whatever I ate up before two hours, before you knew it was going to be digested in four, so I had strict guidelines to follow - and it’s not digested and half the time it’s not even masticated properly - so it still looks like what it went down as so it’s really different ... I used to throw up till I bled so I was always going to get it all out regardless.

*Yeah, I was going to say - how do you know when to stop or when it’s all come out?*

Well you have to drink a lot of water or milk - you have to do it during otherwise it’s just too hard - but when you can taste bile, that’s generally a good sign, or when you bleed and there is just nothing else coming out until the water runs clear that you have just drank. It’s quite disgusting really.

Many commented on their ability to vomit and purge without others (at home, at school or work) ever being aware. Ellen started vomiting when she was 12 years old, and for the next 6 years no-one ever knew about her “terrible, dirty secret”. In lunch hour at school she would vomit in the toilets: “I got very good at it and I got very quick. I didn’t need my fingers after a time and it was just like second hand almost, I wouldn’t even think about it”. Amanda told me how she could easily hide her purging practices from her parents, proudly elevating her techniques of vomiting to an “art form —you do it very quietly, silently in fact so no-one can hear you”. She described the movement of undigested food up through her body: “I can start it just by bending over and just squeezing - you know if you see a belly dancer squeezing their muscles, it’s kind of like that. You start down there and then squeeze gradually up the oesophagus, kind of like peristalsis in reverse”. To disguise the fact that she was in the bathroom, she would often turn the sink tap or shower on, to fill the silence.

Others had never talked about the details of purging with anyone and welcomed the opportunity to speak about such experiences, and there were a small number who had talked about it with therapists and psychiatrists and were willing to share their ‘techniques’ with me. Emily told me how she learnt to lavage her own stomach with a length of green garden hose after having her stomach ‘pumped’ in an emergency department for a drug overdose. “I thought if they can do it, so can I”. She carried around a 12 inch piece of hose in her handbag so she could lavage at any time.<sup>4</sup> I found it hard to imagine this demure and well-dressed woman, with precision applied make-up, slipping a garden hose down her throat. These contradictory images and the openness of her detailed descriptions surprised me, as I wrote in my fieldnotes at the time:

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<sup>4</sup> Catherine of Sienna was unable to vomit spontaneously, and so was compelled “to let a fine straw or some such thing be pushed far down her throat to make her vomit” (Rampling 1985: 91). This became part of her daily routine up until the end of her life (ibid).

*I was somewhat taken aback by her frank descriptions of the garden hose that she uses to flush her stomach out with - in fact she said that she had done this on her way to meet with me (she has the hose in her hand bag). She knew all too well the potentially fatal dangers of this practice, she has already perforated her oesophagus and had it surgically repaired. She said that it must sound really weird to me, and that doing it disgusts her, but that she is driven to do it as she must get the food out of her body.*

Emily had been lavaging her stomach every day for the last 17 years, drinking up to a litre of warm water and sometimes adding a squirt of Fairy Liquid washing detergent to help the food “slide” out more easily. Rather than use oil as a lubricant Emily chose a detergent that doubled as a cleaning agent. I asked her why she felt driven to lavage her body:

It means that I become smaller and then there's less of you to contaminate the atmosphere. I feel that I pollute society.

*Why do you feel that?*

I have very strong feelings of no self worth, that is the nucleus of my problems. Sometimes when I eat I feel the food absorbs the badness and when I get rid of the food I am getting rid of the badness.

Emily liked to feel empty, it made her feel “clean and calm”. Feeling clean, empty and calm were often highlighted as the immediate benefits of purging, as Hornbacher remembers of her first purging experience:

And so it came to pass one day, stuffed full of Fritos, I took a little trip downstairs to the bathroom. No one gave me the idea. It just seemed obvious that if you put it in, you could take it out. When I returned everything was different. Everything was calm, and I felt very clean. Everything was in order. Everything was as it should be. I had a secret. It was a guilty secret, certainly. But it was my secret. I had something to hold on to. It was company. It kept me calm. It filled me up and it emptied me out. (Hornbacher 1999: 41-2)

“Emptiness” as MacSween (1993) suggests, “means being clean ... not contaminated by external things ... pure” (1993: 248).

## **Purging histories**

As outlined in the introduction, calmness, cleanliness and purity were terms to which people returned. In describing the need to keep her body pure, Tamara made a direct

link between anorexia and the asceticism of medieval Europe. Things that came into the body, she said, like food — “the forbidden fruit”— or sex, carried impurities and would sully a body’s purity. She traced this belief through history:

...there was the whole monastic era where the monks denied themselves things because they wanted to purge their bodies of everything and be pure and so they wouldn’t eat and do this and that and I think we still have a lot of that in our culture that is sort of unconscious, or comes along those lines of need to keep purity in our bodies so putting things in that make us either fat or unhealthy is sinful - because that’s what they all thought.

These parallels between asceticism and contemporary self-starving practices of anorexia have been vigorously debated in historical and feminist literature (and to a much lesser extent in the medical literature).<sup>5</sup> A number of authors have explored whether contemporary anorexia has links with medieval ascetic fasting practices. The central question is: “were the medieval fasting saints ‘holy anorexics’?” The arguments have tended to fall into two camps: those who argue for historical continuity between the practices (Bell 1985; Banks 1992 and Bordo 1988), and those like Bynum (1987), Brumberg (1988), Vandereycken and van Deth (1994) and Lester (1995) who insist that there is none (Garrett 1998: 113).

Asceticism is a term that is derived from ‘askese’, “a Greek concept originally developed from athletic training, and modified by the ascetical school of the Cynics and Stoics to mean the practice of conquering one’s vices and faults, the control of impulses and self-conquest in preparation for the realisation of the moral life” (Peters 1995: 55). It implies a spiritual or religious foundation, one that relates to self-discipline and resistance to the temptation of food as exemplified in prolonged fasting (Vandereycken & van Deth 1994: 2).

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<sup>5</sup> Medical discussions of the links between anorexia and asceticism can be found in Rampling (1985); Bruch (1973: 11-3); Crisp (1980: 5, 10) and Mogul (1980).

The practices of self-starvation, binge eating and self-induced vomiting have a lengthy history (see Nasser 1993). Bordo (1988) traces the cultural preconditions of fasting and feasting back to the times and writings by Plato, Augustine and Descartes and the laying down of a dualistic heritage of mind and body (1988: 92). She argues that this heritage constitutes “the basic body imagery of the anorexic” (ibid) in which they gain self-identification through control of the body: “intellectual independence from the lure of its illusions, to become impervious to its distractions, and most importantly, to kill off its desires and hungers” (ibid: 93). Eckermann (1994) describes how bingeing and vomiting were central features of the wealthier classes in Ancient Rome, where it was considered *au fait* to visit the vomitorium for group vomiting after feasting (Eckermann 1994: 83). Even earlier, Hippocrates recommended the use of laxatives, emetics and restrictive diets to maintain the balance of the four humours. Purging by way of cows milk and infusions of fennel, honey and sea salt were used by the Ancient Egyptians for both the treatment and prevention of illness (ibid).

Bell (1985), Bynum (1987) and Brumberg (1988) have traced practices of self-starvation and purging back to the 13th century when food abstinence occurred in close relationship to Christian religion and could give rise to either devout veneration or suspicion of possession. Fasting saints such as Catherine of Sienna, were often accused of being witches in league with the devil and supposedly fed by demons at night. In order to ward off persecution, St Catherine took pains to eat something during day-light hours to avert accusations of possession (Vanderekyen & van Deth 1994: 35).

Similarly, the 15th century saint Columbia of Rieti supposed that she had been possessed. Her vomiting was said to relieve her of evil spirits, “just as she had seen in pictorial representations of exorcisms” (ibid). Unlike Bordo’s analysis however, Bynum sees ‘the body’ acting in new ways at particular historical moments and argues that there are major differences between the motivations of the holy anorexics and

contemporary self-starvers. Medieval asceticism was not rooted in dualism, an attempt to escape from the body, but rather “an effort to plumb and to realise all the possibilities of the flesh” (1987: 294).

There is, however, a fundamental difference between fasting practice and anorexia that these writers overlook. One is concerned with a path to connect with the afterlife and the other is concerned with disconnection from life itself. Religious practices of fasting and food avoidance are related to a very particular *communion* with an afterlife.

Iossifides’ fieldwork in a Greek Orthodox convent demonstrates this connection. She describes how the nuns in the convent were on “a spiritual journey which they hoped and prayed would lead them to permanent unity with the divine after their death” (1992: 82). To achieve this they renounced major aspects of ties that served to incorporate people within a secular society: ties associated with the body, and kinship ties of marriage and child bearing. Partaking in the ritual of Holy Sacrament (a liturgy and communal meal) is when the nuns were united with Christ and the laity, and “all are members of a blessed community” (1992: 85). Relatedness was thus negated on one level (in the everyday world) in order to establish an infinite connection of spiritual relatedness.

Those few participants who did cite religious doctrines as a parallel framework for understanding the purging and restricted eating of anorexia did so, not in relation to communion with an afterlife, but as a disconnection from dirt and life itself. Sonya, for example, related her desire for denial of food in a very particular way: “I feel like I need to deny myself. I need to deny myself clothes, I need to deny myself nurturing stuff. I was raised very orthodox Catholic where you deny yourself stuff in order to be clean and pure”. Purity here is not only couched in a religious framework, but also in a moral hygienic discourse. Carolyn, in describing her intense preoccupation with cleaning her

body, cited Reverend Wesley’s statement that cleanliness was a virtue “next to Godliness” (cf. Hoy 1995: 3).

Garrett (1998) argues that spiritual/religious backgrounds are central to people’s development of (and recovery from) anorexia. Most participants, however, did not use a religious framework to describe anorexia, even those who were actively engaged in church or spiritual pursuits. My concern was not with forcing this connection (a critique that has been levelled at Garrett), but rather to focus on the language and bodily sensations that people were using to describe restricting and purging, the *purity* and *cleanliness* that being *empty* effected. Rather than taking a religious view, I found that participants related purging and restricting practices to dirtiness and disgust — the dirtiness and disgust of food and most particularly of their own bodies. Their desires for cleanliness were not related to spiritual connection and cohesion, but were concerned with removing, casting out and separating from that which disgusted them.

## **EMBODYING DISGUST**

In *The Woman in the Body* (1987) Martin suggests women’s imaginings of themselves and their bodies have been shaped by the language and models of medical discourse. This shaping has provided popular perceptions of women’s bodily experiences (and most particularly reproductive processes such as menstruation, childbirth and menopause) that are overwhelming negative. Scientific models, she argues, denigrate women’s bodily experiences by “implying failed production, waste, decay, and breakdown (Martin 1987: 197). Menstruation, for example, is described in standard texts for medical students as a negative process, exemplified by words such as failure, deprivation, constriction, diminished, disintegration, haemorrhage, debris, loss and necrosis (ibid: 45).



Participants with anorexia often drew on similar negative metaphors to explain their experiences, describing themselves as like “toilets”, “full of shit”, as “garbage”, “scum” and “rubbish”. Like food, they felt their bodies to be “out of place”, “dirty and polluted”, “dangerous”, “disgusting”, “diseased”, “contaminated”, “soiled” and “impregnated with evil”. More than Martin’s metaphors of ‘failed production’, these women experienced their bodies as inherently abject.

The women in this project wanted to cut the flesh off their bodies and be left with the clean, hard ‘truth’ of bones. For Sonya, ‘flesh’ was feminised and associated with excess, sin and guilt. As I describe in the following chapter, she wanted to strip away the flesh that she believed had led to her sexual abuse: “bone is strong and carries no female flesh or semblance of femininity. No man would ever want me”. Kristeva similarly notes that “the brimming flesh of sin belongs, of course, to both sexes; but its root and basic representation is nothing other than feminine temptation” (1982: 126). The power of sin lies within female flesh.

In contrast, the men involved in this project wanted more definition of their muscles. Despite their small numbers, the ways in which men and women spoke about and experienced their bodies was, as one would expect, different. The men did not experience their bodies or bodily fluids as dirty.<sup>6</sup> They did, however, describe aspects of their sexuality as dirty and disgusting, such as a desire to view pornographic materials, masturbation, a fear of being homosexual, and for one young man, the experience of sexual abuse. All three men involved in this project spoke of their desires

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<sup>6</sup> Kristeva and Douglas classify semen as non-polluting (Douglas 1966/1984: 125; Kristeva 1982: 71). Findings of this research highlight the opposite, for women in this project found the viscosity and taste of semen to be intensely disgusting and polluting. Those I spoke to about oral sex shuddered at the thought of swallowing semen, and it was, as Bettina described, ‘matter out of place’:

... it has that mucus quality and it’s cloudy and it reminds me of someone with a cold (laughs) - don’t even think about it - it’s horrible. I have swallowed it before but I prefer not to because then I start thinking about its way - its journey through my system. It kind of to me seems a bit like when someone drinks their own urine - there’s something not right about this ... I don’t like my own bodily fluids.

and fears around homosexuality, a category that is in itself feminised, marginalised and considered by some as ‘dirty and polluting’.<sup>7</sup> This view was fuelled considerably by the advent of AIDS and the demonisation of ‘contaminating’ homosexual practices.

As mentioned in the introduction to this work, the limited data on men’s bodily experiences precludes their full inclusion in this argument. What is interesting, however, is the ambiguous positioning of both the men and women in this project (through differing aspects of gender and sexuality). Both were symbolically polluted and polluting. Emily and Estelle, for example, made a distinction (which was not always clear cut) between the food that polluted their bodies and also their selves as polluting society. Such a positioning for all the women led to a desire towards feeling empty and clean.

There were various ways in which women came to experience their bodies as dirty and disgusting. Specific events such as unwanted sexual experiences left some feeling disgusted and ashamed of themselves. To be violated was to be transformed into “damaged or spoiled goods”, where the only solution was, as Sonya explained in relation to her experiences of abuse: “to be clean and transcend above this hideous society that you can’t stand because it’s so mean and cruel”. Others described their own sexuality and bodily processes (such as menstruation and pregnancy) as disgusting, dirty and dangerous. Catherine, for example, knew that there was something dangerous about her teenage years as her parents allowed her brothers to socialise, but she was no longer allowed to go out. In justifying the need to protect their daughter, Catherine sensed that her teenage body had the capacity for desire and danger. Beth described anything to do with sex or bodily functions as ‘unclean’. Having periods was ‘messy’,

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<sup>7</sup> I do not wish to suggest that all men who have anorexia are homosexual (as Crisp & Toms 1972 report) as this would only compound the taken-for-granted assumption that anorexia is a ‘feminised’ condition. The more interesting question concerning men with eating disorders and their sexual orientation would be concerned with their own perceptions of identity, connection and displacement in fields of relatedness that privilege heterosexuality.

and she remembers her utter disgust at waking up one morning to find that she had ‘leaked’ blood all over her pyjamas. She felt dirty after having sex with her boyfriend. Others who felt alienated from families or friends (as discussed in Chapter Three), came to feel out of place, worthless and uncared for: “when you feel like you’re not worth anything you feel like you are the scum of the earth, a real dirt bag”.

### **Turning on disgust**

What these experiences have in common is the feeling of disgust. In his early writings on disgust Rozin claimed that this emotion circulated around ideas of contamination and contagion, a fear of oral incorporation and food rejection. In tracking this body of work, Miller (1997) notes that Rozin positioned taste as “the core sense, the mouth the core location, ingestion and rejection via spitting or vomiting the core actions” (Miller 1997: 6). Certainly this is the case in anorexia, the desire of food and the desire to rid it. Later, Rozin broadened these core ideas of disgust to incorporate not only food, but also “bodily products and animals and their wastes, and then five additional domains: sex, hygiene, death, violations of the body envelope, and sociomoral violations” (Miller 1997: 6).

These domains are very similar to that which Kristeva defines as abject: food and thus bodily incorporation; bodily waste; signs of sexual difference and death/the corpse. All of these involve an embodied and visceral responses to disgust that “seem to erupt immediately, spontaneously from the gut” (Probyn 2000: 133). It is precisely because disgust is so visceral that it needs to be distanced, pushed away or eliminated. Disgust, as Miller notes, “differs from other emotions by having a unique aversive style ... [it] constantly invokes the *sensory* experience of what it feels like to be put in danger by the disgusting, of what it feels like to be too close to it, to have to smell it, see it, or touch it” (Miller 1997: 9). In disgust we gag and turn away, we cover our mouths, purse our

lips and fend off with our hands. Even stomachs turn. Things which are disgusting are out of place, too close, dirty and dangerous.

Disgust is the core sensations on which abjection turns. When disgust comes too close, as in rape or imbibing dirty food, the body is violated and needs to be distanced.

Distancing means reducing it, disconnecting experiences, cleaning it, and numbing it.

For Ellen, whose tiny stature always seemed to be further dwarfed by the chairs she sat in, it meant disappearing:

Like I wanted to disappear, honestly. I really felt very ashamed about who I was and I didn't want to be me. I had some bad experiences as a child - I was abused quite a bit and I always thought it was my fault and I thought that I had brought it on and so that meant that there was something drastically wrong with my person so I just wanted to erase everything that was me - become an empty slate.

The most powerful expressions of disgust were when people recounted experiences of sexual abuse. Words were ‘spat out’, bodies recoiled, voices trailed off and anger rose. Some asked me to change the subject or preferred not to discuss it at all: “Let’s not go there. Can we steer away from that?” At times Natalia became increasingly silent and rolled into a ball; these were the times she could not open her body to speak of the disgust that she felt. The following section examines the experiences of those participants who had experienced sexual abuse, focusing on how such overwhelming sensations were ‘cast out’ from their own bodies.

### **Interiorising abjection**

The literature that has examined the relationship between sexual abuse and eating disorders suggests that approximately 40–50 % of the adult women who have a clinical presentation report a history of unwanted sexual experiences (Waller *et al.* 1993: 873). Despite these strong links, there are other studies that cast doubts over such assertions. Some suggest a much lower prevalence rate (Lacey 1990) and others highlight the high

rates of sexual abuse in the general population and argue that any links are simply coincidental (Finn *et al.* 1986; Pope & Hudson 1992; Gordon 2000).<sup>8</sup>

In light of these criticisms, recent studies have narrowed their focus and examined the specificities of each eating disorder, looking at prevalence rates *and* specific diagnostic categories. One such study found a strong association between reported unwanted sexual experiences of 100 women with anorexia and vomiting/laxative abuse (Waller *et al.* 1993). Although cautious in its claims, and reminding the readers of the “multi-causal nature of eating disorders”, the findings of this research have direct relevance to my explorations of anorexia and purging; to dirt and rituals of purification. The researchers ask for further research “to elaborate on the ‘links of meaning’ between reported sexual abuse and specific psychopathologies of anorexia and bulimia nervosa”, such as the nature of the abuse (Waller *et al.* 1993: 878).

In attempting to avoid assumptions surrounding anorexia, I specifically did not ask participants with anorexia about histories of sexual abuse. Despite this, one quarter of the group spontaneously recounted experiences of sexual abuse to me (including one male participant).<sup>9</sup> Some told me when we first met and others skirted around it as it was a painful memory to recount. In all its different accounts, abuse was viewed as central to their experiences of anorexia. As I described in Chapter One, there came a time when Natalia felt it was important to tell me about childhood abuse if I was to understand “her anorexia”. It was what linked all the contexts together. It would explain, she said, the bitter self-loathing and disgust that she had towards her own body.

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<sup>8</sup> The APA (2000) reports that :

Sexual abuse has been reported in 20–50 % of patients with bulimia nervosa and those with anorexia nervosa, although sexual abuse may be more common in patients with bulimia nervosa than in those with the restricting subtype of anorexia nervosa. Childhood sexual abuse histories are reported more often in women with eating disorders than in women from the general population. (APA: 2000: 28)

<sup>9</sup> I suspect that if I had specifically asked every participant that this number may have been higher.

The following sections attempt to elaborate the ‘links of meaning’ through Estelle’s narrative. Her story is an evocative and powerful telling that demonstrates the complexities surrounding not eating. It is not only about sexual abuse, for it encapsulates a number of major recurring themes: of rape, sexuality, menstruation and poor self esteem, all factors that coalesced to form an embodied sense of disgust.

Estelle stood out from the majority of people with anorexia in my fieldwork for two reasons. Firstly, she had recovered from anorexia, a claim few could make.<sup>10</sup> Not only had she achieved this goal, but she had wanted to recover, again a claim few could make. But she also stood out because of her flamboyant appearance, being one of the very few who had a distinctive and ‘alternative’ style of dress.<sup>11</sup> The majority of people with anorexia who I encountered were conservative in appearance, they liked to follow current fashion trends. Their distinctiveness was not in what they wore, but rather (as I argue in Chapter Three), it was through being ‘anorexic’.

Most of Estelle’s shoulder length hair was matted into dreadlocks, and the ends were dyed bright pink, some entwined with silver jewellery. Her fringe was pulled back by clips that sparkled in the light, accentuated by the glitter eye shadow that was dotted around her eyes. She was dressed in ‘club’ gear, wearing two overlapping lycra black tops (the outer with the animated Japanese character of *Astro Boy* on the front), and a blue hooded unzipped top. She repeated the layering with two skirts, one long, tight

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<sup>10</sup> There are many clinical studies of recovery (psychiatric and psychological) from anorexia nervosa in the form of long-term follow up studies (see, for example, Herzog 1988, 1977; Zipfel *et al.* 2000). Despite the varying definitions of ‘recovery’, most of these studies agree that “the percentage of individuals with anorexia nervosa who fully recover is modest” (APA 2000: 23).

<sup>11</sup> In fact for Beth, an important part of her recovery was radically altering her conservative appearance to a Gothic style. On our last meeting at her house, when I went to follow up some ethnographic data from other participants, she had rung to tell me that she would be late as she was in the hairdressers “being transformed”. When we met later that day she indeed had been transformed, and Beth’s housemates and I could not hide our expressions of delight at her new found appearance. Her brown hair, usually straight and pulled back off her face, was dyed black with red streaks, and she had a new short and crooked fringe that framed her face. Her black eyeliner was taken out to the corners of her eyes, and she had put on weight, her face didn’t look anywhere near as drawn. She was wearing completely different clothes - all black - a long straight skirt with heavy ankle length leather boots, and a black long sleeved top with embroidery around the front opening. She wore a blue beaded necklace around her neck. This transformation was integral to her recovery, which she said, “was all about learning a new way of relating to myself”.

fitting black skirt with purple sandals peeping out, and a shorter red skirt over the first layer.

Estelle’s flat was also distinctive. As I walked across the asphalt car park to her suburban ground floor flat I could hear the sounds of heavy metal music floating out of her open front door. It wasn’t often that I heard music in people’s homes. Her flat (shared with her ‘bulimic friend’) reminded me of a typical teenage/student place — posters stuck up on the walls, a chair acting as a stool, a couch covered with a blanket, ashtrays sitting precariously on armchair rests, and a TV and stereo. What was distinctive about her living space was the disarray, the music and the open front door. Many of the homes I encountered were remarkably ordered and clean (a theme I explore at length in Chapter Six); there was rarely music playing and front doors were never open (except in Natalia’s case when she purposefully left the door open to invite danger).

One day, sitting on her lounge room floor, Estelle and I were discussing why it was that certain foods evoke disgust. She began in general terms: “food is disgusting” she said, then reflected for a moment and moved the discussion to a different focus.

Um ... (pause) no it’s more me that’s disgusting, this is the thing. Food isn’t disgusting - it’s me but I can translate it to food. Maybe I thought that the act of eating food was in a way - I’ve always thought that eating food was pretty gross. The chewing and the stuff in your mouth - I think it’s also the thing of having something in your mouth - uugh - even the thought of that now (she shivers and laughs)<sup>12</sup> - it goes back to the rape ...

Walking home from school orchestra practice Estelle was raped. She was thirteen years old.

Yeah, so it’s more me that’s disgusting ... like because he [the assailant] couldn’t enter me down there because I was so petrified - he ended up forcing me to give him a head job and he came in my mouth and so the thought of putting stuff in my mouth is disgusting anyway - especially if it’s anything long

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<sup>12</sup> While recounting horrific events or ‘strange’ practices, some participants laughed. Kristeva notes that “laughing is a way of placing or displacing abjection” (1982: 8).

and thin like a banana, I can't. I always felt so dirty - I've always associated food with sex - I don't know how but they are one and the same and it just made me feel dirty sometimes after I ate it. It made me feel like I'd been like impregnated by something - like penetrated on the inside by something I didn't want inside me, something I didn't want to be there at all (laughs).

Estelle often highlighted the co-terminous relationship between food and sex and recognized the pleasure, desire, and when forced, disgust, that both can arouse:

They can both be pleasurable or you can see them the other way as well. That's why I'm glad I was never actually force fed [with a naso-gastric tube] in hospital because that would almost be like the rape ... It's something against your will and you can't really do anything about it.<sup>13</sup>

Counihan (1999) notes how “food and sex both have associated etiquette about their appropriate times, places, and persons ... and they can be dangerous when carried out with the wrong person or under the wrong conditions” (Counihan 1999: 63). To be forced to eat or have sex is desire that is misplaced. Rape (and indeed any form of sexual assault), as Moreno writes of her own assault in the field, “is a vicious, murderous relation” (1995: 247). “A prevalent notion in many societies”, Moreno continues, is “that women are themselves to be blamed for rape” (ibid: 219). This stems from the idea that: “... it is the responsibility of women to make sure that they are not ‘in the wrong place at the wrong time’. In other words, there are times, places and situations out of bounds for women, which they traverse only at their own risk” (ibid: 219).

Being in the ‘wrong place’ was exactly how Natalia’s experiences were construed by others. In her diaries, Natalia wrote that her mother repeatedly questioned her after being raped as a child; “what were *you* doing in there, how could *you* let him do that?” Natalia swore to me through gritted teeth: “I will *never* forgive my mother for asking

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<sup>13</sup> Ellen similarly described her experiences of being ‘fed’ via a naso-gastric tube as one of “violation”:  
My stay in the hospital was very scary because it was the first time I was getting any sort of real treatment and I had a tube down my nose and that really, really scared me to tell you the truth ... I felt *violated*. I was angry with having this food coming in me that I had no control over and I was scared.



those questions, for blaming me”. Women are deemed ‘at risk’ and often culpable, when out of place.

Clinicians frequently noted in Estelle’s case notes the causal link between her development of anorexia and the rape, an association that Estelle herself was later to come to terms with. For many years after the attack, thinking and talking about certain foods was traumatic for it returned her to that presence, to the touch, taste and smell of the rape. The thought of sticky and greasy foods still makes her feel nauseous, as it reminds her of holding the stranger’s semen in her mouth:

Yuck (she laughs). It’s got that dirty - unable to wash it off - feeling. It’s got the same texture - I don’t know if this is going a bit far - but it’s got the same texture and look and everything as grease, it’s white and gooey just like fat (laughs) It [semen] smells and looks disgusting.

Grease and semen are interchangeable in Estelle’s register of disgust. It is their similitude, their closeness of association that revolts.

Estelle continued to describe a series of events that compounded and confirmed her own embodied sense of disgust. Following the rape her grades at school plummeted and she failed her second year of high school. She started to shoplift, take amphetamines, and at fifteen she left the family home and entered a series of abusive relationships:

I really thought I was disgusting because I had all these people telling me I was disgusting ... My first boyfriend would tell me that I was hopeless in bed and he felt disgusted after having sex with me and stuff like this so I sort of had this real feeling that I was disgusting because that’s what everyone kept telling me ... the teachers said I was worthless ... this Vietnamese boyfriend I had was constantly reinforcing that I was worthless - I was *just a woman* - that somehow something was wrong with me because I was a woman and then there was the rape which just made me feel disgusting anyway. So I had all these things telling me I was disgusting ... I had my boyfriend beating me up but I felt I couldn’t leave him so I was disgusted in myself for staying with him and being so needy of him ... and I translated that not so much into my mind being diseased but my body being diseased and I felt like I had to clean my body out - like I felt that the only way of me not being disgusting would be to sort of not be here in such a physical sense of you know what I mean. Maybe if guys didn’t look at me in a physical sense as a woman then I wouldn’t be as disgusting - I’d

be an equal to them or whatever - I wouldn't be seen as a slut or as just something to have sex with or beat up and discard which to me is something you do to a piece of rubbish - which is disgusting ... I felt like I had to somehow make myself better because I had all these people telling me how horrible I was, how awful I was, how much of a slut I was or whatever and I didn't know how to change myself on the inside.

Like Julia, Estelle drew on metaphors to convey her experiences. And like Julia's use of the tablecloth metaphor, it was one that drew on concepts of dirt and cleanliness. Estelle said that her sense of disgust was akin to a toilet, as her body had become a receptacle for waste. What was put into her (food, sexual organs) and placed on her (criticisms) resulted in her embodying a sense of disgust:

I didn't know how to change myself on the inside so I had to change myself on the outside instead. Cleaning yourself from the inside - somehow like you clean a toilet - flush it. You feel like a toilet or that you're being used like a toilet - being shat on (laughs) and having things placed in you that you don't particularly want there and stuff like that.

The only way to reduce the disgust, which was intimately tied to her sense of womanhood, was to reduce her physical presence and stop putting things into her body. She disconnected from bodily experiences that disgusted her: eating, sex, intimacy, emotions and the memory of the rape.

Others who have experienced sexual abuse use the same language of disgust and disconnection. In setting the scene for her book, Garrett similarly writes of her own disgust and separation that began in her childhood.<sup>14</sup> In her introductory chapter entitled 'personal sociology' she writes:

On the aeroplane which brought us back to Australia, I was sexually abused in the cockpit by an acquaintance of my father's; an Australian judge. Heaving with nausea, I pulled my very pregnant stepmother into the cramped aircraft toilet and told her what had just happened. In the sixties, people did not talk about such things. At least she believed me. What he had done was wrong, she said, but some men were just like that; they could not help themselves and there was nothing to be done about it. I would have to put the experience behind me and get on with my new life in Australia. Only my parents knew what had

<sup>14</sup> In opening a chapter on disgust and shame, Probyn begins with: "like many, I spent much of my childhood feeling disgusting" (2000: 125). She then immediately writes about her experiences of anorexia.

happened and neither of them ever mentioned it again. After a few weeks, the nausea went; but the disgust with my body, the fear of its sexuality and of men were still there two years later when boys began to ask me out. In self-protection, I had separated myself from the source of my troubles — my body — and was frightened by its demands. (Garrett 1998: 8)<sup>15</sup>

Disconnection and alienation from bodies was a recurring topic of conversation with participants. A Canadian art exhibition which visually explored people’s experiences of eating disorders had an installation of a dismembered female body entitled *My Body does not Belong to Me*. Tamara referred to herself as “me and my disgusting body”, suggesting that her body was separate from her ‘self’. Language was often used in this way as a tool for distancing. It allowed people to separate their sense of self from bodies (rather than saying “I” many people referred to their own experiences in the third person). Interestingly, all the men and women in this project referred to their sexual bodies by way of distance – “you know, the bits down there”, “nether regions” or “private parts”.

When participants disconnected themselves from these types of experiences, they not only separated from “the source of their troubles”, but also from relationships with other people. Estelle spoke of problems with intimacy and sexual relationships, lack of networks and loneliness. Ellen, who blamed herself for attracting unwanted sexual attention, distanced herself from all relationships by way of literally disappearing and hiding:

I just thought that if there was more of me I would command more attention from other people and since I didn’t have very good experiences in the past I was worried of what sort of attention of what I might get - or that I might cause someone to do something wrong ... I bordered up my windows with black cardboard paper - I never put the lights on and put candles on ... I was living a recluse life really.

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<sup>15</sup> Liu similarly opens her autobiography *Solitaire* (1979) with an account of a rape by two boys that took place during a holiday family visit.

## The horror within

Other ways in which women reported feeling that their bodies were dirty related to bodily processes such as digestion and reproduction.<sup>16</sup> Whilst attending a conference on the history of food and drink a prominent Adelaide chef commented on the changing obsessions of bodily cleanliness that she saw amongst her female staff:

People are so scared of dying of cancer or high cholesterol that they go on detox diets. They [the female staff] are cleansing their alimentary canals because they feel their bodies are dirty. In the 60s for me menstrual blood was dirty, now it's people's stomachs and intestines as well that are dirty.

Bodily processes *are* marketed as a dirty business. A recent Australian newspaper advertisement claims:

A surprising fact is that few people realise their bowel is the gateway through which dangerous bacteria enter their bodies. Most illnesses, no matter where in the body, start in a contaminated bowel ... your quality of life can be dictated by your bowel. It is hard to be the life of the party if your bowel is not performing properly. (*The Sunday Mail*, Feb 2000: 12)

These claims are part of a naturopath's advertisement for a bowel cleansing programme, a “new bowel cleansing formula that flushes your body of harmful toxins and parasites fast” (ibid). As well as toxins and parasites, the bowel contains “dangerous bacteria, decaying wastes, poisons, and even meat that is decomposing like a dead body”. It is “a sewer, a dustbin, a breeding ground ... and it causes illness, disease and death”. The parasite attacking herbs and multi-cleansing fibers that are recommended “supercharge your digestive system and rid the bowel of unwanted wastes, toxins, restore bowel health and eliminate parasites” (ibid). They work “like an intestinal broom, scrubbing and sweeping the inner walls of your colon ...” (*The Advertiser*, Tuesday Nov 28th, 2000).

While these advertisements are directed towards both men and women, there is growing evidence that it is women's bodies in particular that are construed as dirty and in need

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<sup>16</sup> Bettina exclaimed to me one day “oh god, I'm just dirt, what does it matter?”

of cleansing. Many participants echoed these fears. A naturopath had told Grace that “her system was blocked” and she “needed to flush it”. A plumber would use exactly the same language in regards to a blockage in a domestic toilet system. Grace’s meticulous adherence to the recommended diet, and her concern with bodily cleanliness, was what her general practitioner and psychiatrist blamed for the development of anorexia.<sup>17</sup>

When I asked Amanda how she conceptualised what happened inside her body she described without any flicker of hesitation: “my insides are dirty”. “Insides” to Amanda was her alimentary canal (her stomach and intestines) and her lungs:

My first thought was of them being dirty, kind of black and dark. I also thought after that of lungs, and obviously they’re pretty dirty because I smoke - I thought of that ad [television commercial] where they squeeze the fat and tar out which I can’t even watch – it’s obscene.

Several others had no concept of the “journey of digestion” beyond the stomach, as if “a cork was placed at the bottom of [their] stomach”. These women believed that food travelled straight from the stomach to their outer flesh, where it stuck fast like cement.

Bettina was horrified at any “going’s on” in her body. She watched my pregnant body with fascination, openly apologising for her own embodied and spoken horror at the very thought of being pregnant herself, an unlikely event she joked, as “I have an aversion to putting things into my body”.<sup>18</sup> She leant across a cafe table in a crowded coffee shop and whispered to me:

... being pregnant would absolutely - I don’t know how I’d cope - something *growing* - like growing - it’s like - not a fungus - it’s a parasite that’s feeding off

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<sup>17</sup> Any mention of naturopaths during ward rounds at one major hospital brought sighs of exasperation, rolling of eyes and disparaging comments from attending staff. Naturopaths were seen as assisting in obsessions about certain foods. Psychiatrists fears are validated on a ‘pro-anorexia’ website where the benefits of cleansing from a detoxification diet are highlighted:

Do you want to cleanse your body? Get rid of toxins, feel clean & pure? DETOX DIET. It outlines the diet & specific foods you can & cannot eat. Also features: Mini-Detox, Fasting, Exercise & more. Visit the Detox Diet Website!

<sup>18</sup> Although Bettina presented herself as a ‘demure’ and ‘morally pure’ character, her conversations were often interspersed with humorous (and whispered) stories about her sexual relationships with men. She characterised herself as having ‘a problem’ with sex; while she has some pleasure from sex, she doesn’t like the thought of men ‘entering’ her and has never ‘let herself go’ and had an orgasm. The thought of bodily processes during sex, of vaginal secretions and semen inside of her, disgusts her.

me ... It's taking from me and it's sucking me and I feel like it's drawing it all from me, my life is going ... It's like in the sci fi movies where something takes over you - it's awful for you to hear me say that ...

The thought of something growing, moving and feeding within me fascinated and simultaneously repulsed her, I was the quintessential abject maternal body. She tentatively asked if I could feel the baby kick and move (quick to point out that she did not want to feel “my stomach”) and when I said I could she put her hand to her mouth in shock, saying it made her feel sick and squeamy. In fact, whenever we talked about bodily processes — secretions, digestive systems<sup>19</sup>, or reproductive systems — she screwed up her face and closed her eyes. She couldn't bear to think of “things moving inside [her]” and wanted to think of herself as completely empty.

A moment later Bettina withdrew back in her chair and held her arms and hands out in front of her in disgust of her own periods:

I don't like to think that those things are happening, I don't like to think that my body is working inside, in fact that makes me feel ill ... it makes me feel sickly. I'm never sick, like vomit, but it just gives me a feeling of wooziness all the way through - from the pit of my stomach all the way through – something's happening in there and it's best that I don't focus on it and that's the only way that I can get away with it now is not to focus or think that it's happening.

Although Bettina was horrified at the thought of being pregnant her home displayed an obvious desire and fascination with children. Standing in the spare bedroom of her apartment I commented that although she was adamant that she would never have children, much of her house displayed a passion for children's things: the miniature crib made up for a baby, the small tea sets that she collected since childhood, and her

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<sup>19</sup> Early feminist writing on anorexia argued that it was a form of female social protest against oppressive and contradictory roles of femininity (Orbach 1978, 1986; Chernin 1986). Within this formulation, protesting against the ‘digestive system’ could have been taken as a humorous extension, as one of Attwood's characters in *The Edible Woman* wryly points out:

Says Marian who can't eat anymore prior to her wedding;  
 ‘I'm sorry I don't know why I do it, but I can't seem to help it’. She was thinking, maybe I can say I'm on a diet.  
 ‘Oh’, said Duncan, ‘you're probably representative of modern youth, rebelling against the system; though it isn't considered orthodox to begin with the digestive system ...’. (Attwood 1969/1980: 192)

elaborate wall display of dolls (that were arranged “in order with [her] life”). These objects however, remained at a distance — the crib was in its original plastic wrapper, and all the dolls were out of reach behind glass doors. They were only to look at and not interact with. Like Natalia’s display of Japanese objects (described in Chapter Six), what was important about these objects was their smallness. To take up less space, be “a little fairy”, “fit into the size of a matchbox”, or to simply disappear was an aspiration. Bettina explained that she loved the dolls because, “like children, they are small, don’t speak and have perfect skin and features”. Babies were appreciated for their smallness, as Rita said as she touched my pregnant belly: “I love babies because they are so small and perfect”.

### **Coming into new gender relations**

Bettina’s reaction to the disgust associated with her periods is not a new phenomenon. Much of the ethnographic and feminist literature that explores concepts of menstruation has focused on the constructions of taboo (supernaturally sanctioned law) and pollution (symbolic contamination). Within these frameworks, menstruation is negatively constructed as ‘the curse’, or, more fully “the curse of Eve: a part of God’s punishment of women for Eve’s role in the Biblical Fall” (Wood 1981, cited in Buckley & Gottlieb 1988: 32). Ussher similarly notes the maligning of menstrual blood:

Whether menstruation is deemed to be a woman’s relic of Eve — the punishment for the Fall — or merely a biological phenomenon which is inherently debilitating, the taboo ensures that, within patriarchal culture, menstruation is conceived as a curse ... Our blood marks us as Other — as we bleed we fail, we fall. (Ussher 1991: 22)

More recent ethnographic work has criticised the universalising and reductionistic analyses of menstruation, arguing that “its symbolic voicings and valences are strikingly variable, both cross-culturally and within single [sic] cultures” (Buckley and Gottlieb 1988: 3). Similar to my argument in the previous chapter, symbolic analyses

of pollution are limited for they have obscured the ambiguity and multivalence of women’s experiences of menstruation. A framework that focuses on ‘social facts’ has not only reduced understandings of menstrual blood to a universal biology, but also failed to explore the many and changing social relationships that menstruation brings into play.

While critically appraising the earlier contributions to menstrual symbolism, Buckley and Gottlieb (1988) argue that ethnographic specificity is required to redress some of the limitations in previous works. Emily Martin’s work (1987) perhaps exemplifies this ‘new’ approach to menstruation. She does not deny the usefulness of past theories, or claim a singular alternative; rather her ethnography examines the *different* ways in which women’s reproductive processes are perceived, ranging from dominant scientific ideas to women’s own everyday experiences and understandings. For example, Martin describes the positive aspects of menstruation: “[as a] sweet secret ... it is clear that women construct the significance of menstruation in terms of the range of opportunities open to them and their expectations about how they will make use of them” (1987: 101-3).

As in Martin’s work, I found a variety of different understandings of menstruation at play: positive, negative and ambiguous. The range of responses revealed the range of experiences – many women were not menstruating and others had only just had their periods return (one after an absence of 28 years). What all women had in common at one time or another was an absence of periods. Amenorrhea, the cessation of the menstrual cycle, is a major diagnostic criteria of anorexia. “In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles” (APA 2000: 20) is a symptom of anorexia nervosa.<sup>20</sup> Those who think or hope they might

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<sup>20</sup> Possible causes for amenorrhea have been related to physiological causes such as “endocrine dysfunction (hypothalamic dysfunction or to dysfunctions of the hypo-thalamic-pituitary-ovarian axis)” (Malson & Ussher 1996: 506).



have anorexia also ‘weigh’ this diagnostic marker as a defining signal that they have the credentials to ‘join the club’. Amanda expressed her delight at “losing her periods”: “I lost my period for a fair while which was good because that meant that I had lost enough weight and maybe I was anorexic”.

Having her period “signified womanhood”, a state that she was trying to avoid: “I think periods signify womanhood in a way and I feel like what I’m doing sometimes is getting back to childhood, and that’s why I got such pleasure in not getting my period”. This explanation concurs with much of the medical literature that suggests anorexia is a fear of sexual maturation and a retreat into childhood. Amenorrhea is said to be symptomatic of this retreat, a rejection of adult femininity (Malson & Ussher 1996: 506), a failure to accept female psycho-sexual maturity. Such a perspective locates anorexia within the individual, divorced from cultural, historical and social contexts and relationships.

This was, however, not a frequent explanation for lack of periods. Hornbacher strongly argues against this interpretation of regression:

Too often the shrinks assume an eating disorder is a way of avoiding womanhood, sexuality, responsibility, by arresting your physical growth at a prepubescent state ... The shrinks have been paying way too much attention to the end result of eating disorders — that is, they look at you when you’ve become utterly powerless, delusional, the center of attention, regressed to a passive, infantile state — and they treat you as a passive and infantile creature, thus defeating their own purpose. This end result is not your intention at the outset. Your intention was to become superhuman, skin thick as steel, unflinching in the face of adversity, out of the grasping reach of others. Anorexia develops when a bid for independence on the part of the child has failed. It is not a scramble to get back into the nest. It’s a flying leap *out*. (Hornbacher 1999: 68, emphasis in original)

The most common understanding amongst those with anorexia in this study related not to regression into childhood, but to cleanliness. Like many women, participants spoke of periods as “a messy and dirty business” (Martin 1987: 93) and were glad to be

unencumbered by the associated embarrassment and shame of menstruation. Menstrual blood itself was construed as “not real blood”, dirty in comparison to the clean, bright red blood that circulates in the cardio-vascular system. And participants themselves often “felt dirty and bloated” when they had their periods. For Rita, menstrual blood, like any form of bleeding, indicated that, “something was wrong – the first time it happened I thought I was dying, it shouldn’t be happening”. For her, it was blood that was ‘out of place’.

The concept of menstrual blood as ‘out of place’ is at the heart of arguments put forward by authors such as Martin (1987), Grosz (1994), Shildrick (1997), Kristeva (1982) and Vertinsky (1994), to name a few. Women, they argue, have not only been aligned with a lack or absence, but also with seepage and uncontrollable liquids. “For the girl”, Grosz argues, “menstruation, associated as it is with blood, with injury and wound, with a mess that does not dry invisibly, that leaks, uncontrollable, not in sleep, in dreams, but whenever it occurs, indicates the beginning of an out-of control status that she was led to believe ends with childhood” (1994: 205). Tamara hated the way in which menstrual blood “oozed out” over several days and wished that “there was another way it could come out”. Her suggestion was to “just get it out all in one go, like going to the toilet and urinating rather than having it drag on”. Having it drag on meant days of feeling “a lot worse about myself because feeling bloated and just the bleeding and it’s dirty and yuck and inconvenient”.<sup>21</sup>

Despite the negative experiences of periods, Tamara simultaneously highlighted the positive aspects of removing polluting wastes from the body: “In a sense it’s another act of purging really because it’s getting out all the gross things ... so for me being a

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<sup>21</sup> Martin has extensively documented the separation of self from body that women describe when they talk about menstruation, menopause and birth (1987: 77-91).

cleanliness freak I’d rather have it out than in”.<sup>22</sup> Estelle similarly described the benefits of losing “dead blood”:

I sort of used to like it after my period because I felt like I’d lost a bit of weight and lost a bit of blood out of my body ... It’s been lining the walls of your womb for a month or so and it’s dead and it’s sort of sticky too – you think it’s dirty so it’s good to get rid of it.

Lack of periods was also welcomed as it meant not having to deal with sanitary products. Few participants used tampons as they “just didn’t seem right”, were “uncomfortable” and “not supposed to be there”. Beth had only ever once used tampons – “never again” she said, “I really doubt that I’d be able to get one in now that I’ve got this problem with not having enough moisture down there ... I think I’d feel really weird with one inside me anyway, walking around with something constantly inside me”. The thought of using tampons made Tamara “feel nauseous – like squeamish. I can’t bring myself to do it, I think this isn’t right, this isn’t natural, and I can’t do it”. The sense of impregnation or transgression of the body echoed with the descriptions of imbibing foods, and was thus avoided.

Related to the onset of periods was a newfound awareness of changing relationships. Houppert suggests that some “people immediately perceive a girl who has begun to menstruate as being different, and girls are treated differently once they’ve started menstruating” (1999: 109).<sup>23</sup> These changes are concerned with the young girl’s ‘coming into womanhood’, her capacity to reproduce. When Catherine started to physically develop as a teenager she sensed a palpable change in household

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<sup>22</sup> ‘Better out than in’ is a common phrase used to joke about emitting bodily gas (burping and farting) and emotions. It is a phrase that pays homage to the body as a contained and bounded unit that needs to rid itself of wastes.

<sup>23</sup> Becker (1995) notes that the connection between danger and fertility has been well traversed in ethnographic fieldwork (1995: 94). Meigs, for example, has written about female reproductive powers and their association with contamination, potency and danger in the Highlands of New Guinea (Meigs 1984). Weiner has also shown this relationship in the Trobriand Islands where female power is contained in the ability to regenerate human beings (Weiner 1976: 228-9). The embodied, cosmological potency of this power meant that “women represent sexuality and fertility, but also danger” (ibid: 193).

relationships. She had been raised in a strict Baptist family and was taught that sex was “only something that adults did within the sanctioning of marriage”. When she started to develop breasts and have periods she became aware of new possibilities:

Part of it was the family I grew up in. Being a young woman or a woman is dangerous - it's kind of like the feeling you get - boys are out only after one thing and it was too hard, dangerous.

*Why dangerous?*

Dangerous because you could get in trouble.

*You mean trouble as in sleeping around or getting pregnant?*

Yeah, that sort of thing. It was like it wasn't seen as a good thing.

This idea that menstruation is directly associated with reproduction is part of a wider conceptualisation of women's biological grounding. When asked what they understood by the term ‘femininity’, participants designated the arbitrary biology of sexual difference — “the so-called secondary sexual characteristics — the filling out of breasts and hips, the growth of pubic hair, and perhaps most strikingly, the onset of menses” (Grosz 1994: 203). This difference, as described in the sections above, was primarily experienced as negative, for a body “which leaks, which bleeds, which as at the mercy of hormonal and reproductive functions” (Grosz 1994: 204) is one filled with dread, shame and embarrassment.

In their discourse analysis of interviews with women who had been diagnosed with anorexia, Malson and Ussher (1996: 509) reveal that menstruation was negatively construed as a signifier of ‘femininity’. They argue, however, that it signified a very specific ‘femininity’ that was alien, out of control, highly emotional, sexual, vulnerable and dangerous. What is rejected in anorexia is not adulthood or femininity *per se*, but this particular construction of femininity. My research similarly found this list of constructions at play when women described femininity or womanhood. What this list does not include, though, is the prominent theme of disgust, of bodies that are dirty.

\* \* \*

Not everyone had experiences of sexual abuse, abhorrence at the thought of ever being pregnant, or felt their sexuality to be dangerous. What participants did experience at some level, however, was disgust with their bodies, and it was the embodiment of disgust that signalled something that was both out of place and too close. Disgust, Probyn (2000) writes, reminds us of,

... the overwhelming horror that the disgusting object will engulf us, [that we have] been too close to things which we prefer not to speak ... disgust illuminates the body's capacity for reaching out and spilling across domains that we would like to keep separate, or hidden from view ... Basically bodies become too close, to themselves and others ... In other words, in disgust, things, categories, people are just too close for comfort. (Probyn 2000: 131-2)

My fieldwork was redolent with “things [of] which we prefer not to speak”. Depending on the context, anorexia itself was recognised as shameful, as something to hide and deny: “I’m fine really, I’ve just had gastro”. Sexual assault was also not spoken about. Estelle returned to school the day after her rape so as “to make it look as if I’d just had a sick day, to hide the fact that I’d been raped”. Natalia never again spoke with her parents of the assault that occurred whilst the family was visiting friends. Both distanced the experience and it took many years before they were able to speak of it.

Disgust was a central element to people’s experiences of anorexia. Disgust points to the abject relations that participants had with food, their own bodies and other people. In coming too close for comfort, disgust points to the dangers of relatedness.

This chapter has argued for an alternative rendering of purging that is based on the relationships between disgust, dirt and cleanliness. Rather than being simply a means to lose weight, purging was experienced as a practice that maintained the ‘clean and proper’ body that Kristeva outlined. Purging eliminated that which ‘spilled across domains’; it was a movement towards emptiness and purity. The disgust associated

with leaking menstrual blood, transgression of sexual taboo and even bodily processes of mastication and digestion were distanced and disconnected from bodies.

As Malson and Ussher (1996) argue, these women were removing themselves from a particular discursive construction of femininity. However, in turning the focus away from discourses of individualism (of bodily control and autonomy), my argument suggests that these women were rejecting very specific processes of connection. In rejecting the biological grounding of their bodies, participants were rejecting connections of relatedness. Periods, pregnancy, childbirth, and sexual relationships fundamentally connect people. When menstruation ceases, the capacity for childbirth is negated. As one of Eckermann’s participants explained: “I have *produced* a body which *denies* sexuality ... I have stopped having periods so I can’t even have a baby” (Eckermann 1994: 88 my emphasis).

As the cross-cultural literature highlights, it is these processes of sexual maturation that position women *in new relationships* with others. This positioning was often experienced by participants as disgusting, threatening and transgressive. Participants did not want to connect with other people. On the contrary, they wanted to be “out of the grasping reach of others”. They achieved this disconnection through cleanliness, emptiness and purity.

## CHAPTER 6

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### BE-COMING CLEAN

*The dizzy rapture of starving. The power of needing nothing. By force of will I make myself the impossible sprite who lives on air, on water, on purity.*

*(Harrison, 1997: 41)*

The previous chapter described the ways in which women experienced their bodies as dirty and disgusting. When disgust was so viscerally located in one's own sense of self it could not be displaced so easily. Participants could not turn away from their bodies. They could, however, erase dirt and disgust by becoming empty and clean, by avoiding food and purging their bodies through self induced vomiting and taking laxatives. This chapter extends the discussion of purging to a range of other practices that were also cited as cleansing techniques. These included washing and scrubbing parts of one's body with water and/or antiseptic cleansers, or even the sucking of antibacterial lozenges to cleanse 'contaminated' mouths. Participants' goal was to achieve and maintain a body that was sanitised, scrubbed, and exfoliated of experiences, memories and its own corporeality. It was these combined washing and flushing practices that led me to re-examine the experiences of anorexia under the spotlight of hygiene.

In describing these cleansing practices, my attention was drawn to the household spaces in which they occurred: to bathrooms, toilets, bedrooms and kitchens. These were the quintessential sites where anorexic practices took place; the sites where bodies and spaces were most intimately related. Despite the great interest in the anthropology of 'the body' it is only recently that connections with architectural spaces have come into the analytic spotlight. In their edited collection, Carsten and Hugh-Jones (1995) suggest that like the body, the houses in which people dwell are so commonplace and

familiar that we hardly seem to notice them (1995: 4). They may be part of the initial survey of who lives where and who does what in each space, but they,

... soon fade into the background to become merely the context and environment for the increasingly abstract and wordy conversation of ethnographic research ... In time, for both anthropologists and their hosts, much of what houses are and imply becomes something that goes without saying (ibid).

Inspired by Levi-Strauss's writings on 'house societies', Carsten and Hugh-Jones seek to go beyond the assumed priority of kinship or economic dynamics of houses to focus on the complex ways in which *social and cultural relations* are manifest in the domestic sphere. This, they argue, enables them to see houses 'in the round', focusing on "the links between their architectural, social and symbolic significance" (Carsten & Hugh-Jones 1995: 2). Linked in very intimate and conceptual ways, "the body and the house are the loci for dense webs of signification and affect and serve as basic cognitive models used to structure, think and experience the world (ibid: 3).

This chapter argues that experiences of anorexia cannot be divorced from an analysis of spatial practices. Domestic houses were an idiom of *habitus*, a place where people learnt about the pleasures and dangers of cooking and sex, and the cultural logics of privacy and hygiene. Bourdieu's concept of *habitus* extends beyond discursive approaches of hygiene, for it allows an investigation of how people use and transform household spaces and hygiene practices in their everyday lives, the gendered nature of hygiene and the emotional investments with which cleansing is imbued. This chapter is thus structured according to these three intersecting domains of hygiene: to spaces, gender and emotions. I argue that hygiene is more than a discourse; it is a taken-for-granted everyday practice that has the ability to transform relationships and emotional states.



## Co-morbidity or logic of practice?

In order to counter abjection, many women developed highly routinised cleaning practices such as hand washing and teeth brushing. Following a suggestion by her doctor, Bettina meticulously documented the times during the day that she would wash her hands, and what thoughts prompted her to do so. The resultant diaries were recordings of her daily routines in a hospital ward, detailing when she washed her hands, the length of time and what triggered the washing. All of the triggers related to what Bettina considered dirty and contaminating: for example, anything to do with food (she had to wash her hands before and after eating), washing her body (she washed her hands before, during and after washing her face, before and after she showered, before and during brushing her teeth), when she overheard another patient say a “dirty” word (swearing or slang), when she thought of words such as “fat”, “devil” or “pig”, and after using cosmetic cream.

The amount of time that Bettina and many others spent cleaning their bodies and houses suggested to me that there was more to this relationship than first appeared. Whilst psychiatric circles saw these behaviours as symptomatic of obsessive compulsive disorder<sup>1</sup>, I began to ask people why they washed themselves (and why particular body parts), where they washed, what products they used and how it made them feel. Rather

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<sup>1</sup> Some clinicians argue that obsessive symptoms are the result of food restriction, as evidenced by the infamous Minnesota experiment of 1950 (Keys *et al.* 1950; Sorokin 1941: 31). Many self help manuals and treatment texts make reference to this experiment which took 36 male volunteers (later referred to as the Minnesota Men) and put them into a state of chronic starvation for a period of months. The physical, psychological and behavioural effects of prolonged fasting were documented, and included feelings of elation, euphoria, depression, irritability, obsessions with food, and withdrawal from social contact. The term ‘starvation neurosis’ was coined to describe this state (Peters 1995: 47). The effects of starvation on these men are still used to explain symptoms of anorexia nervosa amongst women, as this extract from a recent treatment manual describes:

Some of the clinical features associated with eating disorders may result from malnutrition or semi-starvation. Studies of volunteers who have submitted to semistarvation and semistarved prisoners of war report the development of food preoccupation, food hoarding, abnormal taste preferences, binge eating, and other disturbances of appetite regulation as well as symptoms of depression, obsessionality, apathy, irritability and other personality changes. (APA 2000: 20)

While not disagreeing with the physical effects of starvation, I do take issue with the assumption that men’s experiences can be transposed to all bodies. ‘Male’ is taken as the generic, as the standard template from which all other experiences can be explained. The fact that 95% of people diagnosed with anorexia are women seems to be overlooked in this research. Gender cannot be omitted from research into eating disorders.

than view cleaning from the perspective of illness, I took my interpretive cues from participants' themes of purging and protection from disgust and dirt. Cleansing was a way of disconnecting themselves from relationships with other people, memories, experiences and themselves.

In ward rounds at hospitals staff made frequent references to obsessive compulsive behaviours by those with anorexia. The medical literature on eating disorders clearly highlights this phenomena (Davis *et al.* 1998; Thornton & Russell 1997; Zubieta *et al.* 1995), some even regarding “obsessionality and obsessive-compulsive symptoms as important characteristics in the clinical presentation of eating disorders” (Zubieta *et al.* 1995). While obsessive compulsive disorders manifest in behaviours, it is thought that these ‘disturbances’ are generated by neurochemical changes, specifically the differing levels of the chemical serotonin in the brain (Jarry & Vaccarino 1996).

Despite this neurological ‘evidence’ I found that there was no exploration of the connection between ‘anorexic practices’ and ‘obsessive behaviours’. It was taken for granted that the obsessive behaviours associated with anorexia, which were termed ‘rituals’<sup>2</sup>, were part of an associated disorder, one which often was said to have a deleterious effect on treatment outcomes. If, however, some of these obsessive behaviours are approached with an understanding of dealing with abjection (from both food and one’s own body), the connections between these separate practices are illuminated. Why, for example, did so many people with anorexia have very particular concerns about contamination, washing, cleaning, and order, rather than the other common obsessive behaviours like checking or counting?

Amanda explained how difficult it was for her to wash her hands after eating because there was no running water in her single hospital room. She would ask the nursing staff

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<sup>2</sup> This word ‘ritual’ was used frequently by clinicians and participants to denote idiosyncratic structure and routine of behaviours.

for two separate bowls of water (one to wash her hands in after touching food and the other for ablutions), as well as using “baby wipes” (although not as effective) to clean her hands of contaminating fats.

I always wash my hands after every meal - or even half way through a meal - after the main meal and before a dessert I'd wash my hands.

*Why?*

It wasn't the calorie thing it was just more a dirty thing - I just felt dirty that it had got on my hands - and particularly something like butter.

Rather than categorising her behaviour as an effect of neurochemical fluctuations, I argue that cultural ideas of cleanliness and hygiene are motivating factors, and play a central role in the desire to be empty, pure and clean. Only once during my fieldwork did I hear links between these illness characteristics being made. A visiting psychiatrist at a ward round presented “an interesting case” of a young woman who had both “florid obsessive compulsive disorder and anorexia”. What was most interesting about this case, he reported, was that the young woman had fears of food contamination, a fear that prevented her from ingesting food and compelled her to repeatedly wash her hands after touching food. The psychiatrist remarked that this was an unusual case, a finding that surprised me as many of the women with anorexia who I had spent time with had similar fears and responded in a similar way.

It was the combined washing and flushing practices that fascinated me. It was the *doing* which was important — the washing, flushing and purging of bodies and spaces — that made the transition from dirty to clean. As Kirmayer states:

The meaning of words and gestures is grounded in bodily experience. Meaning resides not exclusively in the relationships between concepts [such as dirtiness or cleanliness] (as structuralism would have it) but in their connection to the body and its skills and practices. Meaning emerges from the capacity to use bodily experience (including socially embodied experience) to think with metaphorically. (Kirmayer 1992: 334)

Thus the metaphoric relationships between food, dirt and cleanliness are intimately connected with the ways in which participants experienced their bodies in space and time.

The transition from dirty to clean was described by Tamara, the youngest married participant (at twenty), who was studying fulltime and lived in a small house with her supportive partner. Tamara explained her daily “symbolic rituals of purification”. She showered twice a day, firstly washing herself with soap, and then exfoliating her skin with a “scrubber”. This exfoliation was to make herself “cleaner” and “to take that disgusting feeling away ... I’m trying to get rid of the gross, dirty, shameful feeling that’s often there”. Her partner Angus, who was fully aware of Tamara’s daily struggles with anorexia, gently challenged her on some of these practices. He would remind her, for example, that it was unnecessary to wash her hands in between the three different facial products she applied in her daily “facial routine”.

There was a very particular order to Tamara’s washing, predicated on what she referred to as the “clean and dirty parts” of her body. She fetched a blue towel from her bedroom to explain the routine to me: “one side of the towel is to dry my face, upper body and arms [not her breasts or underarms] and the other side is to dry the other areas [she hesitates] – my female parts”. She had developed a way of hanging the towel over the towel rail in the bathroom so she knew exactly which side she was using at any given time: “the side with the tag on it is for the clean parts and the other is for the other dirty parts”. Tamara also used two separate flannels for the same reason. The “dirty parts” of her body — her genitals, breasts, bottom and underarms — were sources of contagion, pollution and dirtiness.

For Tamara, the significance of the washing was not only that her skin appeared clean, it was also the easing of the tremendous guilt, shame and disgust she felt. Her

routinised hygiene practices temporarily alleviated these emotions that she has had, she said, ever since she was raped by a male friend in her own home. I return to the emotive qualities of hygiene practices in the later section of this chapter.

Tamara was using cultural rules of hygiene to evince her own sense of disgust. These arbitrary principles of hygiene, which are learnt in the spaces of the domestic home, are taken for granted and hidden in the persuasions of cultural logic. The dialectical interaction between the body and house is central to Bourdieu's writings, most particularly to his schema of habitus and socially informed bodies. In *Outline of a Theory of Practice* (1977) he specifically explores the inhabited spaces of a house, which he terms the "privileged and principal locus for objectification of the generative schemes" (1977: 89). It is in the house that children learn the rules of hygiene: of washing their hands before meal times, of bathing and teeth brushing, of cleaning up, and the etiquette associated with the private spaces of hygiene. In analysing these schemes, or spatial organisations of gender, hierarchy and division, Bourdieu argues that it is necessary to look at the relationship between the social organisation of the household and their bodily incorporation if one is to understand the art of living (Warin 2000: 120).

Using Bourdieu's analytical vantage, the following section explores the spaces most often associated with anorexia, arguing that they are embodied spaces that are heavily invested with cultural frameworks of hygiene.

## **ABJECT ZONES**

### **Performing spaces of anorexia**

Staff at the Anorexia and Bulimia Nervosa Association (ABNA) had given me some flyers for a play that was to be performed at a small city venue, inviting me to attend

and also asking me to advertise the event. I attended *What is the Matter with Mary Jane?* on its opening night, sharing a drink with friends and staff from ABNA in the small foyer before taking my seat. The performance focused on the life of a young woman who was “in the insidious clutch of an eating disorder”. The sole performer (her singularity emphasising the isolation of her predicament) delivered an exhausting one-hour monologue, loudly voicing her embattled desires and fears about her body to the mirror in her bedroom, the audience and to her absent mother and friends.

The stage was demarcated by three domestic spaces: kitchen, bathroom and bedroom. There were no visible walls between these spaces and they were separated by the different objects that spoke of different bodily functions: eating, purging and sleeping. On the left of the stage was a bare oblong kitchen table, in the middle a white toilet (with a toilet brush next to it and a shower curtain behind it), and on the far right a single bed (with weighing scales that slid under it, a full length mirror, and weights and magazines on the floor) to mark the space of the bedroom. The character (who was never identified by name) moved freely between the three different spaces, crying on her bed, vomiting in the toilet and bingeing in the kitchen on vitamised drinks and food.

On stage were the three quintessential domestic sites in which anorexia was practiced, and it was in and between these three sites that the eating disorder started.<sup>3</sup> The absence of architectural boundaries between the performative spaces — no walls, doors or a roof to conceal or contain — was of course necessary for the audience to view the intimate spaces of this young woman’s life. As such we, the audience, were privy to practices that would normally be hidden from view, of vomiting, frenetic bingeing, and

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<sup>3</sup> The cover image from Sydney Theatre Company’s production of *What is the matter with Mary Jane* emphasises the connections between anorexia and private domestic spaces. It depicts a red toilet/bathroom door with an engaged sign on it. The title of the play was taken from AA Milne’s poem *Rice Pudding*, and the first verse is written in small, black handwriting on the toilet door:

*What is the matter with Mary Jane?  
 She’s crying with all her might and main,  
 And she won’t eat her dinner – rice pudding - again –  
 What is the matter with Mary Jane?*

hopping on and off weighing scales. Sitting in the dark, we watched the constant back and forth movement, becoming voyeurs of her world.

As I mapped out the stage in my field notebook I reflected on the relationship between these spaces of theatrical imagination and my fieldwork. The ways in which the spaces were arranged was underlaid with other meanings that had significant resonances with my fieldwork experiences. It was via the physical ‘opening up’ of intimate stage spaces, of observing the movement between spaces, that connections and disjunctures between bodies, places and practices began to (e)merge.

Like the stage play, bathrooms, bedrooms and kitchens were key sites in my fieldwork. It was in these three places that bodies were paramount, where practices of secrecy, privacy, sexuality and hygiene were most overtly performed. Each space was potentially a site of pleasure and desire: the kitchen of eating and tasting, the bedroom of sexual pleasure and the bathroom a space “for pampering the naked materiality of the body” (Yao 1993: 3). Sibley notes that the pleasures and comforts of home are often given priority in analyses of space. Domestic homes are traditionally characterised as havens, “a place of certainty within doubt, a familiar place in a strange world, a sacred place in a profane world” (Dovey 1985: 33-61). Bachelard’s *Poetics of Space* conveys the image of home as comforting and restorative, as a happy memory recalled in dreams and “giving access to the initial shell which shelters the being” (Bachelard 1969, cited in Sibley 1995: 94). While homes can be experienced as ‘cosy’, they can also be sites of violence, child abuse, oppression and depression.<sup>4</sup> More importantly, for this argument, they can also be sites of abjection, where tensions confined in spaces change the social relations of those who inhabit them.

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<sup>4</sup> Mandy Thomas (1999: 49) also makes this point in her ethnography of Vietnamese-Australians living in transition.

In his exploration of the relationships between bodies and space in the Australian home Yao (1993: 3) refers to the bathroom as “a room named desire”, a “space that celebrates sensuality and arousal while at the same time encapsulates security and privatisation of experience”. Rather than straightforward pleasure, there is a dialectic at play, for the “sensuality of the bathroom is as liberating as it is confining; its aestheticisation is concerned with taming the body that is temporarily opened up to arousal” (ibid).

A dialectic was at play in each key fieldwork space, for equally as one can register pleasure, it can also register disgust. In participants’ homes it was kitchens, bathrooms and bedrooms (rather than lounge rooms or hallways) that were most ambiguous and dangerous, for they held contradictory tensions. In each the body’s permeability was heightened, through the ingestion of foods (in kitchens), expulsion of wastes (in toilets/bathrooms) and exchange of bodily fluids (in bedrooms). In each space bodily boundaries were crossed, transgressed and transformed. As such, these embodied places were abject zones, they were ambiguous places of transformation, where desire and disgust, pleasure and fear and dirt and purity coalesced.

Moreover, the bathroom and kitchen were spaces of the home that were demarcated as important sites in “the battle to maintain bodily boundaries against contamination”

(Lupton & Miller 1992: 504):

As settings for physical sustenance and hygienic care, the kitchen and the bathroom — and the product ‘worlds’ they frame — are crucial to intimate bodily experience, helping to form the individual’s sense of cleanliness and filth, taste and distaste, pleasure and shame. These rooms are the home’s most heavily invested ‘objects’ of domestic labour: failure to meet the high standards of hygienic maintenance attached to them is a source of guilt and embarrassment. (ibid)

### **Reconfiguring spaces of relatedness**

These physical and conceptual boundaries between bathrooms, kitchens and bedrooms, although historically separate (for example, one does not find a toilet located directly



off a kitchen), were not distinct in participants' experiences. Spatial boundaries within the home were re-arranged; bedrooms became kitchens, and bathrooms became dining rooms. Participants were utilising spaces that were already signalled as private (bathrooms, toilets and bedrooms) to purge and hide, and transforming shared social spaces within the home (such as the kitchen) into a private space.

When participants did enter kitchen spaces it was often on their own terms: alone and at a time of their choice. Suzi remembers shutting all the doors to the kitchen in her family home – “so it was all private” — and cooking cakes that she would then take hours to meticulously decorate. If her parents or younger brother came into the kitchen whilst she was making cakes she would lose her temper and scream at them, for to be disturbed around food, or “caught eating” was tantamount to a grave invasion of privacy.

Closing off the kitchen and refusing to eat with the family created anger amongst Suzi's family, so she simply refused to eat with them, or even allow them to prepare food for her. Negating family meal times was an affront to her parents, who were “believers in that saying ‘the family that eats together stays together’”.<sup>5</sup> What Suzi was effectively doing was breaking the social bonds created by nurturing within her family (cf. Turner 1984: 195).

Suzi transformed the intimate space of her bedroom into the single space in which she stored, prepared, ate and expelled food.

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<sup>5</sup> Sallis, in her novel about an Arab woman's feelings of displacement in her new Australian home, describes the breakdown of the relationship between the mother (Hiam) and daughter. Food is central to the connection/disconnection of this relationship:

When she turns sixteen Zena suddenly becomes a vegetarian ... Hiam feels a shadow creep over her heart ... They no longer break the same bread, share the same salt ... *and now she won't eat my cooking*. There is something hollow about cooking without the loved one eating it. More than hollow, lacerating even ... Then Zena stops eating oil. Stripped of her olive oil, Hiam's heart breaks. She begins to let Zena cook for herself, harrying her, eyeing her for a slip in the resolve, angry, helpless, exiled from her daughter's stomach. (Sallis 1998: 78-9, emphasis in original)

Counihan similarly writes about food as tie and rupture in her discussions of intimacy and autonomy in a Florentine family (1999: 156-77).

I was buying in tonnes of food - my wardrobe was like stuffed with packets, and packets of crisps, packets and packets of biscuits, anything sweet - biscuits, cakes, ice creams - my wardrobe was stuffed full. My whole life was spent in my bedroom to be honest, that's where I lived all the time.

As well as hiding food in the cupboards, she spat and vomited into plastic containers that were hidden under her bed. Her bedroom was not simply a place for sleeping, it was also a dining room, a kitchen, a pantry and a receptacle for bodily wastes.

Part of the retreat to the bedroom was related to the difficulty of sharing domestic spaces, of having to deal with the sociability surrounding food preparation and eating. Elise knew that her mother would “go spare” (be angry) if she found her wearing rubber washing-up gloves while preparing food. It was easier to avoid people by withdrawing to a bedroom. In family homes and share houses bedrooms were places that were deemed to be private and disconnected from others. Grant explained that his bedroom was a haven, a place where he could retreat:

I've always seen [the bedroom] as my place - I shut the door, that's it - it's my world sort of thing. My parents wouldn't come in there and I could have that space around me and be comfortable. So I'd go down there to retreat and get away from everyone else and that's when I started doing a lot of stupid food things like chucking food away [into the waste paper bin], I saw my bedroom as a safe place to do that.

Bathrooms and toilets were similarly private spaces, and these were sometimes transformed into eating spaces. Lara discussed the difficulty of sharing a house with another woman, outlining her strategy of taking food to the bathroom. Late at night she would take one apple from her “stash” — the “mountain of apples” in her bedroom — to the privacy of the bathroom, avoiding the commensality of eating. It was not only a transformation of spatial practices, but also of time, for she only ate late at night when the stillness of the house ensured absolute privacy.<sup>6</sup>

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<sup>6</sup> This cultural construction of privacy is an important aspect of anorexia. How would Grant practice anorexia in the houses that Carsten describes in Langkawi, where houses are characterised by a general lack of division of interior space? (1995: 113). Houses usually consist of a hearth and one main room, and individual household members do not have their own daytime space.

Amanda preferred to use the bathroom space for not only taking lengthy showers to cleanse her body, but also to vomit. She would sit crouched on the floor of her ensuite shower, vomiting into the drain hole and “poking it” through the grate to be swept away via the plumbing. The water hitting her back from the shower not only assisted in washing the vomit away, but the sound of it splashing on the floor acted as a cover to the noise of her retching.

A similar playing or remapping of spaces is explored in Angel and Sofia’s (1996) psychoanalytic analysis of the film *The Cook, The Thief, His Wife and Her Lover* (1990) directed by Peter Greenaway. The film, which Angel and Sofia describe as having a “voluptuously dirty” aesthetic tension of beauty and violence, produces “an extraordinary mobility and confusion of organs and spaces and the things that go in and out of them” (Angel & Sofia 1996: 475-9). Like the stage performance of *What’s the Matter with Mary Jane?* and the domestic rooms described above there is a similar connection and disconnection between spaces:

There is a fluid tracking of the camera from the dark, wet and blue outside, where there are dogs, a naked man, raw meat and fish, in via the scullery, through the predominantly green and yellow kitchen where a multitude of culinary operations are proceeding, and via two smaller red vestibules (from which the [pristine white and over-illuminated] toilets are accessed) into the sumptuous red interior of the restaurant, past tables laden with artistically arranged delicacies ... this arrangement of spaces in the restaurant could be imagined as analogous to the gut, taking in the raw from outside, washing, plucking, chopping, stirring and baking it, then conveying it to the tables where people stuff their faces and afterwards ... go to the toilet and feed the sewers. (Angel & Sofia 1996: 477)

Not only is there fluidity to these spaces, but also a blurring of the practices that one would normally associate with each. The kitchen, for example, is not only a site of culinary transformation, but is also an important venue for erotic activities, where two of the main characters in the film have sex in the kitchen pantries. In a similar vein, the toilets (whose luminosity is reminiscent of the clean interior of a refrigerator or the

clinical surfaces of operating theatre —ibid: 478) are also locations for clandestine sexual encounters. Throughout the film connections between eating, excrement and sex are constantly interchanged, collapsed and placed in direct positions of tension. This tension, Probyn argues, “produces the politics of eating and sex as complex and ambiguous, not to mention downright messy”<sup>7</sup> (Probyn 2000: 74).

This film plays with key features of abjection. Disgust and desire are continually placed side by side, epitomised in the final scene in which the main character, who derives great pleasure from eating, is forced to eat a boiled dead body (which happens to be the corpse of his wife’s lover) in the dining room. The pleasure of eating is countered by the disgust of eating human flesh. Cannibalism then, is the ultimate abject horror, of the pleasure of eating erased by the visceral disgust at eating ‘oneself’.

In my fieldwork the tensions associated with abject living spaces were most obvious when participants were ‘confined’ to the bed on treatment programs. In one psychiatric ward the single side room (of four square metres) conflated all spaces: it was the bedroom, the bathroom/toilet and the place where patients ate. As such it was a site that was profoundly ambiguous and confusing, for it was a private side room, yet the most public of spaces. I noted this conflation in my fieldnotes at the time:

*There was something ‘odd’ about the space of the single room. On the psychiatric ward of this major public hospital there are 8 beds dedicated to patients with eating disorders. Those who sign contracts with the staff to do bed programs are allocated a single room - a room which contains a bed, a side locker and a cupboard. Nearly all patients transform these rooms into bedrooms - Elise’s room, for example, was heavily decorated with posters of Silverchair on the walls and doors, many cards and letters (some from a friend with anorexia whom she had met in hospital and who was also a participant in my research), photographs of school friends, craft pieces, puzzles, a radio cassette player, a television, candles, gifts from visitors including dried bunches of hanging flowers (arranged in a line above her bed). Her parents had brought in her pillows and duvet from home, adding the final touch of transformation. Like many high-rise buildings, the windows do not open, and the view is of the bricks of the adjacent building. There is a sink, but it has no taps and the*

<sup>7</sup> The politics was played out when the film was realised amongst cries of obscenity and disgust, counterbalanced by its voluptuous visual aesthetics.

*plumbing underneath has been removed. This is to ensure that patients cannot vomit or throw food down the sinks. The door to the ensuite bathroom is locked for the same reason, and patients are brought bedpans to use on a chair. The door to the room should remain open at all times so if you were to be surreptitiously exercising you would be seen and given a warning and the only time it can be shut or the curtain pulled across is when you need to use a bed pan. Activity is restricted to a minimum and bed rest is encouraged. The single room thus becomes the bedroom, the bathroom/toilet and the place where people eat - it is a conflation of what is otherwise sharply demarcated in the private and public spaces of suburban homes. (See Plates 3 & 4)*

For Beth, the difficulty of living in such a space related not only to the conflation of its functions, but to the intimate surveillance of her bodily practices and the inability to wash herself:

... the problem with being on the bed in the hospital is that there's no running water - there's nothing - you can't wash whenever you want to, you have no freedom that way. You've only got these stupid, pathetic little baby wipe things which don't make you feel clean at all so. If they [the staff] were there and they made me spread my jam onto my bread and pick it up and eat it there was like this jam left on my hands and it was awful because I couldn't get rid of it - even if I wiped my hands it was still sticky - it wouldn't go until it was licked or something ... you'd have to dispose of it. It was an extra bit of food that you'd have to try and get rid of because it was there and come hell or high water you didn't want to lick it off ... but it might stay there and get into your body.

*I have noticed in hospital that there is a bowl of water in the sink –*

That's for basically washing your hands after you've used the bedpan. I just found that crusty anyway because it's not changed. It's the same bowl of water all day - it's changed every day - but like you go the toilet and you have running water so it's different when you're at home.

*How did you feel about using a bedpan?*

I hated it, I hated it with a passion. I hated it. I felt totally awful about it. I thought it was disgusting. I hated using my bedroom as a toilet for a start. I also found it quite degrading and disempowering - like they even know when you needed to go to the toilet, they even knew what you did when you went to the toilet ... It's just awful - you have visitors and you become really aware of the smell and you're embarrassed. I know a lot of the girls in the hospital are younger but you do get older ones and not that it makes that much difference but [pauses] all your independence is taken from you - all of it - you're completely dependent right down to the "nurse - I need to go the toilet", you know. That really doesn't make you feel too good - you feel like you're about five - it's awful. I remember once using the bedpan and the nurse coming back in and saying "you need to drink more, you're wee is very concentrated" and I thought "oh my God, thank you, thank you - do I have no privacy?". It's bad enough that you know when I need to go but now you're looking at it - it's terrible. I



Plates 3 and 4. Elise's hospital room

guess it's their job but it's embarrassing, very embarrassing. But I got through it, I survived it, I live to tell the tale!

The privacy associated with the private single room was a misnomer. Positioned directly opposite the nurses' station, occupants of each side room could be observed around the clock. The surveillance afforded by the architectural design of the ward and the placing of eating disorder patients in single rooms close to the nurses' station is reminiscent of Foucault's description of Bentham's design for the Panopticon (Foucault 1977; cf. Eckermann 1997: 157). The interchange between prisons and inmates, hospitals and patients has not gone unnoticed, as Bartky, reading from Foucault, writes:

Each inmate is alone, shut off from effective communication with his fellows [sic], but constantly visible from the tower ... In the perpetual self-surveillance of the inmate lies the genesis of celebrated "individualism" and heightened self-consciousness that are hallmarks of modern times. (Bartky 1988: 63)

There are, however, subtle and important differences between Foucault's panopticon and hospital surveillance.<sup>8</sup> One participant, who at 44 years of age hated "being treated like a child", crawled on her hands and knees out of her room, along the floor on the other side of the nurses' station, and to the smoking room down the corridor so she could have a cigarette. This creative and resistant act belies the 'docile bodies' that are emphasised in Foucault's work. Moreover, it was not simply the private lives of patients becoming public, it was a *complete* reversal of practices: what was deemed private became public and what would normally be associated with sociality, became private. When a patient was eating, for example, as discussed in Chapter Two, I was asked by the nursing staff to leave the room to "give them some privacy".

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<sup>8</sup> Too often the dichotomies of private and public are applied to hospitals with little acknowledgment of the multiple ways in which these concepts operate in such a space. Within public (ie government funded) hospitals there are a myriad of private and public spaces – operating rooms for example, are the quintessential spaces of privacy that are never seen or accessed by the general public (unless of course they are undergoing surgery, and even then their memories of such spaces are anaesthetised).

It is no coincidence that the public spaces that posed the most problems were those spaces that were deemed to be dirty, unhygienic and dangerous. Public toilets, supermarkets and hospitals were the main contenders, for objects in these shared spaces had been touched and handled by strangers.

Hospitals, which supposedly epitomised the height of sanitation, were viewed as a “minefield of germs”. The thought of having to re-use crockery, bed linen, towels, toilets and showers that had been used by others literally terrified people. Amanda considered the hospital to be dirtier than a public toilet:

I won't touch the toilet seat [in hospital]. If I have to put the toilet seat up or down or whatever I'll get toilet paper and hold that around it ... I hate being in the bathrooms here - I hate them - just because so many people use them and I think that they're filthy. I just imagine all these little bacteria everywhere - uugggh. What concerns me is people's cleanliness, their levels of hygiene. I don't know if they're washing their hands or pissing on the seat ... I might catch something.

*And what might that something be?*

Nothing definite - not like any disease that I know of. I don't know - it's just like catching dirtiness - dirty and contaminating. Not just like in the bathroom but in the kitchen and other places - like if I touch something then I have to wash my hands because otherwise I can almost feel something on my hands - like they feel dirty to me until I've gone and washed them.

*How do they feel?*

Just like there's kind of a gritty layer on them and you kind of get a bit of increased sensation under your fingertips as if something's got up there and it's dirty.

*And what do you wash your hands with?*

Just with Sapoderm soap, it's anti-bacterial.

Tamara recounted the high level negotiation required by public toilets whilst stopping at petrol stations on a road trip to Melbourne. She couldn't use the “soggy soap” sitting on hand basins, nor touch the button on the soap dispenser, so she would always take her own cake of soap in a plastic container. Bettina, when living with her parents and younger brother, had to wash her hands with her own ‘personal’ soap after washing her hands with the soap used by her family.



Carolyn was similarly fearful of the potential for contamination that could be transferred from hand to mouth in public spaces. She was amazed to see other people walking through a food market, choosing a piece of fruit and eating it. She explained why she washed “every little skerrick of her fruits and vegetables” before eating them, even the skins:

Even rockmelon and bananas ... I wash oranges too ... I have to wash the outside ... you see you touch it with your hands ... with a banana you can peel it with your hands and the inside might be clean but then your hands may not be clean - it's strange really.

I asked Carolyn why the washing of foods and cleanliness was important to her and she immediately spoke of her strict Baptist and conservative middle class upbringing. As a teenager in the 1950s she and her three siblings were not permitted to wear make up, dress in the current fashions, eat ‘junk’ food, listen to popular music, or watch commercial television. Her parents considered these activities to be associated with sin, waywardness and temptation. What was valued in Carolyn’s upbringing was order, restraint, propriety and cleanliness:

We were brought up with cleanliness - mum was very particular - everything was perfectly clean, perfectly. The next door neighbours used to come and look at mum’s washing and say “beautiful, beautiful” (laughs). That’s why I’ve got a thing about washing. I just like to be really clean. It makes me feel better.

These values have become part of her everyday routines — of her *habitus* — and she reproduces and practises them without reflection.

What was at stake in all these spaces – kitchens, public spaces, hospital rooms and bathrooms — was the embodied, cultural practices of hygiene. These practices, however, were constantly under threat from that which was considered abject: foods, wastes, sexual fluids and people’s own bodies. Hands and mouths, as the above examples highlight, were central to the transmission of dirt and subject to rigorous and repeated washing. As Vigarello notes, the focus on the threat of contamination from such body parts has a history:

The bodily zones traditionally the concern of treatises of manners (hands and face, mouth and teeth) were rapidly adopted by treatises of hygiene at the end of the century [1880-1900]. It was on the fingertips, under fingernails or in the grooves of the parts of the skin that touched that microbes were counted. (Vigarello 1988: 205)

The following section explores this changing history of hygiene, arguing that the embodiment of taken-for-granted rules of cleanliness played a central role in participant's everyday lives and experiences of anorexia. It was through hygienic practices that the threat of abjection was re-ordered and transformed.

## **THE GENDERED HABITUS OF HYGIENE**

The disgust over bodily effluvia and concern with keeping clean through bathing, washing and antiseptics, pervasive as they are today, has not always been so. In his beautifully detailed work *Concepts of Cleanliness: Changing Attitudes in France Since the Middle Ages* (1988) Vigarello highlights the complex historical intersections that have made possible contemporary hygienic practices; of differing representations of the body and advances in medicine. A history of cleanliness, he suggests, should first “show how new requirements and constraints gradually emerge” (1988: 2):

It is a history of the refining of behaviour, and of the growth of private space and of self discipline: the care of oneself for one's own sake ... On a wider plane, it is the history of the progressive pressure of civilisation on the world of direct sensations. A cleanliness defined by regular washing of the body supposes, quite simply, greater sharpness of perception and a stronger self-discipline (ibid).

Vigarello warns, however, that representing this process as “an accumulation of pressures brought to bear on the body risks giving a false picture ... such a history needs to connect to other histories, and the most important history in this case is that of the body ... Cleanliness is inevitably affected by images of the body”(ibid: 3).

To highlight the central importance of changing concepts of the body Vigarello explores the use of water as a cleansing agent. In the Middle Ages in Europe, skin was seen as porous, and the prevailing image of the body was one of openness. Water, and

particularly hot water, was rarely used to cleanse because “the body had less resistance to poisons after bathing ... it was more open to them. It was if the body was permeable; infectious air threatened to flood in from all sides” (ibid: 9). As a consequence, steam baths and bathhouses were forbidden and water was rarely used to clean the body.<sup>9</sup>

In a time of epidemics, plagues and the miasma theory of disease, porous bodies needed to be protected. It was clothes, and most particularly their shape and nature, that were all important in this protection: “smooth fabrics, dense weave and close fit. Infected air should slide over with no possibility of entry” (ibid: 10). Writing in Paris in 1623, Citoys wrote: “One should wear clothes of satin, taffeta, camlet, tabby and the like, with hardly any pile, and which are so smooth and dense that it is difficult for unwholesome air or any sort of infection to enter or take a hold, especially if one changes frequently” (Citoys 1623: 20, cited in Vigarello 1988: 10).

Practices of hygiene and, in particular, practices of cleanliness could not be considered without reference to these assumptions (Vigarello 1988: 10). In bodies that were swaddled in cloth, cleanliness related to the limited, visible parts of the body, to the face and hands. To be clean was to have no dirt on the surfaces of these external areas of skin. Cleanliness was more a matter of appearance and the social etiquette and ‘decency’ of social relations than sanitation (ibid: 46), and was achieved by ‘dry washing’, by rubbing the skin with scented linen. “To cure the goat-like stench of armpits, it is useful to press and rub the skin with a compound of roses”, that is, to wipe vigorously, applying perfume, but not actually to wash (ibid: 17).

Elias (1982) argues that with the internalisation of courtly manners (of whiteness and cleanliness), dirt and filth began to arouse feelings of disgust and intense bodily effects

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<sup>9</sup> Vigarello notes how substances were used to protect the open skin : “The most diverse substances could be used to saturate the skin. Salt, oil and wax, in particular, would all serve to stop up the pores. The body was even coated as if it were a glossy and protected object” (1988: 16).

(cited in Laermans & Meulders 1999: 119). This was particularly evident amongst the aristocracy and ascendant middle classes who shared the symbolic power of fresh, white linen and neat appearance. They considered themselves to be ‘civilised’, “whereas the popular masses appeared as filthy and thus were to be avoided” (ibid: 120). Class (and no doubt race) relations were clearly embedded in the value-laden hygiene discourse, where those ‘less fortunate’ were taught how to maintain standards of cleanliness.

According to Vigarello, these ideas of cleanliness changed in the mid to late 18<sup>th</sup> century with emerging ideas on health, the body and medicine. The real transformation, which introduced the decisive change, derived from the argument of health; cleanliness was no longer a matter of appearance but of health, vigour, strength, austerity and morality (Vigarello 1988: 228). The body, rather than being perceived as passive and vulnerable to external forces as was the case in the Middle Ages, became endowed with endogenous power and vitality which could easily be released by such activities as cold bathing (ibid: 128; cf. Lupton 1994: 34). Emphasis was upon opening the pores rather than keeping them covered, to “free the skin” by removing dirt, perspiration and oils which blocked the surface exits (Vigarello 1988: 131-41).

From the 1880s onwards, cleanliness was legitimated with the scientific discovery of microbes. Microbes were viewed as “invisible monsters capable of breaking down the body barriers” (Vigarello 1988: 204), all the more dangerous because of their invisibility and microscopic smallness. Frequent washing of the body’s “nooks and crannies” was needed to remove the dangerous and infinitesimal “bacteria, protozoa and viruses” (ibid: 202, 207). External signs of cleanliness were no longer considered sufficient (Lupton 1996: 34) and clothes which were not seen, such as underwear, became more important than white collars. Perrot writes in his history of clothes that

clean underwear was not only “more hygienic”, but also “healthier” (Perrot 1984, cited in Laermans & Meulders 1999: 120).

The hidden danger of pathogenic organisms had profound consequences for social life and social relations. According to Vigarello, “the microbe thus materialised the risk and identified it ... the consequences were inevitable: to wash was, as never before, to operate on the invisible” (Laermans & Meulders 1999: 121; Vigarello 1988: 203).

Regular disinfection came into prominence in public institutions (especially hospitals) and domestic spaces — boiling, steaming and chemicals were used to clean dirty fabrics, surfaces and bodies. Private interiors changed to accommodate this new-found attention to body cleanliness; locked bathrooms, washrooms and bidets became private sanctuaries of hygiene. Taking a bath, it was said, and the resultant washing, constituted one of the best disinfectants. In the terminology itself, washing slipped into asepsis (Vigarello 1988: 204). For each of these changes to concepts of cleanliness, an accompanying change in the ways in which people related to each other and to differing spaces, occurred.

The core themes that Vigarello discusses in this particular history of cleanliness saturated my fieldwork. When talking about experiences of anorexia, participants spoke about their bodies, nutrition and spaces through a lens of hygiene. Their bodies and bodily processes were dirty and disgusting; certain foods were dirty and unclean; private and public spaces (as described in the first section of this chapter) were dangerous sites of contamination. Concepts of dirt and cleanliness embedded in hygienic practices fundamentally changed participants’ social relations with themselves and others.

## Healthy homes and healthy families

There are, however, a number of aspects of hygiene discourse that Vigarello has overlooked and are crucial to my approach: the central roles of gender, emotion and embodied spaces. I turn to gender first. Women and men are inserted into hygienic practices in very particular ways (cf. Donzelot 1979; Martin 1987: 201; Burke 1996; Laermans & Meulders 1999) and this is something Vigarello fails to explore.<sup>10</sup> While men like Pasteur and Lister may have had the scientific knowledge to discern bacteria and microbes, it was, as Hoy (1995) points out in her history of the pursuit of cleanliness in America, the domestic woman who was the agent of cleanliness:

By the 1850's [Americans] were coming to see that cleanliness would be maintained in the family through the agency of the 'true woman' and maintained in the community through public boards staffed by men who were leading citizens in a virtuous republic. Thus, when Americans (urban, [white] middle-class ones, at least) talked about being clean, their conversations generally focused on health, women's work and role, good social values, and the proper goals of public policy. (Hoy 1995: 7)

As wives, daughters and domestic servants, a 'woman's role' was intimately associated with establishing and maintaining cleanliness. During the American Civil War the *New York Herald* (1864) proudly claimed that "All our women are Florence Nightingales" (Hoy 1995: 51). Such a sentiment paid tribute not only to the role of female nurses in the fight against disease and infection at the fronts, but also to the thousands of women who were involved in the work of the Sanitary Commission and *Sanitary Bulletin* back home. The Commission collected and distributed supplies to the front — "soaps, sponges, towels, bandages, sheets, and undershirts" (ibid: 52), thereby inculcating and maintaining habits of cleanliness and discipline amongst the soldiers. As information and goods "moved back and forth between Washington, the military outpost, and the

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<sup>10</sup> Foucault similarly traces the history of hygiene as a "regime of health for populations [that] entails a certain number of authoritarian medical interventions and controls" (Foucault 1980: 175). Like Vigarello, his focus is on the discursive powers of collective hygiene; on families, hospitals, public/urban spaces and public health. Despite Foucault's emphasis on the role of parents in 'good health' — "obligations of a physical kind (care, contact, hygiene, cleanliness, attentive proximity), suckling of children by their mothers, clean clothing, physical exercise to ensure the proper development of the organism" (ibid: 172), he does not extend his discussion into the realms of gender or everyday practice.

most distant households of the United States” (ibid: 53), women became the voices of cleanliness in the interest of their families. Helen Campbell wrote for *Household Economics: A Course of Lectures in the School of Economics of the University of Wisconsin* (1897) “to keep the world clean — this is the one great task for women” (ibid: 59).

In these accounts white, middle class women were not only assigned a major role as the guardians of domestic health, but also, as I have argued previously in this thesis, themselves became associated with the unclean. “Sanitary products” can still be found at the rear of pharmacy shops next to the incontinence aides, with the brand names attesting to their unspoken, hidden presence: *Whisper, Invisible, Slims and Ultrathins*. The naming of these products as ‘sanitary’ pays homage to the connection between the germ theory of disease and the resultant sanitary crusade against dangerous enemies within. A tampon product marketed by Modess in 1946 called *Meds* asserted that they were “made of ‘surgical cotton’ and ‘hygienically sealed in individual containers’” (Houppert 1999: 15-6). All manner of sprays, powders, wipes and deodorants can also be purchased “to give extra reassurance, especially during warm weather and menstruation”. The advertising states that these “intimate feminine hygiene” products contain antibacterial agents, designed to “absorb moisture and neutralise odours ... to keep [women] feeling clean, fresh, dry and confident”. There is no equivalent marketing directed towards men’s bodies, their products being sold under the generic banner of “toiletries”.

## **Domestic hygiene**

Within what Sedgwick has called ‘the hygienic imperative’ it is women who are positioned as battling against unseen germs and diseases in the home. This was made clear to me when, after the birth of my daughter, I received a free gift bag from a

leading Australian shopping chain. Included in the bag were a number of free samples, the majority of which were cleaning agents: a spray can of air freshener to “eliminate nasty toilet odours”, and two separate anti-bacterial cleaners for both the kitchen and the bathroom. Now that I was a mother, the accompanying brochure instructed me that “proper cleaning is an important part of maintaining a healthy home for your family”. By using the anti-bacterial cleaners it was my role to prevent cross contamination between the bathroom and kitchen. As Cowan (1976) notes, “cleaning the bathroom sink [is] not just cleaning, but an exercise for the maternal instincts, protecting the family from disease” (Cowan 1976: 151).<sup>11</sup>

The positioning of women in the home as agents of health and hygiene was epitomised by Grace, whose house had been described by the community nurse as “immaculate” and “neat as a pin”. In the home that she shared with her husband and teenage son, Grace showed me the rows of tins and neatly labelled jars in her pantry cupboards, and endless hand written notes about planned recipes. The one bookcase in the kitchen/dining area was filled with cooking books, some that she had used when training as a cordon bleu chef in England. With her orange coloured hands (from eating too many carrots she said)<sup>12</sup>, Grace showed me her treasured cooking books, including one that had been handed down through the generations from her grandmother to her own mother and then to her. *Mrs Beeton’s Book of Household Management* (1907, originally published 1861)<sup>13</sup> was a “guide to cookery in all branches”, and included 74 chapters pertaining to tasks associated with “womenly duties”, such as “mistress and

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<sup>11</sup> Murcott’s ethnographic study of twenty young women in a South Wales valley talking about the body management of their infants similarly notes the extraordinary emphasis placed on mothers concerning purity and pollution (Murcott 1993).

<sup>12</sup> In her hospital case notes a psychiatrist noted that Grace’s orange palms were caused by a sensitivity to beta carotene found in orange vegetables (such as carrots).

<sup>13</sup> The introduction to the most recent edition of this book (2000) describes Beeton’s work as:

... one of the major publishing success stories of the nineteenth century, selling over 60,000 copies in its first year of publication in 1861, and nearly two million by 1868 ... [as] the most famous English cookery book ever published ... it stands ... in the nation’s imagination as a bastion of traditional English fare and solid English values. (Humble 2000: vi)



servant, hostess and guest, home doctor, sick nursing, and the nursery”. The book itself was a weighty, dark red, leather bound, 2500 page volume. The final sections of the book included a detailed section on hygiene and contagious diseases, drawing heavily on the miasmatic theory of disease and germ theory. Ways of countering sickness included “sufficient supply of pure air”, “pure water” (rain water in particular), “frequent washing and clean utensils” (Beeton 1907: 1823-1903). *Mrs Beeton’s Household Management* was far more than a cookery book; it was an instructional manual for women.<sup>14</sup>

Even though Grace found the instructions antiquated and we laughed at their ‘fussiness’, she practiced many of the enduring rules of hygiene and order in her own home. Surfaces in her kitchen were kept hygienically clean. She washed her hands after touching uncooked meats, after reading the newspaper and after a shopping trip. When her anorexia was at its worst, she would take weeks to plan meals for her family, taking notes from each cookbook as to what to prepare. Her attention to the details of household management preoccupied her every thought, so much so that she would sometimes take cooking books to bed at night to read.

Many other participants displayed and spoke about their meticulous attendance to household cleanliness – the arbitrary rules of household maintenance. In fridges I saw cans of diet drink perfectly lined up with their labels facing the front; clothes hung in order on the line — a row of socks, a row of pants, a row of stockings and each row hung with colour matching pegs. Towels and underpants were repeatedly soaked in the antibacterial washing detergent Nappy San to remove and kill germs. Bathrooms were spotless and kitchens belied their functions as there were rarely dishes on the sink and no visible signs of food or cutlery/crockery. Bettina laughed about the times that she

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<sup>14</sup> In the late 1880s hygienists in the United Kingdom concentrated on teaching hygiene to young women in schools. “From 1882”, Forty (1986) writes, “all girls in London Boarding Schools had been given some instruction in basic cookery and housework to equip them for domestic service (their most likely occupation upon leaving school) as well as to prepare them for future marriage” (Forty 1986: 161).

used to wash the laundry sink, taps, washing machine, clothes pegs and the clothes line, all before actually doing the washing. Then she'd have to wash her hands "in case of germs". My initial reaction to her house (in which she had lived alone for four years) captured the sense of order and cleanliness:

*She offered me a seat and said: "would you like to see my house and then we'll have a coffee" ... as she wanted to show me her house before "it got mucked up". She told me how she had spent a good few hours tidying in anticipation of my arrival - washing floors and putting things in their place. There was hardly any indication that this unit was lived in (in the sense of any evidence of everyday household mess or activities) - very few personal momentos of Bettina (except the glass cabinet of dolls and the toy baby bassinette wrapped in plastic) - no toiletries in the bathroom, no papers lying about, no books, no photographs, no pictures on any of the walls, nothing on any of the dressing tables - only two lonely pairs of her shoes next to her queen size bed. She later "confessed" that she slept in the single bed in the spare room as her mother had suggested it would mean less sheets to wash. The flat was quite clinical in some ways because it was so ordered, neat and "clean".*

Some participants were reticent about inviting me to their homes, and this reticence was often related to their homes being unclean (or the presence of family members). Rita and I usually met in a public park, but as the weather began to chill with the onset of winter she invited me to the unit that she shared with Daisy, her pet dog. As I swung my car into her driveway I saw the curtain of the front window pull back, and she was out the front door and ready to go before I could step out of the car. She asked if we could go to a coffee shop at a nearby shopping centre, as her house she said, was "wallowing in [her] own filth". The first time Natalia invited me to her home she explained how she had been cleaning for most of the previous night, laughing that it was a good excuse not to have to sleep, as sleeping slowed "the body's metabolism down and burnt less calories". Every time I visited she would allow me to 'view' a different part of her home. On this occasion she showed me the kitchen, inside her fridge and cupboards and her garden:

*As I entered the front door I noticed the Japanese slippers inside the entrance and asked if she would like me to take my shoes off [which she did] ... She took me through to the brightly lit, open plan kitchen. On the opposite wall over the kitchen bench was a glass cabinet that displayed a number of miniature*

*Japanese scenes; a tea ceremony, musical instruments, miniature people made out of paper, miniature figures of animals representing the years, and a small book to explain it all. We marvelled at the meticulous attention to detail in each case. All surfaces were completely bare - there were no dishes on the sink, or any visible signs of food or cans or anything to do with cooking ... She fetched a flash light and shone it into the huge back yard - down the central path was a line of pots - mainly miniature roses which she had pruned that day. Under the verandah were pots of camellias, to the left was the Japanese section (sacred bamboo and succulents), against the fence were more pots and there was also a line around the bottom of the caravan and the large tin shed (poor man's orchids). All the plants were in pots and grouped according to species ... Back in the kitchen Natalia asked if I would like to look in the cupboards and she opened the one nearest the outer door - it was neatly stacked with food items (arranged from tallest at the back to smallest at the front), and again all grouped and categorised into similar food items. (See Plate 5)*

This overwhelming desire towards cleanliness and order were central to the symbolic rituals of purification described earlier in the chapter. By maintaining an ordered environment participants themselves felt cleaner, as Tamara suggested: “It’s just wanting everything to be clean and perfect and new almost - how I want myself to be”. As already mentioned, her bodily washing was a way of alleviating the guilt, shame and disgust she felt with her own body after being raped. Tamara and many other others used hygienic practices to disconnect themselves from things which they found disgusting and out of place: foods, bodily processes, memories, experiences, and emotions. The next section turns to the central role of emotion within hygiene.

## **(A)VOIDING EMOTIONS**

While the discovery of microbes appealed to reason and was based upon scientifically proven facts about disease and bacteria, an emotional imperative was also central to the efficacy of hygiene. This imperative relied on arousing feelings of anxiety, guilt, fear and shame about dirt. Attempts to transform cleanliness into a moral issue were presented in advertisements, school curriculums, household economy texts, where “disorder and lack of cleanliness [were said to] cause a sort of suffering in the mistress

of the house" (Forty 1986: 169).<sup>15</sup> The design of household items (such as white baths and refrigerators) in the 1920s began to embody these virtues, "warning of the consequences of neglecting health and cleanliness which ranged from emotional rejection by loved ones to social ostracism, illness, death and national downfall" (ibid: 170). Removing dirt went hand in hand with the erasure of these associated emotions,



Plate 5. Natalia's kitchen cupboard

<sup>15</sup> As Forty notes, "the emphasis on simplicity was a response to the danger of attack by enemy constant vigilance against the

<sup>16</sup> In the acknowledgments of the string of family journeys to Japan

<sup>17</sup> Desjarlais notes that "the grief and heartache to family members does not come easily

of the house” (Forty 1986: 169).<sup>15</sup> The design of household items (such as white baths and refrigerators) in the 1920s began to embody these virtues, “warning of the consequences of neglecting health and cleanliness which ranged from emotional rejection by loved ones to social ostracism, illness, death and national downfall” (ibid: 170). Removing dirt went hand in hand with the erasure of these associated emotions, for if dirt was removed, objects put in place and ordered, then fear and guilt concerning disease and domestic duties was alleviated. It was precisely these emotions of anxiety, guilt, fear and shame that circulated in people’s narratives and everyday lives.

These emotive aspects of hygiene continue to play an integral part of its logic, and one cannot speak of dirt or cleanliness without speaking of emotion. Talking about intimate details was often characterised by participants as “airing dirty laundry”, “coming clean”, “like having a big vomit”, or a purging.<sup>16</sup> Estelle described the therapeutic device of talking with psychiatrists as “spilling her guts”; it was a method of “getting it out, of coming clean”.<sup>17</sup> Talking as purging is also a common practice in Christian religions (and popular television chat shows), where the confession is designed to absolve one’s sins.

Speaking, however, was not always an available route for ‘coming clean’. In the introduction to this dissertation I described some participants’ inability to speak about

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<sup>15</sup> As Forty notes, English school textbooks such as those Hood’s *Fighting Dirty* (1916) drew on the simplistic metaphors of warfare and racism to promote the dangers of dirt:

Its premise was that the allies of disease, which were dirt, flies, breathing through the mouth, spitting, impure air and darkness, could be identified with the forces of evil. Through the allegory of warfare, hygiene was presented as a constant battle, with the body as a fort always in danger of attack by enemy germs (represented in illustrations by German soldiers). Only by constant vigilance against the forces of disease could the body survive and be victorious. (Forty 1986: 168).

<sup>16</sup> In the acknowledgments to *Wasted*, Hornbacher thanks her family “for not throwing a fit about the airing of family laundry in public” (1999: 298).

<sup>17</sup> Desjarlais notes that in Helambu the need to express anger, grief and heartache to family members does not come easily:

...despite the social value of hiding feelings from the gaze of others, Yolmo wa consider it important to clean the heart free of pollutants by ‘talking’ them out at home. The Buddhist aesthetic of purity contributes to this idea: the heart needs to be cleansed of such thoughts, as if they were dirty or harmful, just as ghosts need to be ‘thrown’ and pollution ‘cut’ from the body. (Desjarlais 1992: 116).

certain issues, an inability that was compounded by their social withdrawal. For those like Tanya, anorexia took away “all forms of emotional expression”, including singing, listening to music and writing poetry. She remembers being “really withdrawn from everyone and I didn’t see any of my friends and while I’d be home with my family a lot I wouldn’t talk with them or interact with them in any way”. “Anorexia”, she explained, “stops you from being able to connect” and made her feel empty and pure:<sup>18</sup>

I always had the numb feeling inside - I never allowed myself to feel anything and if anything went wrong in my life that might possibly upset me I just pushed it away and convinced myself that I was really strong and could just deal with these things.

*Why would you want to push away emotions - what is it about emotions that makes you want to do that?*

I guess just not wanting to feel - nobody wants to feel pain. I think it’s trying to avoid getting hurt.

### **Fluids that carry emotions**

Those who could not avoid painful emotions, or feelings of disgust and dirt, described other avenues of (a)voiding. The ways in which people with anorexia metaphorically spilled their guts — absolved disgust and shame — was literally by spilling their guts, by vomiting. Emotions were also purged by taking laxatives to induce diarrhoea, excessively exercising to sweat, taking diuretics to rapidly increase urine output, spitting food out, washing bodies and blood letting. It was by way of fluids that emotions were released from their bodies, as Estelle explained:

I didn’t really care about having diarrhoea because I felt better afterwards ... I used to think - it’s really stupid - but it’s a metaphor and I used to think it got rid of all the shit inside me. I felt like a bad person so I felt better. It was a way of flushing out the bad things.

*What were the bad things you were flushing out?*

I thought I was really greedy and selfish and bad ... I was sometimes punishing myself - like if I ate something bad I would take more laxatives than I usually did to make myself feel better ...

*And when you say “better” -*

Cleaner, not so dirty.

<sup>18</sup> Cf. Malson (1998) who, in a play on Pink Floyd’s lyrics, entitles a short chapter: *(Un) comfortably numb: purging, purity and emptiness* (1998: 166).

It is useful to clarify the way in which I use ‘emotion’ in my discussion for anthropological studies of this topic differ in their orientation. In his comprehensive review of theorising emotion in anthropology, Leavitt (1996) highlights the disembodied characterisations that some authors suggest. Lutz and White, for example, argue that emotion is not an “internal state” (1986: 408); Lynch writes that “emotions are not passions” (Lynch 1990: 10), and others, such as Solomon (1984) suggest that “an emotion is not a feeling (or a set of feelings), but an interpretation” (Solomon 1984: 248). Lutz and Abu-Lughod in their edited *Language and the Politics of Emotion* (1990) consider emotion as a discourse rather than a felt experience. They argue that “rather than seeing them [emotions] as expressive vehicles, we must understand emotional discourses as pragmatic acts and communicative performances” (Abu-Lughod & Lutz 1990: 11).

Two incisive critiques have emerged against this formulation, each arguing against a discursive approach to emotion. While acknowledging the attempt to break through ‘the prison house of language’ created by structuralism and certain strands of semiotics, Desjarlais criticises the above approach for it discusses “everything save what poetic discourses themselves seem to speak about: most commonly, profound experiences of grief, sadness and pain ... any reference to emotion implies, by definition, something ‘felt’” (Desjarlais 1992: 100-1). Leavitt similarly attacks Lutz and Abu-Lughod (1990) for their language of construction, arguing that terms such as language, speech and discourse negate the “bodily, expressive, or personal” forms of emotion (Leavitt 1996: 523). Both Leavitt and Desjarlais point to the interwoven relationship between language and bodily experience. Meaning and practice, Desjarlais states, should be studied “in tandem, mapping the nature of meaning in practice and the social practice of meaning” (Desjarlais 1992: 101).

In agreeing with these critiques, my understanding of emotion involves both meaning and feeling, for as Leavitt suggests, emotion words are precisely the ones we use when we do not want to be forced into a choice of 'either/or' categories (Leavitt 1996: 523). In an analytical sense then, emotions are fluid for they cross conceptual boundaries; they connect meaning and feeling and dualist constructions of mind and body. They are also fluid in terms of embodiment because they similarly transgress bodily boundaries by the very nature of their flow. In light of my discussion of purging, I extend Desjarlais and Leavitt's arguments to suggest that bodily fluids carry emotions, and in this fieldwork, specifically emotions of disgust, guilt and shame.

The positioning of emotion within an experiential rather than discursive approach has parallels with the overarching themes of this thesis. Take a moment to consider Estelle's example above. If one was to apply a discursive approach to her purging practices then ideas of containment and individualism – the discursive constructions of the self — would be the focus. This is precisely the interpretation that Malson takes in her discussion of purging (despite her own post structuralist claims of critique):

Within the framework of a discourse of individualism identity is produced as something internal, and 'purging' obliterates this internality, producing an emptied, voided self; a subjectivity that resonates with those constructions of the self as an identity-less, empty shell. (Malson 1998: 168)

By focusing attention away from categories and onto the actual fluids that move between them, I argue that fluids are not simply a means to an end, but rather they play a central role in purging practices. Purging fluids is what transformed experience, for the bodily fluids of vomit, diarrhoea, sweat, urine, spit, blood (including menstrual blood) carry disgust away from the body. Fluids are pivotal because of their ability to transform relationships, to carry and move emotion.

The connection between fluids and emotion is not surprising. The etymology of emotion points to the centrality of movement and motion:



Emotion ... agitation, tumult ... excite, move the feelings of ... after *mouvoir*, motion. Hence ... emotive ... causing movement ... of L. *Emovere* ... (Onions 1966: 310, emphasis in original; see also Epstein 1993: 100)

The central role of emotion in human agency, as Telfer (1998: 271) highlights, is its intimate connection to movement. Kapferer similarly notes that “emotions are forms of the expression of the fluid motion ... of human beings in the world” (1997: 223).

Emotions are a fundamental part of relatedness, for people can be moved by emotions, and use them to form connections and disconnections.

Participants often used fluid metaphors to emphasise the emotional qualities of their experiences; they described “bursting into tears”, “spilling their guts”, things that “made them sick” (metaphorically) and “pouring their hearts out”. More generally, bodily fluids that carry emotions included tears (happiness and sadness), fluids associated with waste that carry disgust and dirt (as described above) and those that, when out of place, carry danger (blood). Yet, as described in the earlier sections of this chapter, expelling these fluids for people with anorexia was also described as a cleansing of emotion. Purging did not leave them without an identity or as empty shells as Malson suggests, but cleansed and transformed their embodied states. Purging not only transformed the embodiment of dirt, but as the next section describes, also removed unwanted emotions associated with memories.

### **Out damn spot: Spilling blood and guilt**

The most dramatic method of purging emotion was the cutting of skin to let blood.

Sonya, who had left anorexia told me:

There’s a lot who do it, and a lot won’t tell you. They’ll cut on the soles of their feet and they won’t tell anybody. But they will tell another anorexic who does the same thing.

These practices are known to psychiatrists as self-mutilation or self-injury (see Favazza 1996), distinct, but not dissimilar to blood letting. Although the techniques of opening

the skin are different, both place importance on the symbolism of blood and the emotional ‘release’ that accompanies the loss of this red fluid.

The practice of blood letting within eating disorders is a rare phenomenon. One psychiatrist noted that in his clinical work with eating disordered patients over the past 15 years, “I have seen it only once in a nurse with chronic anorexia nervosa” (Vandereycken 1993: 851). Blood letting refers to “venepuncture or insertion of intravenous cannulae” (Parkin & Eagles 1993: 246) to let blood from the body. In reported cases it is often those who have access to medical supplies and proficiency in vena-puncture, such as medical students, nurses and doctors, who practice blood letting. One medical student with bulimia nervosa regularly let her blood because:

It afforded her a ‘release’ from feelings of anger and tension. As she lost blood she felt ‘distanced, euphoric and satisfied’. She equated it with the feeling she derived from vomiting after a binge, but felt much less guilty about blood letting. (Parkin & Eagles 1993: 247).

Another clinician (Cosman 1986), similarly describes blood letting as a purging behaviour, a “stress-reducing behaviour” (Cosman 1986: 1188).

Although no participants blood let by venipuncture, I was aware that four released blood by cutting their skin with glass, scissors, knives and razor blades. In the park one day Rita, who always wore long skirts and long sleeved shirts, showed me the scars from Stanley knife cuts: “I’ve done my arms and both thighs. It sounds revolting but I actually like to see the slash ... I like to see the blood coming out, I like to see it pouring out”. Sitting on her lounge room couch, with towels under her arms, she would make deep cuts in her legs and left arm to get “rid of something that is putrid, the ugliness and badness in me”:

To me it’s like an elimination, like a purging, getting rid of something really bad - it’s like polluted - it’s bad blood as I call it. I want it all to ooze out of me and be gone. It’s satisfying at the time but the next day of course you feel like a total prat and an idiot and then you take weeks to bloody heal up again but at the time of doing it there’s some sort of release, some sort of purging thing going on there ... get out of me. It’s like vomiting blood except you do it through your cuts.

Amanda also wanted to remove the “badness in her body”, “to do something bad with [her] bad self”.<sup>19</sup>

I don't know why I do it except for some reason it helps. I don't know if these are my words or someone else's words but it is a bit of a release - it relieves me in some ways [“What are you getting rid of?” I asked. I noticed that she was clenching her fists] I guess it's kind of anger at myself or hatred at myself and at the world and at my lot in the world and this happens when I'm really depressed so it's not like how I am now, it's a lot different. It's that really wound up feeling you get in your chest ... the blood is like you can see it coming - you can see the anger coming out.

It could be argued that the metaphors used to describe this ‘release’ of anger simply draw from dichotomous constructions of the self and body. Desjarlais (1992), in reflecting on the display of emotions among the Yolma, states that, “the idea that unvented anger builds up and then needs to be ‘let out’ to avoid an explosion stems from the mechanistic ‘hydraulic’ theory of emotional expression common to several Western and non-Western philosophies of the self” (Desjarlais 1992: 116). As I argued above, in positioning bodily fluids as carriers of emotion this analysis moves away from a focus on structures, and explores the ways in which meanings move *between* categories. It is literally the movement of fluids that was transformational.

For Sonya, it was the movement of blood out of her body and the smearing or painting of the fluid onto surfaces (including her face) that was transformative. As a visual artist, she sometimes used her own blood as a medium to create pictorial narratives of her disgust and distress. In her white tiled bathroom she would cut her forearms, upper chest and calves to “stop [herself] feeling like a pressure cooker”, to release the guilt and anger. The cutting itself was not painful:

You dissociate from your body, you can't feel your body, it feels numb and you cut and it feels like cutting through butter. It is purging. All that guilt and all that anger is just trickling out. You have to see it and I think part of it is like in our culture what blood represents too - you know it's the life blood, it's red, it

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<sup>19</sup> Ellen West, one of Binswanger's ‘anorexic cases’, similarly wrote in her diaries: “I don't understand myself at all. It is terrible not to understand yourself. *I confront myself as a strange person ... I long to be violated — and indeed I do violence to myself every hour*” (Binswanger (1958): 254-5, emphasis in original).

represents violence. It's just like you see it coming out and it's all that anger pouring out and that's why you don't want to clean it up. And then later I did (weak laugh) this is kinda funny - I did paintings with the blood, yeah.

*What sort of paintings?*

Paintings. I'd take the blood and paint with it - either with my fingers or with the patio brush.

*And what would you be painting?*

Oh some abstract and some figures and some are things out of my psyche - I'll show you them.

(See Plates 6, 7 & 8)

At the time I wrote that and did the painting in blood, I really believed that I was responsible for all the abuse. I felt at the time that it was the female flesh on my body that attracted the men to me for sex at age 11. No matter how much I starved myself or cut at myself to punish the flesh and let out the blood, it was never enough. I would not have been satisfied until all that was left was bone. Bone is strong and carries no female flesh or semblance of femininity. No male would ever want me. But like Lady MacBeth no matter how much she washed and scrubbed it [the guilt and disgust] never went away.

## **Hovering at the borders**

Purification, as Sonya suggests, was not a straightforward process. These practices were only momentarily effective, for the impure, as Kristeva argues, can never be completely removed: "getting rid of [the object] is out of the question ... one does not get rid of the impure" (Kristeva 1982: 28). The closeness of disgust to the body, the sense that it 'never goes away', was a common experience. Purging practices were shrouded in secrecy, they were characterised as "a terrible dirty secret" and "the most disgusting habit" of which people were ashamed.<sup>20</sup> Linda became distressed when she described her experience of vomiting:

*Do you remember how you felt when you were vomiting, when you were purging yourself?*

Glad, very glad but it was hell, it was really, really - it was just hell (she begins to cry and I ask if we should stop). No, it's okay, it's just that it disgusts me, it completely disgusts me but I had to get the food out of me ...

<sup>20</sup> Malson notes a similar response amongst one of her participants:

Whilst purging is construed as purifying it may also, paradoxically, be construed as shameful. Nicki, for example, did not like to say that she takes laxatives and avoided using the word. She also avoided any detailed description of their effects – they make you "sick or whatever" – and both her and Cathy's construal of their effects as cleansing might be read as concealing their defecation-inducing properties. (1998: 167)



LADY MACBETH  
WASHING BLOODSTAINED  
HANDS  
SCRUBBING AWAY  
GUILT  
OVER AND OVER AND  
OVER AGAIN  
CAN'T SHE SEE  
HER HANDS  
ARE CLEAN?

Plates 6, 7 and 8. Sonya's blood paintings

Disgust and shame, as Probyn (2000) argues, are coiled together in the body, they are powerful affects that need to be “reintegrated into thinking about corporeal politics” (Probyn 2000: 125). People not only talked of how shameful purging was to them, but also described the shame of ‘being caught’. Daily purging in share houses meant that people had to have excuses at the ready or feign innocence. The most common tactics of concealment were regular bouts of ‘gastro’ (gastroenteritis) or acting surprised when the plumbing blocked again. Like the tactics of *la perruque* surrounding the outwitting of staff and family, hiding and lying about purging was a common practice. Even those who lived alone would take precautions against unwanted intruders. Lara, who lived alone in a small council flat, described the tension associated with her purging:

I even get paranoid that someone’s going to telephone while I’m doing it and know what I’m doing. I used to leave the phone off the hook so nobody would phone and disrupt me.

*What would happen if someone did walk in or interrupt you?*

Nobody knows except for [one close friend] really that I still do it. I also dread the doorbell going, but I’ll just pretend I’m out. The phone rang once and I actually answered it and it was my friend and I said “I’m in a meeting, I’ll phone you back in an hour!” (she laughs). I thought I cannot be interrupted, I have to get rid of this food.

\* \* \*

This chapter has suggested an alternative framework for exploring the connections between the individual pathologies of anorexia and obsessive compulsive disorders. Rather than understand the range of ‘behaviours’ as symptomatic of a co-morbid disorder, as another layering of illness, I have demonstrated the logic of practice in which participants felt compelled to cleanse themselves. Building on differing experiences of abjection described in the last three chapters (of food, bodies and experiences) I have argued that many of the purging practices associated with anorexia are concerned with the casting out of that which is disgusting. This involved not only

the more common eliminations of purging and laxative use, but also washing, scrubbing and sanitising particular parts of bodies and environments.

This overwhelming desire towards cleanliness and order were central to the ‘symbolic rituals of purification’ described earlier in the chapter. Although purity has been linked with analyses of anorexia, it is always discussed through religious discourses of asceticism. Garrett (1992, 1998), for example, in her Durkheimian studies, suggests that “anorexia can be interpreted as a purity ritual [in which] anthropological theories of asceticism, ritual and religion offer a way of conceptualizing anorexia and recovery as linked stages in a profoundly social transformation of the *individual self*’ (1998: 58, my emphasis). Purity, as this ethnography has demonstrated, is not solely located in these domains but intersects with a number of other fields: medicine, nutrition, sexuality, and ideas of the ‘clean and proper’ body. Hygiene is a central field through which all of these logics of practices resonate.

For the women in this research, everyday practices of hygiene enabled them to disconnect themselves from that which they found disgusting and out of place: certain foods, bodily processes, relationships, memories, experiences, and emotions. Hygienic practices transformed relations of disgust into states of asexuality, asceticism and asepsis. These were not simply, ‘profound transformations of the individual self’, but more importantly, profound transformations of social relations.

## **CONCLUSION**

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The aim of this thesis has been to highlight what Ernst (1990: 111) calls “relations of relationships” amongst a group of people with a diagnosis of anorexia. In my discussion of these relationships there is one player that I have consciously relegated to the background: the media. As I argued in the introduction, I did not wish to reproduce the discursive explanation of anorexia as a ‘reading disorder’, and tried to steer away from media representations of anorexia. I anticipated that in focusing on participants’ everyday worlds my fieldwork would be led away from the disembodied textual analyses that have already been extensively explored in the eating disorder literature. As my fieldwork progressed, however, I came to realise that to disengage from the power of these representations would be a grave methodological error.

This realisation was most clearly displayed when, towards the end of this writing process, parts of this research were broadcast and printed in the national and international media. It was these very particular representations of anorexia, and their relationship to psychiatry and anthropology, that this conclusion addresses. It is through an examination of the underpinning framings of these characterisations that the major analytical strands of this thesis come together. Ironically, it is by turning to that which I initially tried to ignore — the intertwined relationship between ethnography and the media — that my conclusions are situated.

## **TURNING UP THE WHITE NOISE**

The relationship between the media and ethnographic enquiry is problematised by Ortner (1999), who broadens the term ‘media’ to ‘public culture’ in order to generate a more inclusive approach to representational systems. Public culture, she argues,



includes “all the bodies of images, claims, and representations created to speak to and about the actual people who live in the US: all of the products of art and entertainment (film, television, books, etc), as well as all of the texts of information and analysis (all forms of journalism and academic production)” (1999: 55). It is through these pervasive and taken-for-granted representations that the “lifestyles, habits, tastes and attitudes are everywhere, and inescapably before us ... Who [then] can presume to step “outside” of it? Its ideas and assumptions are everywhere, and not least in our own minds” (Ehrenreich 1990, cited in Ortner 1999: 55). The same can be claimed about knowledges and representations of anorexia.

One such example of this inescapable relationship was the anonymous flyers that appeared during my fieldwork with increasing regularity: ‘Lose weight fast’; ‘Lose 15 kilograms in 3 weeks’; ‘Lose weight now, ask me how’.<sup>1</sup> At first these advertisements annoyed me and I tried to ignore them; they smacked of the insidious commercialism that flourishes around the weight loss industry and ‘get rich quick’ schemes. But I couldn’t ignore this pervasive “white noise” of fieldwork (cf. Marcus 1998: 96). Their appearances became more intrusive and significant. Returning to my car following a hospital visit, I found a flyer stuck to the windscreen. When I was unchaining my bike late one night from a lamp post outside a community support service for people with eating disorders I looked up and there, glued to the pole, was a flyer. After pouring over the minute details of food packaging labels with a participant in a supermarket, we returned to the car only to find a weight loss advertisement flapping under the windscreen wiper.

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<sup>1</sup> ‘Lose weight now, ask me how’ is the motto of the Herbalife business, an American based company that sells weight loss tablets to a world wide distribution network. The founder, Mark Hughes, dedicated his life to ‘bringing the finest weight loss, nutritional and personal care products to people around the world’. On May 21<sup>st</sup> 2000, Hughes was found dead at his home following ingestion of a lethal mix of anti-depressants and alcohol (*The Weekend Australian*, October 7-8, 2000).

The flyers acted as a forceable reminder of the connections between the fields in which participants and I moved, between institutions, community organisations, public spaces and people's homes. Media representations were ubiquitous in each. Whilst waiting in hospital corridors and waiting rooms I picked up women's magazines and read stories about different movie stars' weight losses/successes, and sometimes stories of someone's 'battle with an eating disorder'. At *Vista* a young woman recovering from anorexia leapt across the cushions of the lounge to turn off the television advertisement for a multi-national weight loss consortium. Amanda would waste away hours on the bed program by cutting out stories about weight loss (and recipes) in magazines that she would add to her already voluminous collection at home. The plethora of these type of media sources provided community groups with ammunition against stereotypes of women and anorexia, so much so that one community organisation had a pin board at its main office entrance with an everchanging array of offending clippings.<sup>2</sup>

These were the fields in which people travelled, these were part of their everyday worlds and experiences. To ignore the interconnections between experiences and objects, between people and places, would be to only explore part of their worlds. As I argued in Chapter One, my field sites, like the everyday worlds of participants, were not pristine, bounded or contained. People moved back and forth between a number of fields, each field enmeshed in and generating its own representations, knowledges and powers. And in these fields, people were always "caught in fragments of representational systems" (Chakrabarty 1994: 100).

Chakrabarty's statement was brought home to me during the 'writing up' phase of this thesis when a journalist from my home university's paper approached me and requested an interview (and photograph) about my research. An intense media interest followed

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<sup>2</sup> This community organisation publicised a number of web sites (such as *About Face* and *Adios Barbie*) that 'exposed' negative media images of women.

publication of this story. I was inundated with phone calls from national (and international) radio and television presenters, and print media journalists (including magazine editors and newspaper journalists). Many of those involved in the visual media requested interviews with women from this project, and when pressed it was clear that they wanted images of emaciated bodies to fuel their stories. Even though these requests were denied, one television interview drew images from its archives and displayed semi-naked pictures of starved young women as the backdrop to my research. It was thus not only the participants who were caught in representational systems, but also my own ethnographic research.

## **PRIMITIVISING ANOREXIA**

The media story I now turn to in order to illustrate the relationship between this ethnography and public culture was printed in a major Australian newspaper and covered two pages. Headlined “Tribal Starvation” and “The Secret Suffering”, the story outlined how “new research has discovered a surprising subculture among people with eating disorders ... within the inner sanctum of eating disorders lies a maze of cults ... you are either part of the strange starvation tribe — or you are not” (*The Age*, June 22<sup>nd</sup>, 2001). Two black and white images were used in conjunction with the story (See Plates 9 & 10). The first was of two shadowy figures facing the reader (one clearly a woman from her mode of dress); both were faceless and with willowy bodies. The other image was of a young woman standing in front of a mirror, her frowning face reflecting her dissatisfaction with her distorted image. The mirror was similar to those found in a side show alley at any carnival or travelling show (indeed there is a warped image of a ferris wheel in the mirror). This oft repeated idea of distorted body image clearly points to the ways in which this women’s experience of her own body is at odds

# TRIBAL starvation

New research has discovered a surprising subculture among people with eating disorders – a complex hierarchy involving secret practices, codes, language and even dress. **CHARISSE EDE** reports.

**J**ANE" never felt fully accepted into the "club". Despite being diagnosed with anorexia-bulimia three years ago, and having lived with the disorder for almost a decade, she knew her peers thought she was not a "real" sufferer because she wasn't sick enough.

"I had thought about attending a group with other people with my condition but didn't feel I would be eligible, that I wouldn't be accepted by the other girls because they didn't see me as anorexic enough," says the 25-year-old social worker from Melbourne's south-east.

"People thought they were better than everyone else if they had been hospitalised and had tubes down their throats. And with bulimia, there was the feeling that if you didn't spew up a couple of times a day, you weren't really bulimic."

And yet, being diagnosed with an eating disorder was an empowering experience that made Jane feel "normal", like she was part of something greater.

Jane's story is a startling revelation that within the inner sanctum of eating disorders lies a maze of cults that have systems of hierarchy, secret practices and even language.

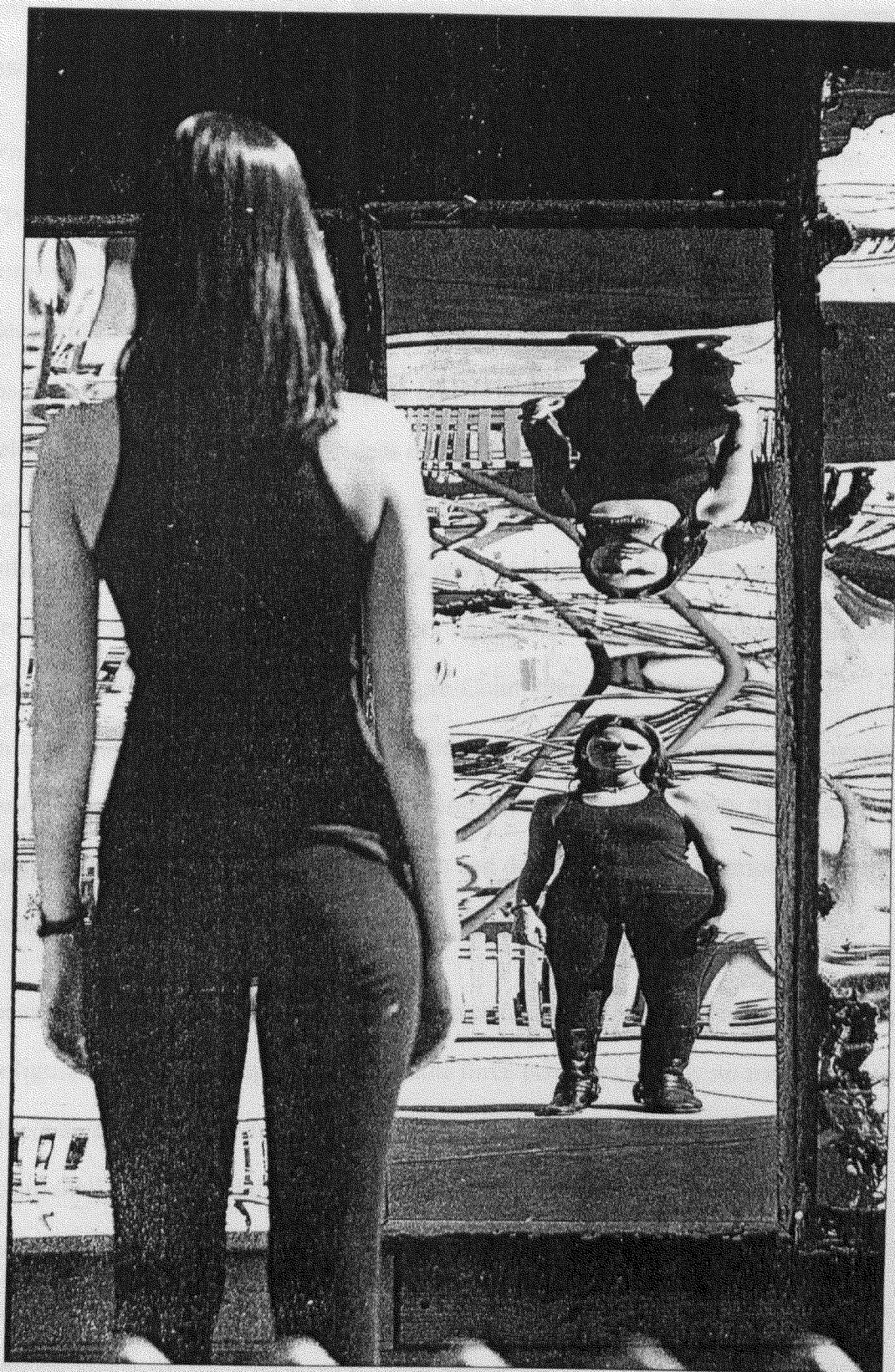
You are either part of a strange starvation tribe – or you are not.

Sufferers find comradeship and solace among each other, but remain highly competitive. Many liken their battle with the condition to taking part in the Olympic Games – with the ultimate prize, the gold medal, being death.

They swap information on how to "improve" their conditions through better dieting, share which foods are easier to vomit out of the system once eaten, how to lose weight easier and which exercises are most effective.

They can pick other sufferers by the way they dress, organise themselves, talk and even walk. It's an allegiance only available to those on the "inside", but even then, sufferers are typecast by the extent of their illness or the purity of their disorder.

Continued **T3**



**Image  
problem:  
Anorexic  
sufferers are  
reluctant to  
talk about  
their  
condition,  
except with  
other  
sufferers.**

Plate 10

with how other people view her. Her perceptions (in this case her gaze) are deemed distorted and irrational.

What the text and images of this story play with are key concepts of primitivism: representations of difference, distance and otherness. Primitivism, as writers like Torgovnick (1990), Clifford (1990) and Lucas and Barrett (1995) suggest, is “a body of ideas, images and vocabularies about cultural others” (Lucas & Barrett 1995: 289) that has been used to construct and imagine otherness and identity throughout a variety of fields. The history of primitivist ideas can be traced in any number of ‘western’ fields that categorise and represent ‘cultures’; for example, the arts, literary genres, anthropology and psychology (to name a few). All these fields, as Torgovnick notes, are imbued with the language and imagery of primitivism as an interchangeable set of ideas. These ideas include the “savage, pre-Columbian, tribal, third world, underdeveloped, developing, archaic, traditional, exotic, “the anthropological record”, non-Western, and Other [which includes women]” (Torgovnick 1990: 21). “All”, Torgovnick argues, “take the West as norm and define the rest as inferior, different, deviant, subordinate, and subordinateable” (ibid).

Lucas and Barrett (1995) demonstrate how psychiatry is implicated in this particular configuration of knowledge. They examine three principal (but by no means definitive) subject areas of cross-cultural psychiatry (*amok*, the therapeutic potential of ‘traditional’ society, and the shaman), arguing that ‘psychiatric primitivism’ has been invoked as an explanatory framework in each. In accounts of *amok*, for example, it is claimed that “people in less developed societies exhibit a “passivity of mind and an unpreparedness for sudden decision and action, reducing them to ‘primitive’ defence reactions such as fright” (Kiev 1972: 73, cited in Lucas & Barrett 1995: 299).

Similarly, shamans have been represented by two opposing types of psychiatric

primitivism, through both Barbaric images of madness (as a malevolent trickster and fraud) and Arcadian images of healing (a visionary or seer). In all these schemas, images of society, person and mental illness converge so that each comes to signify the other. These “clichéd categories of primitivism” (Lucas & Barrett 1995: 313) underpin cross-cultural psychiatry’s understanding of mental illness.

Primitivism is not simply confined to representations of the Other, for it is also fundamentally concerned about the ways in which ‘the self’ is imagined. It is, as Lucas and Barrett argue, “an essentially reflexive tool by which the West comes to understand itself. In the process it constructs the Other as an exotic from a distant land, or as a threatening presence concealed within the Western self” (ibid: 313). These types of constructions, as Clifford (1990) suggests, are “a way of coming to know and contain that which is forbidden, marked off and tabooed in our own society, in this case ‘madness’ (Clifford: 1990: 142). In terms of psychiatry, primitivism is thus “one of the principal means of understanding mental illness in Western psychiatry” (Lucas & Barrett 1995: 314).

It was the Barbaric form of primitivism that the print media continually drew from in its characterisations of my research. This is not to suggest that the journalists concerned were familiar with the history or epistemologies of psychiatry. Rather it points to the wider circulation of primitivist ideas within what Ortner has defined as ‘public culture’. Moreover, I suggest that it was the particular configuration of my research — of anthropology, psychiatry and anorexia — that proved irresistible to such primitivist characterisations. Those images and words used to describe my research, such as “tribal”, “maze of cults”, “strange”, “subculture” (*The Age* June 22<sup>nd</sup>, 2001), “mysterious starving condition” (*The Advertiser* June 5<sup>th</sup>, 2001), “dangerous” (*Daily Telegraph* June 5<sup>th</sup>, 2001), and “cult-like” (*Canberra Times* June 5<sup>th</sup>, 2001), are

synonymous with barbaric primitivism; “a stranger from an exotic land” (Lucas & Barrett 1995: 290), part of an “inchoate tribe”, “bound by superstition and irrationality” (ibid: 296). Primitivism was ‘the hook’ to engage the reader; an invitation to be fascinated and horrified by ‘tribal starvation’. The message was that people (and predominantly women) with anorexia may be familiar to ‘us’, but they are most remarkably ‘not like us’ by their ‘strange’ desire to waste away.

Despite the ‘reflexive turn’ within anthropology (and social sciences and humanities more generally), the relevance of these debates have not entered public culture with the same fervour. In the public domain anthropology remains trapped within a primitivist understanding, as a discipline that continues to represent the ‘Other’. Psychiatry, similarly, is characterised in public culture as a marginal stream of medicine that deals with the ‘Other’ of madness. The media representations of my work engaged with the simple dichotomies that primitivism provides, unable (or not willing) to engage with the complexities, subtleties and ambiguities that anorexia might present.

## **THE ‘OTHERING’ OF ABJECTION**

It could be argued that there are certain parallels between primitivism and abjection; that the language of Kristeva’s abject is synonymous with the language of primitivism. Both, for example, are concerned with difference and desire, self and other, familiarity and strangeness, horror and fascination. These are the precise tropes from which I distanced myself from in the introduction to this thesis, where I criticised simplistic reductions of anorexia to carnivalesque image of thinness, horror, fascination and death. Certainly, as Lechte suggests, there is an “emotionally charged fascination with abjection. Horror and fascination are intertwined” (Lechte 1990: 167). There is a danger that abjection could be taken as simply another way of representing people with anorexia as ‘primitive other’.



While this ethnography is as much a representation of anorexia as the media story presented above, its modes of representation are entirely different. It is important to re-emphasise these differences, for they underpin the central arguments of this thesis and highlight the significant contribution of ethnography to this domain of research.

Although primitivism and abjection use a similar wording of difference and otherness, their usage is framed by different epistemologies that result in completely different meanings. As I suggested in Chapter Three, my strategy was not to erase problematic terms such as 'self' or 'other', but rather to rethink their relationship ethnographically. I have done this by approaching these terms through a concept of relatedness; by examining the ways in which "selves *become [and unbecome]*... within a matrix of relations with others" (Ingold 1991: 367). This matrix is, in Bourdieu's sense, a field of social relationships in which relations *unfold and enfold* in the processes of social life (ibid). For people with anorexia these processes were often experienced as abject, for they conflated and transgressed representational categories that constructed their social worlds.

The constructions that frame primitivism rely on static dualisms that fix the separate categories of self and other into an either/or schema. This fixing serves to create autonomous categories that stand in hierarchical opposition to one another. The concept of civilised, for example, is conceptualised as present and near, whereas primitive is located in historical time, and in far away places. As Fabian (1983) has shown, a certain politics of time and space is evoked in primitivist constructions to distance others, despite their contemporary presence.

While Kristeva's concept of abjection uses the language of self and other it is not dualistic, for it is concerned with the movement within and inbetween these categories. In extending abjection into an ethnographic domain this thesis has highlighted the

relational aspects of anorexia (with oneself, with others and with objects). Chapters Three, Four, Five and Six described the relationships that people with anorexia had with each other, family members and friends, with different types of foods, their bodies, and with spaces. What was striking about these relationships was that they were experienced as abject: as simultaneously threatening, desired and disgusting. That which is abject is not trapped in dualisms or reduced to oppositions. On the contrary, what is abject is inbetween, ambiguous and composite. Abjection is thus contrary to dualist concepts because it undermines and threatens that which is separate. As such, abjection is fundamentally concerned with the complexities and contradictions of relatedness.

The dualist categories of self and other pay homage to the notion of an autonomous and unchanging subject or self. As an on-going *process*, Kristeva's understanding of self-identification involves a new model of otherness *within* the subject. Recall the descriptions in Chapter Two of my own experiences of alterity through pregnancy. Pregnancy problematises the concept of the autonomous self for "the maternal body is the very embodiment of alterity-within. It cannot be neatly divided into subject and object" (Oliver 1993: 4). While a discussion (and critique) of Kristeva's problematic account of 'becoming mother' is outside the purviews of this thesis, my own experience of pregnancy in the field highlighted the very notions of self-identity and difference that abjection holds in tension.

Participants experienced this alterity-within through the personification of anorexia. This ethnography has described how people entered into and developed intimate relationships with anorexia; it became a friend, an angel or the devil in disguise. Anorexia had the attributes of an abusive lover. It was, as Elise described: "very seductive, it draws you in, it's like a safe relationship ... it's like an abusive

relationship, but it's very difficult to get out of and you can go back so many times". These constant struggles of separation and seduction are, Kristeva argues, integral to the process of self-identification, of acknowledging and confronting *the other within the self*. This confrontation is the substance of abjection, the experience of a "violent, clumsy breaking away, with the constant risk of falling back under the sway of a power as securing as it stifling" (Kristeva 1982: 13).

The relationships that participants had were never static, but like any social relationship were constantly shifting and transforming. As Estelle's account of her 'recovery phase' in Chapter Three highlighted, relationships in treatment settings were complex sites of negotiation, not only with other in-patients but also with staff members. This was a place where her identity was performed, constructed and deconstructed in multiple ways. Although Estelle was legitimated as a 'patient' through the diagnosis of anorexia, there was an entirely different level of legitimation being played out amongst other in-patients. To the ward staff Estelle had anorexia, but to other in-patients with anorexia she was 'outside anorexia' because of her desire to overcome it. Estelle found this multiple identification problematic, in that she was caught between the authoring of competing forces. In short, the narratives described in this thesis reconceptualise the discursive production of self and other as relational rather than oppositional.

The final difference between abjection and primitivism relates to differing experiences of self and other within fields. As I have argued, primitivism works on the premise of a clear-cut relationship between self and other; of the distant gaze upon the object of display. What is objectified — be it Kafka's hunger artist behind the bars of the performing cage, static displays behind glass in museums or art galleries, or photographs of other locations and peoples — evoke the spectacle of primitivism. The distance reinforces the conceptual relationship between self and other. Unlike the gaze,

abjection is located in visceral and sensual bodies. It may be evoked through the gaze, but it is fundamentally experienced through the many different perceptual modalities that evoke emotive responses: taste, touch and smell. It is not disembodied, objectified and distant, but felt and close. Experiences of anorexia are thus not simply concerned with body image — with how one looks — but experiences that are felt.

In focusing on the embodiment of anorexia this ethnography has not represented participants as objects for others to gaze upon, but positioned the intersubjectivity of their experiences as central. These experiences were grounded in relatedness. In their everyday lives, participants manoeuvred in and out, between and within a set of indeterminate relations. Jackson argues that the *experience* of constant manoeuvring between self and other (rather than the terms themselves) is “indicative of the way human experience vacillates between a sense of ourselves as subjects *and* as objects; in effect, making us feel sometimes that we are world makers, sometimes that we are merely made by the world” (Jackson 1996:21). Experiences of anorexia are clearly not one thing or another, but oscillate between categories.

The emphasis on relatedness and abjection throughout this ethnography has taken the arguments on a very different course from that of a discursive reading of anorexia. Discursive representations such as primitivism bear no relationship to people’s experiences of anorexia. Participants were not part of a strange starvation tribe, “an exotic being, unpredictable and governed by instincts and emotions” (Lucas & Barrett 1995: 289). On the contrary, I have argued that experiences of anorexia draw directly from people’s *habitus*, from their everyday relationships with people, places, food, bodies, sexuality and gender relations. For a variety of reasons, participants began to experience these aspects of their lives as dirty and disgusting. They turned to the cultural frameworks of purity and hygiene to cleanse themselves and their

environments. Hygienic practices ensured that purity could be attained in all its ideological and functional facets. Bodies could become clean through practices of purging, washing and eating only 'clean' foods, disengaging from the messiness of sexuality and sexual relationships, and sanitising and ordering environments.

This process, however, did not completely remove dirt and disgust, for purging was a temporary alleviation of disgust. What was cast out could never be completely removed, but as Kristeva suggests, hovered close to the body. Experiences of anorexia are replete with ambiguity and misrecognition, as Hornbacher succinctly captures:

It is, at the most basic level, a bundle of deadly contradictions: a desire for power that strips you of all power. A gesture of strength that divests you of all strength. A wish to prove that you need nothing, that you have no human hungers, which turns on itself and becomes as searing need for the hunger itself. It is an attempt to find an identity but ultimately strips you of any sense of yourself, save the sorry identity of 'sick'. It is a protest against cultural stereotypes of women that in the end makes you seem the weakest, the most needy and neurotic of all women. It is the thing you believe is keeping you safe, alive, contained — and in the end, of course, you find it's doing quite the opposite. (Hornbacher 1999: 6)

The very ambiguity of people's experiences is thus not written away in this thesis, but brought to the forefront of relatedness. As I suggested in the introduction, ambiguity is a term that is not often used in anthropological theory, much less so in rationalist medical discourse. Abjection is premised on ambiguity, and it is a term I embrace, as it allows the ethnography to partially understand the complexities of anorexia, while acknowledging the impossibility of explaining it completely. Thus my argument does not replace one rationalist explanation for another, for abjection and relatedness create interconnected spaces of transformation, ambiguity and intersubjectivity rather than order, stasis and predictability.

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