

**THE PHENOMENOLOGY OF THE
ANOREXIC BODY**

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ABSTRACT

The purpose of the study is to articulate the phenomenology of the anorexic body. In order to describe the complex meaning of the anorexic body, the present research adopts the qualitative and exploratory approach of Seidman's (1991) in-depth phenomenologically based interviewing method. This involves a series of three separate interviews, with three research participants who have had personal experience of anorexia. The method of data analysis used is essentially on editing style of analysis (Miller and Crabtree, 1992) and is based on a hybrid of the grounded theory approach of Glaser and Strauss (1967) and Heidegger's (1927) ontological hermeneutics to form what Addison (1992) calls grounded interpretive research.

Anorexic embodiment is conceptualised as precipitating a fundamental disturbance between the interactions of embodied consciousness and the world. The body is no longer taken-for-granted, and becomes an object for scrutiny. As an object, the body is experienced as a thing exterior to the self, and this awareness contributes to the sense of disorder which permeates anorexic embodiment. Bodily intentionality is frustrated when the sphere of bodily actions and habitual acts become circumscribed. The character of lived temporality and lived spatiality are also effected with the anorexic's focus on the now, ushering in a spatiality of the here. These findings indicate that anorexic embodiment is

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experienced primarily as a disruption of the 'lived body' rather than that of the biological body.

The prevailing discourses of anorexic embodiment are shown to be split between the naturalized discourses that provide a model of the body that is biologically determined and ahistorical, and the denaturalized discourses that provide a model of the body that is culturally constructed and lacks embodied givenness.

It is argued that Merleau-Ponty's phenomenology of the body offers a renaturalization of the body that overcomes the nature/culture dichotomy of the naturalized and denaturalized discourses, thereby providing a solid foundation that more directly addresses the phenomenology of the anorexic body. The theoretical and treatment implications of Merleau-Ponty's renaturalization of the anorexic body are highlighted, and suggestions for further research are presented.

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“The body is a great intelligence, a multiplicity with one sense, a war and a peace, a herd and a herdsman.”

(Nietzsche, 1960, p.61)

CHAPTER ONE

INTRODUCTION

1.1 STATEMENT OF THE PROBLEM

In 1945, when Ludwig Binswanger chronicled the now famous case of Ellen West, who suffered from anorexia, he was able to say that "from a psychiatric point of view we are dealing here with something new, with a new symptom" (May, 1958, p.288). In 1973, Hilde Bruch, one of the pioneers in understanding and treating eating disorders, could still say that anorexia was "rare indeed" (Bruch, 1973, p.4). Gremillion (1992) argues that whilst the syndrome is relatively rare in the population as a whole, the incidence of anorexia has risen markedly and more than doubled since Bruch's (1973) statement. While there is some debate about whether anorexia is peculiar to Western and highly Westernized cultures (Crisp, 1980, p.29), most agree that anorexia appears in significant numbers only in Western and Westernized societies, occurring almost exclusively among whites within the middle and upper middle classes, and that 90% of all anorexics are female (Gremillion, 1992, p.69).

Regarding diagnosis, Crisp (1980) notes that there is a lot of confusion surrounding its classification, in that anorexia has been classified as a hysterical syndrome, as an affective disorder, as an obsessive compulsive syndrome, as a biomedical problem, as a 'fear of femininity', as a schizophrenic disorder, as a cognitive disorder, as a familial problem, as insanity, as adolescent depression, and as existential dread (Crisp, 1980, p.29). In attempting to resolve conflicting ideas about the syndrome, Garfinkel and

Garner (1982) have resorted to calling it a "multidetermined disorder with familial, perceptual, cognitive, and possibly biological factors interacting in varying combinations in different individuals to produce a final common pathway" (Garfinkel and Garner, 1982, p.4). Regarding the issue of treatment, even those anorectics who undergo the "contemporary 'multidimensional' treatment approach which combines two or more of the abovementioned factors with their varying emphases on soma and psyche, have a poor prognosis. The mortality rate is close to 10%, and up to 50% of those who live 'remain poorly adjusted' (Steiner, 1982, p.125).

The present research will explore whether some of the difficulties involved in understanding and treating the disorder might not arise from dominant explanations and treatments being embedded in a medico- and psycho-cultural milieu which reflects attitudes towards the body which are part of the problem for anorexics. The general philosophy of the body in much of the writing about anorexia provides no real alternative to the way of relating to the body which defines anorexia in the first place. It is important to realise that anorexia reveals a form of contemporary control over the female body, and the term itself is produced by a discourse which is patriarchal and masculine, within which the anorexic has little hope of 'finding herself'. The possibility of a woman experiencing "anorexia nervosa is as much a result of her place within language and patriarchy as it is an indication of her pathology" (Robertson, 1992, p.69).

If this is true, then it is not clear how a woman being treated for anorexia is to find a language for her experience beyond the language of her symptoms. It is also not clear how the anorexic body might free itself within a masculine discourse, and how the

woman being treated for anorexia might find meaning for her symptoms outside the discourses that define her.

There have been many theoretical models for understanding and treating anorexia. Some of the more prominent are: the biomedical model (Gull, 1868; Laseque, 1873; Long, 1987; Steiner, 1982); the psychoanalytic model (Freud, 1958; the behaviourist model (Bemis, 1978; Blinder, 1970; Garfinkel, 1973; Halmi, 1975; Moldofsky, 1974); the psychodynamic model (Sylvester, 1945; Bruch, 1966; Palazolli, 1974); the family system theories (Dare, 1983; Gilchrist, 1986; Kog, 1985; Minuchin, 1978); and feminist theories (Chernin, 1983; Irigaray, 1985; Keller, 1985; Lawrence, 1987; Orbach, 1986). Although many of these models have been and continue to be developed in relation to clinical work, each one contains strong theoretical presuppositions which, as has already been suggested, may be part of the problem for anorexics. Most of these models tend to see anorexic symptoms as pathological developments which have been strongly linked to an underlying cause, be it in conditioning, the life history of the individual, the biochemical body, the family or the culture. There has been relatively little work done on understanding the meaning of anorexic symptoms as a failed attempt to speak in contexts which do not provide legitimate pathways for symptoms to come to language. The phenomenological tradition in psychology is concerned with understanding the meaning of symptoms in these terms, and within the phenomenological tradition in psychology there has been little work in the area of anorexia.

A review of the literature on the phenomenology of the body shows that the phenomenology of the anorexic body has not been discussed at any length, and there has been no major work in this area. The Study Project in Phenomenology of the Body, founded in 1987 as a research venture and networking organization, devoted to studying the lived body and bodily experience, list the following previous research on the body, namely: "Body and Self" (Morris, 1982); "Body and World" (Seamon, 1979); "The Compromised Body" (Karel, 1992; Toombs, 1992); and "The Musical Body" (Behnke, 1983), but the phenomenology of the anorexic body remains an area requiring further investigation.

1.2 GOALS OF THE RESEARCH

The first goal is to obtain rich, accurate descriptions of the experience of the anorexic body from participants who have been diagnosed as anorexic and experienced the phenomenon. In order to illuminate the complex meaning of the anorexic body, the present research adopts the qualitative and exploratory approach of Seidman's (1991) in-depth phenomenologically based interviewing method which is elaborated on shortly.

The second goal is to rigorously analyze this data so as to yield a general structure and account of the anorexic body experience. The interview protocols are analyzed by various coding procedures which form the bases of the grounded theory approach originally developed by Glaser and Strauss (1967) which are explained in the present chapter.

The third goal is to interpret the above general structure with reference to the already established body of ideas about the anorexic body (i.e. psychoanalytical, behavioural, psychodynamic, family systems, and feminist discourses) on the one hand, and in relation to Merleau-Ponty's (1963) notion of the 'lived body' on the other. It is hoped that this leads to the advancement of new ideas about anorexic embodiment which is more faithful to the experience of the anorexic body and better represents the difficulties which the anorexic has in attempting to understand/speak her symptoms. It is also hoped that such analysis provides new treatment directions for psychotherapists.

1.3 PROCEDURES

In order to investigate and illuminate the complex meaning of the anorexic body, this research adopts a qualitative and exploratory approach, following Seidman's (1991) in-depth, phenomenologically based interviewing method. This model involves conducting a series of three separate interviews with each participant. The first interview establishes the context of the anorexic experience. Here the participants are asked about their early significant experiences prior to the onset of the diagnosis of anorexia. Seidman (1991) calls this stage of interviewing the focused life history.

The second interview focuses on the concrete details of the participant's present experience of anorexia. Here the participants are asked to describe their feelings and experience of their anorexic bodies.

The third interview focuses on reflecting on the meaning of their experience of anorexic embodiment.

Three participants who are English-speaking and reasonably articulate, who have been diagnosed as anorexic and were willing to share their experiences were chosen. The anonymity of the participants by the use of pseudonyms for all names and places was guaranteed, and the confidential nature of the interview established. Furthermore, the researcher in his capacity as clinical psychologist did avail himself to render further interviews in the event of the in-depth interviews opening up issues that required further discussion or treatment.

The method of analysis used in the present research is essentially an editing style of analysis (Miller and Crabtree, 1992), and is based on the grounded theory approach which was proposed by Glaser and Strauss (1967), and further combined with Heidegger's (1927) ontological hermeneutics, to form what Addison (1992) calls grounded interpretive research.

The aim of the grounded interpretive approach used in the present research is to analyse the data and construct a theory that is grounded in the data that emerges. In this approach, both data collection and analysis occur simultaneously. The purpose of the analysis is to identify underlying patterns or themes that emerge from the data, which is achieved through a process of coding the data and organising the data into themes.

The framework for the analysis of the data involves five stages:

1. Developing a narrative account
2. Developing an interpretive account
3. Refining of the interpretive account
4. Collective interpretation
5. Comparative interpretation

1.4 A NOTE ON TERMINOLOGY

The term 'anorexia' or 'anorexic' will be used in place of 'anorexia nervosa'.

The concept, the 'naturalization' of the body, following Bigwood (1991) means that the body has been understood to rest on the firm foundation of the 'natural' body, where 'natural' means ahistorical and cross-cultural, and thereby fixed. The concept, the 'denaturalization' of the body, following Bigwood (1991) refers to an understanding of the body as a product of cultural meaning, where 'denaturalized' refers to an understanding of the body only as a product of cultural construction.

The concept, the 'renaturalization' of the body, following Bigwood (1991), refers to an attempt to understand the body, in a new model, that goes beyond both the fixed biological body (i.e. the naturalized body) and the culturally inscribed body (i.e. the denaturalized body).

1.5 STRUCTURE OF THE THESIS

Chapter 1 involves a basic introduction and overview of the thesis in general. Chapter 2 comprises the literature review, beginning with the history of the concept from Medieval Europe (1200-1500) to the modern anorexic (1900's). The various dominant psychiatric explanations, i.e. the biological, psychoanalytic, Kleinian, behavioural, object relations and family system perspectives are presented, demonstrating the differing viewpoints on the anorexic, and the manner in which the anorexic body is naturalized in these discourses. Attempts at the denaturalization of the anorexic body, by the various feminist discourses, are then presented. These include the work of Orbach (1978), Chernin (1983), Lawrence (1984) and Macsween (1993). Binswanger's (1958) existential view of the anorexic completes the literature review. The basic theme of this review is to demonstrate the manner in which the anorexic body is both naturalized and denaturalized, and demonstrates that the renaturalization of the anorexic body remains to be articulated, which is the aim of the present research.

Chapter 3 documents the research methodology used in this study, called grounded interpretive research, which is argued to be most congruent with the philosophical tenets and objectives of this research.

Chapter 4 presents the results of the study, and ends with the presentation of a model of anorexic embodiment as it emerges from the data. Chapter 5 presents the discussion and conclusion of the study by comparing the model of anorexic embodiment from the present research to that of Merleau-Ponty's (1963) notions of the lived body on

the one hand, and with existing literature on the other, so as to demonstrate the renaturalization of the anorexic body. The practical and theoretical implications are also documented, as well as the limits of the present research, with suggestions for future research.

1.6 SYNOPSIS

The present chapter outlines the basic goals, procedures and framework for the present research, and provides a brief overview of the thesis.

CHAPTER 2

LITERATURE REVIEW

2.1 ANOREXIA NERVOSA: THE HISTORY OF THE CONCEPT

In 1859, in the American Journal of Insanity, William Stuart Chipley (1810 - 1880) published the first American description of sitomania, a "phase of insanity", characterized by "intense dread of food" (p.4). Chipley regarded sitomania as a phase of insanity rather than a distinct form, casting the refusal to eat as a secondary symptom in various forms of insanity. Chipley (1859) said of food refusal:

"It is remarkable that a feature of insanity of such frequent occurrence, and fraught with so much interest in the patient, and indescribable anxiety to the practitioner, should have received so little attention. Other phenomena of insanity, far less grave and important, have received more attention, and become the subjects of elaborate research".
(p.2)

Chipley's clinical description of sitophobics distinguished between organic and moral cause, elaborating on two of the most predictable types: those who feared poison in their food, and those who sustained belief in a divine command, or other supernatural direction, not to eat.

The significance of Chipley's commentary for the prehistory of anorexia nervosa, however, was his specification of another type of food refuser: food-refusing adolescent

girls who were brought to the asylum as a result of parental concern and as a function of the physician's inability to forestall the physical deterioration accompanying her anorexia:

"There is another description of cases met with by the general practitioner, but which do not ordinarily fall under the observation of our speciality (asylum superintendents) until they have so far progressed as to have ceased to be wholly mental - the digestive organs having become involved, and appearing then to be principally at fault. I allude to those cases in which a morbid desire for notoriety leads to protracted abstinence from food, in spite of the pangs of hunger, until all sustenance is refused. I have never witnessed a case of this kind except in females predisposed to hysteria".
(Chibley, 1859, p.3)

Chibley's comment on this type of patient was related to a social fact about sitophobic girls:

"because they are almost peculiar to well-educated and sensible people, belonging to the higher walks of society, enjoying all the advantages that wealth and station could confer"
(Chibley, 1859, p.4).

Such patients were not the usual asylum clientele. Consequently, Chibley regarded such food-refusal as a particularly annoying form of profligacy (Brumberg, 1988, p.109).

Other factors working against the incorporation of this type of adolescent anorexia into the general medical institutions were: the bias against incarcerating the young; the stigma of institutionalization; the ability of the middle-class and upper-class families to provide other more individualistic solutions such as private 'nervous' homes, spas, recuperative travel to therapeutic environments, and extended visits with relatives

(Brumberg, 1988, p.10). Only after severe emaciation and exhaustion of family resources did the hospital become an acceptable site of treatment for these patients without the stigma of a lunatic clientele. Little professional recognition was given to the existence or description of Chipley's sitophobic girls.

However, in 1868, at the annual meeting of the British Medical Association, Sir William Withey Gull (1816-1890), an eminent London physician, made reference to some cases of emaciation occurring without evident organic cause in young women. Gull (1868) termed this 'apepsia hysterica' (p.175), digestive problems of hysterical origin. By 1873, Gull was convinced that anorexia, meaning lack of appetite, was a more correct term than 'apepsia', since "what food is taken, except in the extreme stage of the disease, is well digested" (Gull, 1873, p.534).

Gull's primary contribution was his conception of anorexia nervosa as a coherent disease entity distinct from starvation among the insane, and unrelated to organic diseases such as tuberculosis, diabetes, or cancer (Brumberg, 1988). Furthermore, his disease had a very specific clientele; young women between the ages of 16 and 23. The anorexia nervosa diagnosis (Gull, 1873) also served to distinguish the female food-refuser from the mentally ill who would not eat. Sitophobia, as proposed by Chipley (1859) was a broad and imprecise subcategory of insanity, in which adolescent girls were only one sub-group. By contrast, anorexia nervosa, as proposed by Gull (1873) was a discreet diagnosis associated with a specific age group. This was an important etiological consideration, namely, that the lack of appetite was nervous (nervosa) in origin.

Simultaneously, and independently of William Gull, the French neurologist, Ernest Laseque (1873) introduced '*l'anorexie hysterique*' to the medical establishment. It was Laseque, not Gull, who first provided a glimpse of the pressurized family environment in anorexia nervosa. Unlike Gull, who aimed at isolating a new disease and concentrated on strictly medical aspects of differential diagnosis, Laseque provided some *entrée* into the interpersonal relationships of middle-class families and their daughters, in anticipation of what is today called family systems theory.

Laseque (1873) wrote:

"It must not cause surprise to find me thus always placing in parallel the morbid (diseased) condition of the hysterical subject and the preoccupations of those who surround her. These two circumstances are intimately connected, and we should acquire an erroneous idea of the disease by confining ourselves to an examination of the patient"
(p.265).

A deep sensitivity to food and its meanings also underlay Laseque's astute clinical portrait of the anorectic and her family. Laseque was, after all, a member of the French bourgeois, a class notable for its commitment to the importance of cuisine and eating. For the French, cuisine had great import: the unexplained rejection of attractive foods was a decidedly strange and provocative art (Brumberg, 1988). Laseque (1873) marvelled: "I have seen an anorectic chewing morsels of rhubarb whom no consideration would have induced to taste a cutlet" (p.368).

According to Laseque (1873), *l'anorexie hysterique* typically began between the ages of 15 and 20 as a result of "some real or imaginary proposal, as a violence done to

some sympathy or to some more or less conscient desire" (p.265). Laseque was relating the onset of anorexia nervosa to developmental frustrations linked with the transition to adulthood; inappropriate romantic expectations, blocked social or educational opportunities, struggles with parents. The natural course of the disease was never less than 18 to 24 months, evolving in three distinct stages, each with a unique set of emotional and medical developments.

The abovementioned clinical descriptions of Gull and Laseque differed enormously in emphasis. Gull differed with Laseque over the use of the term 'hysterical', a label that technically implied a gender specific condition. Gull rejected the designation 'hysterical anorexia' because of its derivation from the Greek hysteris, meaning uterus. Laseque (1873) treated *l'anorexia* as a 'hysteria of the gastric center'. Gull preferred 'nervosa', because it implicated the central nervous system instead of the uterus. Gull (1873) argued that "the subjects of this affection are mostly of the female sex, and chiefly between the ages of 16 and 23, but I have occasionally seen it in males at the same age" (p.14). Following Brumberg (1988), however, Gull never said anything more about male anorectics, nor did any other 19th-Century writer on the subject. Gull further suggested that the anorexic girl had no appetite for food, and Laseque argued that a positive aversion to food existed. Contemporary consensus (Macswain, 1993) is that anorexia - meaning lack of appetite - is a misnomer, as the anorexic woman does still experience hunger, and her appetite remains normal.

By the turn of the century, the initial articles by Gull and Laseque became the accepted and unquestioned views of anorexia. The central features of anorexia for Gull and

Laseque, as is for contemporary psychiatry, are: emaciation occurring without organic causation; a specific distribution by age and by gender (although the class distribution was not confirmed by Gull and Laseque); the denial by the patient that she was ill, and the corresponding recognition of a degree of conscious choice in anorexia; a view of anorexia as a non-organic disorder.

This view remained dominant until 1914 when Simmonds (1914) described a case of death from starvation in which the pituitary was found to be damaged. This resulted in the diagnosing of the still infrequent cases of anorexia as 'Simmonds Disease' and the term anorexia and the acceptance of psychological causation all but disappeared. It was not until the late 1930's that the distinction between Simmonds Disease (starvation due to pituitary malfunctioning) and anorexia (starvation deliberately chosen) was redrawn (Palazolli, 1974). In 1936, Ryle, in opposition to the theory of pituitary cachexia, formulated a traumatogenic concept, preparing the way for a psychosomatic viewpoint which later supported the thesis that anorexia represented a rejection of the wish to be pregnant and put forth a psychophysiological mechanism underlying functional amenorrhoea. The controversy finally ended with the publication of a study by Sheehan and Summers in 1944, demonstrating that pituitary gland atrophy and hypothalamic symptoms were not causally related (Morgan, 1977).

In the 1940's, additional psychoanalytic formulations of anorexia appeared in the literature (Walter *et al*, 1940; Berlin *et al*, 1951; Falstein *et al*, 1956; Selvini, 1963; Thoma, 1967; Bruch, 1970; Gladston, 1974). However, up until the 1960's, anorexia was still viewed as a relatively rare condition, and it is really in the last 30 years that the

vast increase in interest in and work on anorexia has occurred (Macswen, 1993). Bruch (1978) refers to anorexia as a 'new' disease because of what, she argues, is a rapidly increasing incidence since 1960, an incidence which she relates to "media pressure on young women to slim" (p.7). Macswen (1993) also treats anorexia as a '20th Century' phenomenon, but for somewhat more complex reasons. Macswen (1993) argues that anorexia originates in the late 19th-Century with the first 'modern' wave of female aspiration to patriarchal individualism, and intensifying only in the post-war period, widening its social base to the extent that the contradictory pressures of femininity and success are felt by the majority of young middle-class girls.

The current psychiatric view is that anorexia has always existed, but has only recently been discovered due to increased medical knowledge and increased prevalence (Crisp, 1974; Slade, 1984; Wellbourne and Purgold, 1984; Macswen, 1993). Part of the proliferation of research into anorexia has been an attempt to establish the existence of cases before 1873 by 're-diagnosing' cases of voluntary starvation in young women as anorexia (Morton, 1694; Bell, 1985).

Macswen (1993) argues that such research and the assumptions that back it up are problematic because of ahistorical assumptions and blurring of distinctions between action and meaning. In these arguments, Macswen (1993) asserts that:

"Human behaviour and personality are assumed to be more or less constant over time, the atomized individualism of bourgeois society being naturalized as eternally existing 'human nature', and seen as inherent, rather than created in social relations" (p.17).

Further, according to Macsween (1993), it is assumed that "all non-organically based starvation, especially if voluntarily undertaken, is anorexia" (p.18). Macsween (1993) argues that the meanings entailed in the control of food and body can and do change, both historically and gender-specifically. To develop and ground Macsween's abovementioned argument, a brief overview of medieval fasting and control of appetite will be presented.

2.1.1 From Medieval Europe (1200-1500) to the modern anorexic (1900's)

In Medieval Europe, particularly in the years between 1200 and 1500, food refusal occurred, and prolonged fasting was considered a female miracle. The chronicles and biographies of this period document numerous accounts of women saints who ate almost nothing or claimed to be incapable of eating normal everyday meals. The best-known of the saints, Catherine of Siena (1347-1380), ate only a handful of herbs each day and occasionally shoved twigs down her throat to bring up any other food she was forced to eat (Brumberg, 1988). Figures such as Mary of Oignes and Beatrice of Nazareth (13th Century) vomited from the mere smell of meat, and their throats swelled shut in the presence of food. Other women saints covered their faces at the sight of food, refused to partake of family meals, and some, such as Columba of Rieti (15th Century) actually died of self-starvation. In the 17th Century, Saint Veronica ate nothing at all for three days at a time but on Fridays permitted herself to chew on five orange seeds, in memory of the five wounds of Jesus (Brumberg, 1988).

By the 17th and 18th Centuries, fasting was on the decline as a result of the break-up of medieval culture, the Protestant Reformation, and the scrupulous efforts of religious reformers to disavow traditional practices such as the worship of saints (Brumberg, 1988). During the Reformation, prolonged abstinence was regarded as the work of Satan (rather than God), and female fasters were frequently regarded as victims of evil delusion or possession. By the 18th Century, abstinence became a medical problem. In the post-medieval world, ascetic practices were discouraged, and acts of autonomous female piety, such as prolonged fasting or extraordinary food miracles, were to be resolved by a set of empirical, predictable validation techniques: "around-the-clock watches, calculations of food intake, observation and measurement of excrement, and weighing of the body" (Brumberg, 1988, p.55). The renunciation of food, once experienced and understood as a form of female holiness, was increasingly cast as demonical, heretical, and even explained as insane. In the apt words of Brumberg (1988), there was a shift from "sainthood to patienthood" (p.46).

As Macsween (1993) has noted, there are some medical writers and historians (Paterson, 1982; Lacey, 1978; Demos, 1969; Hajal, 1982; Lewis, 1966; Haberman, 1986; Silverman, 1983; Bell, 1985; Morton, 1694), who claim that anorexia mirabilia (miraculously inspired loss of appetite) and anorexia nervosa, are one and the same. In the words of Brumberg (1988): "they would have us believe that Karen Carpenter and Catherine of Siena suffered from the same disease" (p.47).

Advocates of this view adopt the 19th and early 20th-Century biomedical and psychological models of anorexia as if there was absolute certainty regarding the

etiology of the disease, and as if there were complete, verifiable case histories available on historic subjects. In actuality, documentary evidence of the congruence of anorexia mirabilia and anorexia nervosa is exceedingly weak and usually rests on interpretative acts of faith or inconclusive medical evidence (Brumberg, 1988). The sequelae of symptoms, such as the fact that the individual lost her appetite, did not eat, or stopped menstruating, need not necessarily point to anorexia nervosa. Furthermore, given that after chronic starvation the medieval ascetic and modern anorectic have similar biomedical experiences, i.e. they are both actually unable to eat, the pathways to these end points are abundantly quite different.

According to Bell (1985), however, Catherine of Siena, Margaret of Cortuna, and other holy women, were engaged in 'anorexia behaviour patterns' that closely resemble the modern disorder, anorexia nervosa. Bell (1985) claims that there is a psychological (rather than a biomedical) continuity across the centuries; anorexia mirabilia and anorexia nervosa, he writes, are "psychologically analogous states in medieval and modern women" (Bell, 1985, p.20). The psychology of women is thus assumed to be fixed in time, and past and present are the same.

The alternative interpretation of medieval women provided by medievalist Bynum (1985) suggest that Bell's approach focuses attention on only one small aspect of medieval women's behaviour, and, in so doing, reduces the totality of their experience. Catherine of Siena, Bynum argues, did more than just fast; her life was filled with a program of austerities that included self-flagellation, scalding, and sleeping on a bed of thorny substances. "It is only modern historians", writes Bynum (1985), "who have

given food-rejection its startling and privileged place in medieval women's piety" (p.12). Following Macsween (1993): "The narrow concentration on Catherine's eating habits, demonstrates Bell's desire to force her asceticism to fit anorexia symptomatology" (p.21). Many medieval women spoke of "their hunger for G-d and fasted in order to feast at the delicious banquet of G-d" (Brumberg, 1988, p.45). Food practices and religious symbols were consciously interconnected.

In sum, medieval women's legendary asceticism, the pattern of renunciation and austerity, is not the whole story (Brumberg, 1988). In the medieval world, Bynum (1985) has astutely shown that women were preoccupied with eating and non-eating, because food practices provided a basic way to express religious ideals of suffering and service to their fellow humans. Medieval culture therefore promoted a specific form of appetite control in women, anorexia mirabilia, which symbolized the collective values of that age. Anorexia nervosa, however, "expresses the individualism of our time" (Brumberg, 1988, p.96).

Thus, from a historical perspective:

"We need to know not just what was done, but what is meant; the same act does not always have the same significance and to interpret the events of the past through the categories of the present is to make the error of historical anachronism"
(Cameron and Frazer, 1987, p.21).

The existence of a female tradition of anorexia mirabilia does have implications for an understanding of anorexia nervosa. However, it is obvious that sociocultural contexts, at differing points in time, encourage control of appetite in women, for reasons and

purposes that are very different. In the history of Western Civilization, argues Brumberg (1988), there have:

"been at least two periods in which non-eating and control of appetite have been notable aspects of female experience; in Catholicism in the 13th to 16th Centuries, and now in the post-industrial age. In the earlier era, control was linked to piety and belief; through fasting, the medieval ascetic strove for perfection in the eyes of her G-d. In the modern period, female control of appetite is embedded in patterns of class, gender, and family relations established in the 19th Century; the modern anorectic strives for perfection in terms of society's ideal of physical rather than spiritual beauty".
(p.46).

Brumberg (1988) thus argues that although Catherine of Siena and Karen Carpenter do have something in common, the use of food as symbolic language, it is inappropriate to call the former an anorectic as it is to cast the latter as a saint. To describe pre-modern women such as Catherine as anorexia is to flatten differences in female experience across time, and discredit the special eucharistic fervour and penitential asceticism as it was lived and perceived. Insisting that medieval holy women had anorexia nervosa, is "reductionistic argument in that it converts a complex human behaviour into a simple biomedical mechanism. To conflate the two is to ignore the cultural context and distinction between sainthood and patienthood" (Brumberg, 1988, p.46).

In conclusion, it can be said that the modern anorectic is part of a tradition of females who have used food and the body as a focus of their symbolic language. While there are important biomedical continuities in female fasting behaviour, anorexia nervosa is very different from anorexia mirabilia. Thus, what appears to be significant about a

anorexia nervosa is that it is impossible to detach it from social aetiology and social symbolism.

2.2 THE NATURALIZATION OF THE ANOREXIC BODY

Following Bigwood (1991), the naturalization of the anorexic body refers to those explanations "whereby 'gender' is understood to rest on the firm foundation of the 'natural' body, whereby natural means ahistorical, cross-cultural and thereby fixed" (p.59).

In the 20th Century, the treatment of the anorexic body changed to incorporate new medical theories and developments. Because 19th Century medicine had not resolved the problem of etiology, the 20th Century was characterized by a multiplicity of explanatory paradigms and treatment strategies. According to Brumberg (1988), this reflected new developments within both medical and psychiatric practice. However, in agreement with Crisp (1980), it will be argued that such overconcern with categorization and explanation of the anorectic body also reflected the contemporary scientific inability to recognise its complicity in this construction.

The dominant existing approaches to the aetiology of the anorexic body are underpinned by biomedical, psychological and cultural theoretical models. Biomedical studies revolve around the investigation of somatic elements in search of underlying physiological explanations of organic causes. Psychological conceptualizations of the anorexic body are formulated within psychoanalytic, behavioural, family interfactual,

and social perspectives. Within the psychoanalytic framework (Freud, 1905; Walter, Kaufman and Deutsch, 1940; Thomae, 1963; Deutsch, 1981; Hughes, 1985; Sayers, 1986), food-refusal is symbolic of latent anxieties in the individual psyche. Behavioural psychologists (Bandura, 1969; Beck, 1976; Lambley, 1983) factorise eating into responses that are learned, reinforced, may be unlearned or cured through reward and punishment. Family interactional analyses (Laing and Esterson, 1984; Palazzoli, 1974; Minuchin, 1978) concentrate on the anorexic body as a symptom of malfunctioning family systems. Cultural models such as the feminist (Orbach, 1978; Chernin, 1983; Lawrence, 1984), socio-political and anthropological viewpoints (de Beauvoir, 1972; Mitchell, 1974; Cixous, 1976; Irigaray, 1985) attempt to comprehend how socio-cultural constructions of food and the body are made meaningful in the anorexic body.

A brief overview of these explanatory models, along with a critical analysis of their basic assumptions and practices, will highlight the ways in which the contemporary explanatory models lack a comprehensive theory of the phenomenology of the body, especially important in the case of anorexia, where the symptomatology is expressed and experienced at the level of the body.

The importance of the present research and its absence in contemporary explanations of anorexia will be highlighted.

2.2.1 The Anorexic Body and the Biomedical Gaze

In addition to severe weight loss and amenorrhea, anorexia nervosa presents other biophysical signs and symptoms. These include haematological abnormalities, renal complications, gastrointestinal problems, metabolic and cardiopulmonary complications, dental problems, electrolyte disturbances, neurological complications, primary central nervous system dysfunction, endocrine and thyroid abnormalities (Mitchell, 1985).

Researchers taking a biological approach to anorexia follow in the tradition that Gull established in locating physiological 'causes' of this disorder. Whilst attention to the biological aspects of anorexia is warranted, as there are many serious medical risks and complications, the main issue that biomedicine must address is not whether there are medical and biophysical components to anorexia, but rather whether the hypothalamic dysfunctions and abnormalities noted for anorectics are causes of anorexia or the consequences of starvation, serious nutritional deprivation, and weight loss (Banks, 1992).

Further important issues that biomedicine does not address are the prevalence of anorexia predominantly amongst females, in the middle to upper classes, in Western societies (Crisp, 1980). Biomedicine attempts to discern the physiological etiology and treatment of the disease entity, and in this focus is unable to cater for the broader non-physiological, albeit important factors, surrounding anorexia. Biomedicine is able to achieve a sense of explanation of the physiological body, but falls short with the anorexic body which is a syndrome having physiological consequences, but is grounded in a broader psycho-socio-cultural milieu, requiring then a broader understanding of

embodiment to reveal the etiology and attempts at treatment. This is the aim of Merleau-Ponty's theory and present research.

2.2.2 The Anorexic Body and the Freudian Father

Freud at first held anorexia to be the product of real trauma associated with food, eating (Freud, 1895) and childhood sexual abuse (Freud, 1896, 1898). Later, he regarded hysteria, including anorexia, as an effect of fantasies of childhood seduction. An example was 18-year old Dora whose disgust at food Freud (1905) he traced to regression from adolescent sexuality to forbidden infantile wishes for oral sex with her father (Sayers, 1986).

Treatment, according to Freud, required making conscious the unconscious effects of childhood seduction, whether real or imagined. But he also warned against treating severe anorexia psychoanalytically, urging that its life-threatening effects call for immediate physical rather than psychoanalytic treatment (Freud, 1905). His subsequent development of the theory and practice of psychoanalysis accordingly includes virtually no mention of anorexia, apart from a brief re-emphasis of the view implied in his account of Dora, namely that anorexia "expresses aversion to sexuality associated with the oral phase of sexual life" (Freud, 1918, p.106).

Freud's theory that anorexia expresses fantasy of oral sex was subsequently developed by Walter, Kaufman and Deutsch (1949). They argued that anorexia stems from parents' disapproval of their adolescent daughter's sexuality, resulting in her defensively

regressing to infantile orality. As evidence, they cited the cases of two 19-year old girls whose anorexia was preceded by compulsive eating which they associated with becoming pregnant. They then foreswore food - the first girl because her father disapproved of her boyfriend; the second because of the similarity of her boyfriend to her father. In the name of the father, both girls refused sex and food, now equated with each other on account of their regression from adolescent to infantile sexuality.

Another case, Ellen West, was also interpreted in these terms. Her anorexia seemingly originated in breaking off her engagement to a 'romantic foreigner' at her father's request, instead marrying a cousin of whom her father more approved (Binswanger, 1958, p.241). Her anorexia was analysed as involving the unconscious equation of eating with being fertilized, of getting fat with becoming pregnant (Binswanger, 1958, p.260).

Deutsch (1981) followed this approach. She described the case of a 22-year old who, rejected by her stepmother, turned to her father, symbolically expressing through compulsive eating her desire for impregnation by him. Deutsch argued that her subsequent anorexic self-starvation stemmed from fear that she would actually become pregnant, and thereby be an imitation of her hated stepmother. Deutsch maintained that her anorexia expressed repudiation of this possibility and of the incestuous desire for her father, seemingly realized, albeit unconsciously, through eating.

Deutsch's paper marked a shift from attributing anorexia to fantasies involving the father to those involving the mother. This change is further realised in Thomae's (1963)

account. Like other analysts, he argues that anorexia is a defensive regression from adolescent genitality to infantile orality. The focus, however, is on the ambivalence experienced with the mother. By starving herself, he says, the anorexic becomes as physically dependent as a baby on the mother. Refusal of food, however, also expresses rejection and independence of the mother's feeding role. Therapy, argued Thomaes, involved making conscious this ambivalence as transferred onto the analyst, unconsciously equated with the other. Thomaes does, however, acknowledge the perils of this task, given the counter-transference reactions evoked in the therapist, including anxiety at the anorexic's physical dependence and hostile control evoked by their negativism. Thomaes recognizes the necessity of hospitalization to allay these untoward counter-transference reactions. This viewpoint that anorexia expresses infantile ambivalence towards the mother is reiterated today, mainly by Klein's followers.

2.2.3 The Anorexic Body and the Kleinian mother

Expanding on Freud, Klein believed that the infant is driven by instincts toward both love and hate of the mother. The infant's ego is, however, so fragile and precarious, it fears annihilation by its own hatred. This feeling is therefore expelled out of itself into the mother. The mother is now experienced as hating and persecuting the baby. Re-internalized, she is experienced as persecuting.

Hughes *et al* (1985) argue that adolescence can exacerbate the fantasy of the other as an internal persecuting object. This is especially the case in females, insofar as they experience the female bodily changes of puberty as making them progressively similar

to mother. Anorexia, they maintain, is an attempt to fend off this experience. Treatment therefore involves interpreting the anorexic's fantasy of identity with the mother as transferred onto the therapist. The intention here is to enable the anorexic to achieve a more realistic distinction between herself and mother, and between internal and external reality generally.

Boris (1984) suggests that anorexia stems from the greed and longing triggered by differentiation from parents in adolescence. It is suggested that the anorexic defends against these feelings by excluding them from awareness through narrowing attention to food and body weight. Illustrating this point, Dunbar (1987) presents the case of Catherine who blocked out the pain of feeling and thinking about her mother's leaving home by instead obsessively dwelling on the minutiae of her weight and diet. Boris (1984) adds that anorexia also involves defence against longing and greed evoked by separation through projection and evocation of these feelings in others where they can then be attacked rather than painfully endured and worked through. The anorexic's refusal to eat, he maintains, is an attempt to awaken in the parents the longing that she eat. Similarly, Boris writes, the anorexic seeks to excite the envy of others. This is done through superlative academic and athletic achievement, and through superlative accommodation to society's ideal of slenderness for women.

For Gremillion (1992), psychoanalytic commentary on the anorectic's difficulty in establishing the therapist as an appropriate and safe parent-substitute with whom conflict can be worked through. The anorectic's tenacious self-control is interpreted as an unco-operative, stubborn and hostile denial of her need for others, i.e. psychiatric

authority. In addition, "the negative attitude of the anorectic is said to manipulate the therapist into a counter-transference reaction, a carefully coded, inappropriate exercise of therapeutic control" (Gremillion, 1992, p.62).

The power structure of psychoanalytic and Kleinian theories is thus apparent in the location of illness as strictly within the anorectic, so much so that even the negative character of the therapeutic relationship is interpreted as symptomatic of the anorectic disturbance. With the patient verbalizing her psychic monologue and the analyst decoding its significance, illness is grounded as deeply internal and separate from dialogical or interpersonal encounter (Focault, 1965). Gremillion (1992) concludes that these features of psychoanalytic and Kleinian theory "reproduces anorexia as the individualistic, self-flagellating struggle of a powerless and inadequate person in need of control" (p.62).

Psychoanalytic and Kleinian explanations and treatments provide important insights into the subjective experience of anorexia. Lacking an appropriate theory of the body that articulates the subjective and intersubjective intertwinement of embodied existence, the psychoanalytic and Kleinian account reveal a subtle, continued displacement of social and cultural norms to the individual anorectic psyche, unable then to articulate the linkages between the subjective, intersubjective and cultural influences in this disorder.

2.2.4 The Anorexic Body and the *Puer Aeternus*

Based on Jungian theory, Caskey (1986) interprets anorexia nervosa as a result of a peculiar combination of forces, designated as psychic incest. Contrary to the Freudian notion that incest suggests a direct sexual relationship, Caskey introduces the Jungian concept of the *animus* as the contrasexual inner element of a woman which may be projected out. This makes it possible for incest to involve a highly invested relationship with this masculine figure, which in Jungian terms is the carrier of the woman's *Logos*, which is both an inner figure and is projected onto the father.

That anorexics are caught in a relationship to the *animus* as it is projected onto the father, is suggested both by the special quality of the bond between anorexics and their fathers, and by the emphasis on academic achievement. Minuchin (1978) describes that in triangulated families, the girl is most often allied against her mother. Bruch (1978) and Dally and Gomez (1980) suggest the relationship with the father seems to involve a special emphasis on academic achievement and the life of the mind. Woodman (1980) goes further and argues that such relationships involve a highly specific form of the *animus*, the *puer aeternus*. In Woodman's view, anorexia involves a rejection of the other and mother's body in favour of a delusional relationship with the pure male adolescent spirit who has all the spiritual attributes of divine masculine youth.

Looking at incest from this perspective, Caskey argues that the concept of incest can be extended from a physically expressed relationship to one of eroticized spiritual union with the *puer*. But while this spiritual union provides the feeling of purity that anorexics

find so enticing, it has serious consequences for the anorexic's social and intellectual growth, as well as for her sexual development.

This occurs because the *puer*, the incarnation of intellectual and spiritual purity and high aspirations, is balanced by its opposite, the *senex*, the negative old man. Typical of Jungian theory, too great an emphasis on one pole inevitably constellates the opposite. Thus, the anorexic in her search to find unity with the *puer* and holy *puer* finds herself caught between *puer* and *senex*. In order to remain pure and youthful enough to meet the standards of the *puer*, the anorexic must purify her body to the point where sexual development stops or is reversed. Simultaneously, she must withdraw from the outer world in order to avoid its contamination. This tendency to withdraw is reinforced by the devastating inner criticism of the *senex*, whose standards of "badness" are as exaggerated and absolute as are the standards of the *puer* for "goodness" (Caskey, 1986).

According to Woodman (1980), the fathers of anorexics are most often *puers* who seek continued contact with the unconscious via idealized relationships with their daughters on whom they project their feminine *anima* figure. Such men turn to their daughters in preference to their wives, whose maternal qualities they reject. Since the *senex* remains unintegrated in the father, the daughter remains susceptible to the negative pull of this pole of the *animus*.

Regarding the mother, Woodman suggests that she herself often has an over-developed relationship to the *animus* and a lack of relatedness to her own body and the

bodies of those in her care. Following Caskey (1986), such mothering results in the imposition of rigid rules in areas in which rules are inappropriate or impossible to obey (i.e. body functions). Bruch (1971) in fact remarks that such maternal care has an 'inappropriate quality', leaving a vacuum where the delusional spiritualized relationship with the father can develop without mediation via rootedness in the female body.

For Caskey, women who are locked into this relationship achieve illusory spiritual and intellectual perfection at the expense of relatedness to their female bodies. The anorexic's rejection of fat is a rejection of the sexually mature feminine as represented by the maternal image. It is unity with the father against the mother and all the mother represents. To reach true feminine maturing for such a woman involves, according to Woodman (1980), "*an opus contra naturam*, a conscious working through of aspects of the feminine that cultural and family factors have prohibited from instinctual expression" (p.120).

By interpreting anorexia as a result of a peculiar kind of incest, namely incest which involves a psychic relationship rather than a physical one, Caskey (1986) deepens the Freudian interpretation as primarily a sexual phenomenon, specifically an oral impregnation phobia. Caskey furthermore makes apparent the paradoxical nature of anorexia; "For if anorexia results from a physically incestuous relationship with the father, it is simultaneously an expression of that relationship via its shift into the magical spiritual world of the *puer*, and a defence against it, an attempt to escape domination" (p.186). Thus, if impregnation is feared, Caskey argues that what anorexics fear most is impregnation by the father, thereby making imprisonment by him complete. The

sexual instincts are therefore kept in abeyance as a way to avoid realizing the incest and making it pervasive.

Looking at anorexia nervosa as a communication, as a gesture intended for effect, Caskey (1986) then asks of its intended audience: "Who is to hear what is being said? Who is to respond to this gesture of mingled defiance and obedience, of captivity and escape, of independence and helplessness?" (p.188).

The empirical answer is that anorexia is of far greater interest to women than it is to men. Many women respond to anorexia with envy; some feel its romantic fascination, its overtones of consumption and the love of death (Chernin, 1983). Others look on anorexia with horror and pity. Nevertheless, the responses of women to anorexia have an intensity absent from the responses of men (Caskey, 1986). This for Caskey is the anorexic's main function. If the disease results from an incestuous entanglement with the father, it can also be seen as a cry to the mother for help.

Maternal attention is sought, partly with the aim of resolving father/daughter incest. Should the mother return to the triangle and take up her rightful place with the father, then the daughter is relieved of the guilt of this association. Furthermore, she is now free to develop independently of her family and to become sexually mature for the first time. Caskey (1986) argues that Minuchin's strengthening of the spouse subsystem is precisely forcing the parents to resume sexual partnership, and free the daughter from her role as father's lover. Simultaneously with this manoeuvre is a quest for continuity

of identity between mother and daughter. For Caskey, this is what Minuchin achieves by strengthening the mother as model of competence for the daughter.

The illusion of perfection is the greatest lure offered by the *puer*, but this becomes fatally attractive only when desire for "goodness" seems incompatible with having a female body. Anorexia then, for Caskey, calls attention to the plight of its sufferer in a way that is intended to bring resolution to the problem: "In its misguided and paradoxical way, anorexia is a search for autonomy, independence, and spiritual growth" (p.189).

In a similar fashion to the psychoanalytic tradition, Jungian theory elaborates on the intrapsychic dynamics of the anorexic, in a rich and insightful manner, but takes the embodiment of such dynamics for granted, and thereby does not explain the incarnation and contextual nature of this 'psyche'. Lacking a phenomenology of the body that articulates the manner in which the body is both the bearer of self-consciousness and simultaneously open to an intersubjective world, the Jungian view of anorexia presents an individualistic disembodied psyche that is decontextualised from others and cultural influences.

Merleau-Ponty's critique of psychology is aimed at this disembodied psyche, and his alternative is aimed at a theory of the body that incarnates psyche, as part of a natural and cultural existence. An understanding of the anorexic requires such a theory of psyche if the syndrome is to be understood in its multidetermined presentation and in order to resolve tensions around the treatment options.

2.2.5 The Anorexic Body and Behavioural Reprogramming

Behaviourist approaches to anorexia became popular in the 1960's, partly in response to the inefficacy of psychoanalytic approaches (Modolfsky and Garfinkel, 1974). Bruch (1982) writes that many anorectics who experienced psychoanalytic therapies "withdrew even more from participation in life" (p.153). The lengthy process of these treatments was, for the behaviourists, one of the key reasons for this failure. The search for a rapidly effective treatment program was initiated, supported by the belief that the longer the illness is allowed to persist, the poorer the prognosis (Gremillion, 1992).

Most behaviour therapy for anorexics is conducted in hospitals, either in wards or on an outpatient basis (Lambley, 1983). One approach in particular has gained favour among many practitioners, and that is the selective reward system whereby the patient is encouraged to eat, in order to put on weight, by the use of certain deprivations or rewards. The anorexic is locked in a ward and denied the privileges of television, visitors and books, for example, unless the anorexic eats. This is a very effective method in assisting the anorexic to put on weight in hospital.

However, one needs to be aware of the massive drawbacks of this approach. Anorectics conform to get out of hospital, and it may become the very impetus an anorexic needs to push her into bulimarexia (Lambley, 1983). Finally, it often involves marked hostility and personality conflict between patient and staff, which together with the shock of hospitalization and discipline of the regime, distress the patient (Lambley,

1983, p.117). The point, however, is that where all else fails and there is risk to life, clearly such techniques have to be used for a short time.

Cognitive behaviour therapy has been employed to monitor, maintain and address weight gain. Cognitive-behavioural theories do not focus on internal psychic explanations, but concentrate on the disordered behaviour itself in an attempt to alter it (Bandura, 1969). Cognitive behavioural theory is based on the conception that an individual's problems are derived largely from distortions of reality, stemming from erroneous beliefs. These incorrect beliefs are seen as having originated in defective learning during the person's cognitive development (Beck, 1976).

In changing cognitive patterns maintained by the anorexic, she must be enabled to become aware of the consequences that 'maladaptive ideation' has on her life. She would need to be vigilant initially in learning to substitute rational thinking for her previous irrational and destructive cognitive pattern. However, over time, it is hoped that adaptive cognition would arise quite naturally. The cognitive theorist focuses techniques on the modification of ideational content involved in the symptom (namely, irrational interferences), whilst the behaviour theorist concentrates on overt behaviour such as maladaptive avoidance response. With increased emphasis on the cognitive component in the management of anorexia, the development of self-control in the individual assumes greater importance in the treatment process, resulting in more effective long-term results.

In treating the anorexic by means of reinforcement programmes based on various reward and punishment schedules, behaviourist theory adopts the premise that the anorexic is a natural object whose maladaptive behaviour patterns could be changed to adaptive ones. Ignored in this stance is the intentionality and self-consciousness of human nature (Lambley, 1983). Cognitive behavioural therapy developed, to correct this vision of the human as only a natural object, by recognising the human as a natural object that embodies self-consciousness.

This shift in the history of behavioural theory and treatment indicates the tensions within behavioural discourses revolving around the nature of self-consciousness and the self-consciousness of nature, a tension that is indicative of a lack of an appropriate phenomenology of the body that simultaneously caters for the embodiment of self-consciousness and the self-consciousness of embodiment, a discourse that Merleau-Ponty's (1962) lived body can provide and that the present research aims to achieve.

2.2.6 The Anorexic Body and the Depriving Mother

Palazolli (1974) argues that the child's original experience with the primary object (mother or food equalling mother) is a "corporeal incorporative" experience (p.79). Unable to distinguish self from object, the infant relates through incorporation of both positive (pleasurable, nurturing) and negative (unpleasant, rejecting) aspects, until the perception of being a whole separate body which is not the source of negative sensation, is successfully achieved. Development is psychopathological, when separation is only partially successful. Here, many of the negative feelings experienced

during the incorporative primary narcissistic phase remain immured within. It is therefore the body itself that the anorexic fears: "the body of the anorexic does not merely contain the bad object but is the bad object" (Palazolli, 1974, p.87). The body is thus equated with the negative and overpowering aspects of the incorporated object.

Puberty becomes the crucial moment for the anorexic, in that it is at this time that an independent identity must be shaped. The anorexic, however, because of early faulty learning that rendered her compliant and dependent, finds herself unable to meet this challenge. The ensuing trauma, says Palazolli (1974) "reactivates the overwhelming sense of helplessness experienced during the infantile period" (p.89). Borrowing from Arieti (1947), Palazolli points out that "whatever cannot be borne abstractly because it generates too much anxiety will eventually be concretized" (p.148). Thus, at puberty, the fears and threats that the anorexic experiences, becomes concretized into the newly-developing adult female body as a phobic object. The female body that will develop into womanhood is feared.

The second process of anorexia then, is the transformation of the early psychic incorporation of the object into a physically concrete incorporation; "because of the development of the breasts and other feminine curves, the body is experienced concretely as the maternal object. The patient considers and experiences her body as one great incorporated object which overpowers her, and forces a passive role upon her" (Palazolli, 1974, p.90).

The pre-adolescent sense of the bad object as invincible is also transformed at puberty. Now that the bad object is concretely equated by the anorexic with her body, it is now amenable to the active aggression of starvation. However, because the body, like the bad object, is fascinating as well as overpowering, it cannot be simply abandoned but must be kept under control and its growth prevented.

Finally, during adolescence, the third process of "passive receptive aspect of feminine life" is first experienced (Palazolli, 1974, p.70). Not only is the physical aspect of puberty experienced as a "sudden, mysterious, and humiliating bodily happening over which the poor girl has no control, but the adult female body must be accepted as an essentially receptive passive object" (Palazolli, 1974, p.70). Palazolli (1974) argues:

"The adolescent girl experiences her feminine sexuality in a passive and receptive way. She is exposed to lewd looks, subjected to menstruation, about to be penetrated in sexual embraces, to be invaded by the foetus, to be suckled by a child".

The new woman's body thus comes to signify concretely this passivity and receptiveness. It is controlled (or rejected) not only as the concrete manifestation of the negative and overpowering aspects of the maternal object, but also as the concrete manifestation of receptiveness (passivity). The anorexic girl thus experiences stasis since she is forced to contain and control the body without destroying it, i.e. she must continue to live but cannot grow.

Like Palazzoli, Bruch (1973) attributes anorexia to real rather than fantasized deprivation. For Bruch, the anorexic symptoms of delusional body image, disturbed perception of bodily need, and a paralyzing sense of ineffectiveness is a product of real

failure of the mother to respond to her daughter's needs in infancy. The mother, in Bruch's understanding, in effect abused and seduced the daughter into compliance with her needs, her daughter accordingly becoming obsessed with sensing out what others want, thereby losing sight of what she wants. The resulting lack of sense of self, writes Bruch, is aggravated by adolescence with its demands on the individual to develop an identity separate from the parents.

Anorexia, says Bruch (1978), tends to belong to highly successful families. They feel hemmed in by a 'golden cage' of felt parental expectation, that they perform, feeling not loved for themselves but only for their achievement (Bruch, 1978, p.13). Adolescence exacerbates this feeling both because it pressurizes the individual into independent achievement and the anorexic's achievement-oriented response is to be "as good as a man", to be "super-special by being super-thin" (Bruch, 1977, p.56).

Arguing that anorexia stems from parents imposing their own needs on to their children, Bruch opposes the use of psychoanalytic interpretation lest it be experienced also as an attempt to interpose the therapist's experience in place of that of the anorexic. Instead, Bruch recommends therapists to authenticate rather than interpret the anorexic's needs so as to correct the parent's seeming failure in this respect. In this manner, Bruch argues, the anorexic's authentic self emerges from the hollowness of its glittering inauthentic and false self.

Bruch (1982) draws a parallel between her theory and the self-psychology of American psychoanalyst, Heinz Kohut. Kohut (1971) argues that development of a secure,

genuine sense of self depends on parents acting as 'self-objects', reflecting and mirroring back to the child its initial grandiose sense of self, and its corresponding idealization of the parents. Only then can it progress from an initially unrealistic and precarious, idealized sense of self, and towards a more realistic and secure narcissism.

Bruch argues that the anorexic's parents fail her in this respect. Instead of being the self-objects she needs, they look to her to be a self-object to their narcissism (Bemporad and Ratey, 1985). There occurs a reversal of roles and needs. Applying this perspective to the treatment of anorexia, Goodsitt (1985), in agreement with Bruch, argues that the therapist should act as the self-object the parents seemingly failed to be, that this includes sometimes acting as the patient's alter ego in, for instance, supervising and managing her eating.

Lerner (1988) likewise advocates this approach, but adopts the work of British psychoanalyst, D.W. Winnicott. Winnicott (1958) also argues that integrated self-development depends on the mother recognizing, reflecting, and meeting the infant's needs rather than frustrating them by interposing her own needs such that, in order to survive, the infant then has to comply with her needs, thereby developing a compliant, 'false self' facade. Lerner (1986, p.41) attributes anorexia to "failures in maternal holding behaviour, particularly empathic mirroring".

Thus, anorexia is viewed fundamentally as a disorder of the self, rather than a disorder of weight, food, or appetite. The possible role and meanings of food and the body in anorexia is virtually ignored by these theories. Both are taken as relatively

unproblematic, as Macsween (1993) argues, "Food is simply 'available' to be used in the struggle for selfhood and control, and its possible social significance is ignored, apart from a brief consideration of increased food intake as the fuel of the pubertal processes" (p.41). Furthermore, the real significance of the anorexic body is minimal.

"What having an adult female body means in a culture which simultaneously eroticizes, degrades and devalues both women and their bodies, and how the transformation of the formally asexual child's body into the icon of the female body is experienced, are questions which are simply left unmasked as the focus of analysis is exclusively on inferred underlying psychological forces" (Macsween, 1993, p.42).

As has been mentioned, in this paradigm anorexia is presented as a struggle for identity and selfhood, precipitated with the onset of adolescence demanding a transition to independence and maturity of which the pre-anorexic personality is incapable.

2.2.7 The Anorexic Body and the Anorexigenic Family

Family therapists work to free anorectic families from the type of controlling, manipulative collusions among family members that Bruch (1973) described. Having long sought to treat anorexics psychoanalytically, Palazzoli (1974) claimed to achieve quicker and better results through directive, strategic intervention, rather than through non-directive interpretation and empathy. In founding the Milan Centre of Family Studies, Palazzoli emphasized the interdependence and circularity of forces: the individual's behaviour is simultaneously causal and causative. Palazzoli postulated that certain family relationships are closely related to the development and maintenance of

anorexia, in much the same way as Laing and Esterson (1969) described the development of schizophrenia within the family context. Palazzoli argues the anorexic illness plays an important part in maintaining the family homeostasis. This thesis was supported by the work of Crisp *et al* (1974), which found that the "psychoneurosis" of family members was relatively minor during the most critical time of the anorexic illness, but increased after recovery (p.167).

Although Palazzoli was similar to Bruch's approach in identifying the anorexic as symptomatic of unbearable family conflict, Palazzoli emphasized changing destructive communication and behaviour patterns within the family as a way towards identity and autonomy for the anorexic. Extending Laing's and Esterson's work (1964) in schizophrenic family communication, Palazzoli found that anorexic families have poor conflict resolution, each member refusing to take on responsibilities, a strong pervasive spirit of self-sacrificial behaviour, the marital relationship shows a facade of unity concealing profound disillusionment, and the central family issues in the formation of covert coalitions crossing generation boundaries (Palazzoli, 1974). Within this context, the anorexic is "prey to the most disastrous Cartesian dichotomy; she believes that her mind transcends her body" (Palazzoli, 1974, p.233). By looking at the psychosocial dimensions of food (in a similar fashion to Bruch), Palazzoli argues that food becomes the main focal point for familial power struggles. Thus, for Palazzoli, the anorexic is engaged in a battle for control against both her body and the family system.

Minuchin *et al* (1978) developed a similar approach through his general psychosomatic model, focusing on the detouring of marital conflict through the anorexic child.

Such family interventions have been criticized for taking place only within a self-contained and reified unit, that isolates itself from the broader culture. Palazolli (1974) admitted that "our current practice of treating the family as a subsystem in relative isolation is a heuristic artifice. This is a shortcoming which, for the moment, I have no means of remedying" (p.251).

Gremillion (1992), elaborating on this issue, argues that even as the systemic approach, attempts to reject attributing the cause of illness to the individual anorectic by focusing on the detrimental effect that pathological family ties can have on individuation, "it still reveals a commitment to the western sociocultural dichotomy that is itself implicated in the anorectic condition: because the family is viewed as a system unto itself, the realms of public (individualism) and private (enmeshment) remain separated" (p.64).

For Bruch (1973), the two extremes of the domestically dominant mother and the emotionally distant father are implicated in creating anorectic pathology. Ignored in this perspective is the fact that the domestically dominant mother and emotionally distant father are part of the broader social system, as Turner (1984) argues, "the particular family structure of the anorectic household can said to be itself a product of patriarchal relations" (p.203). Within this perspective, no explanation is given as to how this conflict becomes embodied so that the wilfully emaciated body can become a meaningful symbol of this conflict, except to see it as a form of adolescent rebellion against enmeshment, a rebellion that nonetheless reproduces the anorectic's dependence.

2.2.8 Conclusion

Thus far, the history of the concept of anorexia and psychiatric discourses about anorexia have been presented. Anorexia was identified first as a type of hysteria, then as a manifestation of pituitary dysfunction, and finally as a syndrome of 'unknown etiology', cutting across all four of the major psychiatric orientations: the biomedical, the psychoanalytical, the behaviourist, and the psychodynamic. The biomedical model locates the anorexic pathology in an internal physiological space. The psychoanalytical model locates the anorexic pathology in an internal psychic space. The behavioural model locates the anorexic pathology in the external environment. The psychodynamic model locates the pathology in an interactive arena of faulty representations. System theory locates the pathology in inappropriate family networks.

Anorexic symptomatology ushers in a proliferation of theoretical discourses, each with their own language, formulation and perspective. The result is a multitude of competing models, ideologies, and conceptualization, standing in a complex and ambiguous relation to one another. The contemporary multidimension treatment approach, combining two or more of the discourses, with their varying emphasis on soma and psyche, leaves the social reality of the anorexic's bodily ordering untouched, and takes for granted the embodiment of psychic life. The former issue becomes the focus of feminist discourses which is presented in the section that follows.

The latter issue is a consequence of the naturalized discourses of the anorexic body that ignores or takes for granted embodied existence, and therefore lacks an

appropriate theory of the body that can simultaneously cater for the subjective and objective dimensions of bodily existence. This absence gives rise to a strange combination of 'subjectivism' and 'objectivism' (Sass, 1990, p.121) amongst these naturalized discourses. The subjectivism of the psychoanalytic, Kleinian and Jungian discourses is evident in their focus almost exclusively on the internal mechanisms and experiences whereby the anorexic is a product of innate constellation of images and phantasies that determine the anorexic response to the environment. Such subjectivism ignores the substantiality of the body, and epitomizes the solipsistic vision and primitive egocentricisms of the disembodied psyche, inherent in these discourses. Furthermore, the relational and external dimension of embodied existence is underscored. This adherence to one pole of existence provides a partial account of anorexic embodiment, and attempts at greater inclusivity of the external dimension of embodied existence, is incumbent upon the behavioural, psychodynamic, object relations and system theories.

These discourses adhere to the opposite pole of embodied existence, emphasizing the importance of the external holding environment whereby anorexic pathology is a product of an intrusive, unsafe, external environment. Such objectivism, with its emphasis on environmental determinism, devalues the intentional aspect of bodily existence, and struggles to cater for the self-consciousness of embodiment.

This split within the naturalized discourses of anorexic embodiment accounts for the epistemological tensions inherent in the diagnostic treatment and prognostic difficulties experienced in understanding this disorder. The multitheoretic, multiepistemic and multidisciplinary treatment involved in anorexia encourages cross-fertilisation of ideas

and calls for co-operative cross-paradigm co-operation that leads to unsatisfying technical eclecticism and conceptual confusion.

The anorexic body highlights the need for a view of the body that goes behind and beyond the subjectivism of the psychoanalytic, Kleinian and Jungian discourses, as well as the objectivism of the behavioural, psychodynamic, object relations and systemic discourses to a horizon in which both subject and object are not separate and opposed to one another. The anorexic body reveals the pitfalls inherent in the separations and oppositions of subject and object in the naturalized discourses, and calls for a more meaningful discourse of the body that would not reject the naturalized discourses but would capture the interworld of lived experience in a theory of the body that is both subjective and objective, blended in such a way that both dimensions cannot be separated or completely distinguished. This is the achievement of Merleau-Ponty's philosophy and the aim of the present research.

In the section that follows, feminist discourses of anorexic embodiment are articulated, and it is debated whether these discourses, with their focus on the social ordering of the body and denaturalization of the body indeed heal the split exposed by the anorexic in the naturalized discourses.

2.3 THE DENATURALIZATION OF THE ANOREXIC BODY: FEMINIST DISCOURSES

Following Bigwood (1991), the denaturalization of gender and the body refer to those strands of post-structuralist feminist theories who have worked to redefine the body itself

as a product only of cultural meaning purging gender from any connectedness with the body and any natural determinants.

Feminist explanations challenge orthodox psychiatric explanations for their lack of understanding of the gender issues in anorexia nervosa, and attempt to set up alternative explanations of this condition. Feminist discourses assume that no theory is neutral, and that underlying political and methodological biases must be articulated. Furthermore, feminist theorists argue that a diagnosis of anorexia nervosa is not an apolitical judgement but one which indicates the tensions inherent in the dominant gender order.

Orbach (1978) and Lawrence (1984) engage with the issues of control and boundaries, similar to that of Bruch and Palazzoli, but engage with these issues from a feminist perspective. Their focus is on an analysis of the meanings of these concepts for women in patriarchal culture, and their centrality in anorexia. Chernin (1983) highlights the vital issue of guilt, making important points regarding the ritual behaviour of anorexia. Both Chernin and Orbach developed their interest in anorexia out of a concern with women, eating, and body-size as a whole, while Lawrence worked with anorexic women as a psychiatric social worker.

All three writers were also influenced by feminist theory on subjectivity, namely, the works of de Beauvoir (1949) and Mitchell (1974), and the French feminist theorists, Irigaray (1974, 1985) and Cixous (1976). A detailed exposition of these theories is beyond the scope of this thesis, but a brief overview will be presented.

de Beauvoir was influential in developing a feminist discourse of the female body and the oppression of women. de Beauvoir (1949) argued that the male is regarded as the norm, the positive subject, and the female is set up as an inessential object, defined in relation to the male. Consciousness for de Beauvoir is the locale for the opposition between the male subject and female object. The male is defined independently of the female. Woman's identity in culture, however, is found in her status as other. de Beauvoir sees woman's body as a social construction, "the inessential other; an object incapable of acting as the meaning-giving subject" (de Beauvoir, 1949, p.29). The meaning of the female body is determined by its reproductive capacity: "Woman, like man, is her body; but her body is something other than herself" (de Beauvoir, 1949, p.61). de Beauvoir draws attention to the nature of the oppression of women, which is in part a consequence of the way in which women's bodies are constructed by culture. In patriarchal culture, woman is alienated from her body, as the female body is not the subject which gives meaning but rather the object of a cultural view which is masculine. A woman's body thus becomes something apart from herself (Robertson, 1992).

In an analysis of the role of the unconscious, Mitchell (1974) articulates the means by which women internalise their oppression. Although critical of elements of Freud's theory (for example, penis envy, rather than envy of the privilege of male status) (Mitchell, 1974, p.179). Mitchell uses Freud's concept of the unconscious to explain the mechanisms whereby the dominant ideology about women and their status is reproduced. Mitchell (1974) argues that the unconscious is the site where women come to terms with their status as the "inessential other", influencing their conscious

perceptions of the possibilities and opportunities available to them in life and their ability to act in the world (Robertson, 1992).

Irigaray (1985) uses the concept of difference to develop a positive image of femininity. Psychoanalysis, for Irigaray, defines both men and women in reference to the male. Irigaray's description of the manner in which the male becomes the 'subject' and the female becomes the 'other' is relevant to the anorexic's construction of women's embodiment. Using psychoanalysis, Irigaray demonstrates how gender identity is socially constructed through language. Irigaray points out how men speak universally for men and women. For Irigaray it is language that directs individuals in their orientation to the world. Subjectivity and meaning expressed in language mirror patriarchal power relations. A patriarchal symbolic order inscribes women's bodies with limited possibilities and restricted access to the dominant gender hierarchy.

Irigaray suggests that both Freud and Lacan emphasize vision and male ways of perceiving the world. The little girl, for example, sees she is castrated. Patriarchy defines the female as not having a phallus, as in Freud, or as non-masculine as in Lacan (Robertson, 1992). Women's identity then, is predicated upon a perceived lack of phallus rather than a possession of her own sex which will become the core struggle for the anorexic.

For Irigaray, however, the feminine body could be conceptualized in other ways, for example, via touch instead of vision: "then the lips of the female genitalia touch each other while the penis is dependent upon contact with another " (Robertson, 1992, p.63).

The male needs an instrument to know himself and sublimates this in language (Irigaray, 1981). Irigaray also points to a different construction of femininity whereby the pre-Oedipal unity with the female is not repressed but continues into the next stage, so that the possibility of a new language and logic emerges. A woman's femininity is then constituted by her relationship to her own body and to her mother's body, instead of the masculine. In this manner, Irigaray attempts to subvert the dominant ways in which women are presented to themselves.

For Irigaray (1985), women's silence in history is a silence of her 'double lips', born of the need to silence both her speech and her sexuality. The double lips are a textual metaphor to suggest a different entrance to the symbolic. Irigaray develops the concept of "jouissance" (Irigaray, 1985), or female playful pleasure, which, unlike male pleasure, is the gateway through which women speak in their own voice, with their own lips, in Irigaray's own words:

"I see the lips as entrance to female sexuality. All holy texts mentions a threshold, to me the lips of a woman are that threshold. The entrance to the home. The entrance to intimacy" (Irigaray, p.195).

This is Irigaray's challenge to phallogocentric symbolic dominance.

The woman in the patriarchal symbolic is defined only in relation to the male (the subject) who is the real person. Irigaray presents woman with the possibility of a multiplicity of concepts: woman who is not man and not subjected (Berg, 1982). So long as the female continues to be the male's symbolic mirror image, a woman is:



"captive when a man holds me in his gaze; I, too, am abducted from myself. Immobilized in the reflection he expects of me. Reduced to the face he fashions for me to look at myself".
(Irigaray, 1981, p.66).

Irigaray thus explores the ways in which the feminine is defined as a lack, a negative image of the subject in Western culture, a silent subject (Robertson, 1992). Women, she says, "have been misinterpreted, forgotten, variously frozen in show cases, rolled up in metaphors, burned beneath carefully stylized figures, raised up by different idealities" (Irigaray, 1985, p.144).

This observation of patriarchal ideology is also made by Cixous (1976). Drawing on her experience of women who are at the edge of culture, the madwomen, Cixous suggests that with their bodies, women support the realm of the proper (heterosexual society, patriarchy). To challenge the 'proper' is regarded as the madness within a patriarchy:

"Without the hysteric, there's no father. Without the hysteric, no master, no analyst, no analysis. She's the unrecognizable feminine construct, whose power of producing the other is a power that never returns to her ... She is given images that don't belong to her, and she forces herself as we've all done to resemble them".
(Cixous, 1976, p.47).

Cixous argues that woman's body and sexuality have been repressed and shamed into love of another's body, not her own female body. Cixous urges woman not to remain within psychoanalytic closure, and advocates a return to woman of the body that has become for her "an uncanny stranger on display" (Cixous, 1976, p.250). Language is the mechanism by which women's bodies become a reflection of woman as 'other'. Woman's body is made a stranger to her:

"Isn't this fear convenient for them? Isn't the worst, in truth, that women aren't castrated, that they have only to stop listening to the sirens (for the sirens were men) for history to change its meaning? you have only to look at the Medusa straight on to see her. And she's not deadly. She's beautiful and she's laughing".
(Cixous, 1976, p.255).

These French feminists offer alternative ways of understanding femininity. They provide strategies for emergence of differences in women's embodiment and for a change in language. According to Robertson (1992), in a feminine imaginary, women could explore their potency, strength and power. This imaginary could be based in the pre-Oedipal feminine, but, argues Robertson, it need not be. To deconstruct the feminine body requires:

"a fluid femininity in which the expression of sexuality and eroticism is possible. A feminine imaginary may offer women unconscious images which could in culture create for them different ways of embodiment".
(Irigaray, 1985, p.66).

Based on the works of the abovementioned feminist theorists and philosophers, Orbach (1978), Chernin (1983) and Lawrence (1987), all ground anorexia within culture, and point to continuities in the relationship between food and the body in anorexic and non-anorexic women. Further, the concepts of desire and dependence, appearing so minimally in traditional psychiatric approaches, are given a more thorough articulation.

2.3.1 Susie Orbach: The Anorexic Body and the False Self/Body

In 'Fat is a Feminist Issue', Orbach (1978) argues that women use body-size to express feelings which are otherwise inexpressible. With Eichenbaum, neediness and dependency are isolated as central issues in the psychology of women (Orbach and Eichenbaum, 1983). In 'Hunger Strike', Orbach (1986) argues that anorexia consists of two processes: the pursuit of thinness, and the denial of emotional neediness. The anorexic woman is engaged in transformation of the body. Whilst the aim is thinness, the meaning of the symptom changes during the illness, and the aim becomes the control of eating and the body, rather than simple thinness. Losing control terrifies the anorexic, and Orbach argues that denial of food and bodily control are symbolic of the denial and control of emotional needs. The anorexic woman, argues Orbach, speaks with her body:

"Her body is a statement about her and the world and her statement about her position in the world. Living within prescribed boundaries, womens' bodies become the vehicle for a whole range of expressions that have no other medium. The body, offered as a woman's ticket into society, becomes her mouthpiece. In her attempts to conform to or reject contemporary ideals of femininity, she uses the weapon so often directed against her. She speaks with her body".
(p.98).

Anorexia is thus a protest and a language; it expresses unconsciously a solution to problems which cannot be consciously articulated (Orbach, 1986, p.17).

Orbach identifies three factors in the changing role of women in Western society that determine the formation of the anorexic symptom. In a consumer society, she argues, women's bodies are "the ultimate commodity", and are, to women and to men, "objects

of alienation, fascination, and desire" (Orbach, 1986, p.35). Womens' bodies and womens' sexuality are objectified, and this objectification has two effects. First, the manipulation of the body-as-object in order to make it acceptable, is a constant reality for women (Macswen, 1993), and secondly, women cannot have "an unmediated or purely physical relation to their bodies" (Orbach, 1986, p.36). Both manipulation of the body-as-object and a 'mediated' relationship to the body are expressed in anorexia.

The second factor is the post-Second World War confusion over motherhood. Womens' increasing dissatisfaction with domesticity and a search for a life outside the home challenged the concept of a biologically destined motherhood (Orbach, 1986). Orbach (1986) argued that for mothers and daughters of this time, confusion and uncertainty about the role of women and mothers was endemic; anorexia then, in its rigid control of the body, "is a symbolic attempt to forge a consistency where little exists, to provide a knowable, reliable way of being that can withstand the demand for change" (p.42).

Thirdly, the mother has to bring up her daughter to accept an inferior position, to subserve her needs in the needs of others, and to live a circumscribed life, simultaneously wanting the best for her (Orbach, 1986, p.43). Anorexia is one way in which the daughter can express the ambivalent relationship to physical and emotional needs which she has learned from her mother.

Drawing on self-psychology and object relations theory, Orbach argues that women do not have their early needs satisfied consistently, and thus their sense of self is shaky

(p.18). Such inconsistency operates both emotionally and physically, in that girls are fed less and weaned earlier. This results in confusion about the acceptability of emotional and physical needs. Because of the inconsistent response of the mother to the internal cues of the daughter, the daughter experiences her needs as insatiable. Following Orbach (1986), "her ego does not integrate around her needs, and there is thus no internal sense of continuity and security around which the self can develop" (p.108).

Orbach identifies three basic demands of femininity which undermine female self-development: Women must defer to others, anticipate and meet others' needs, and seek self-definition through connection with another. Being successfully feminine results in a "shaky sense of self" where women "are unable to develop an authentic sense of their needs or a feeling of entitlement for their desires" (Orbach, 1986, p.43).

With the onset of adolescence, when issues of separation and individuation are re-evoked, the struggle for identity has to be shaped out of shaky foundations. The inevitable uncontrollable bodily changes shake the young female adolescent's tenuous psychic foundations. Insecurity with the self becomes insecurity with the body. Added to this process is the mother's inability to convey unambiguously the 'positive' aspects of female sexuality. Unacceptable neediness is resolved through a rigid control of hunger. The control and denial of a need for food becomes a metaphor for a denial and control of a needy self (Orbach, 1986, p.45). The aim here is to dissociate from the female body, attempting not to be a body, to exist as a non-corporeal being.

The embryonic need self/body is rejected, and a false self/body devoid of needs is projected (Orbach, 1986, p.89). Orbach, following Winnicott, explains:

"The self that one has put forward in the expression of need is implicitly rejected by the caretaker in her failure to respond appropriate to those needs. The psyche then protectively develops a more pleasing 'false self' devoid of the needs and the initiations which seemed to push the much-needed caretaker away".
(Orbach, 1986, p.89).

This concept is extended to include a 'false body':

"Where the developing child has not had a chance to experience its physicality as good, wholesome and essentially all right, it has little chance to live in an authentically experienced body. A false body is then fashioned which conceals the feelings of discomfort and insecurity with regard to the hidden or undeveloped inner body".
(Orbach, 1986, p.89).

Anorexia is, according to Orbach, a somatized solution, to the feelings of uncontrollable and chaotic neediness, "a much needed defence against the exposure of a very vulnerable nascent me" (p.91).

Thus, for Orbach, the individual's experience has social roots, and the psychoanalytic account of the inner world of the anorexic woman must be read in the context of the sociological account of the position of all women. For Orbach, the personal solution to body-image problems must go hand-in-hand with the extension of the scope of women's lives and the transformation of patriarchal social relations and the images of women they produce (Orbach, 1986, p.192).

The therapist's aim is to show that desire and its implementation are not in themselves essentially fearful or negative, and provide an environment in which needs get addressed and are thus seen as acceptable (Orbach, 1986, p.141). The anorexic woman will thus develop her embryonic self to a level at which she can satisfy her needs in a self-regulated way, and achieve psychosomatic unity, i.e. the experience of the body as owned and lived in (Orbach, 1986, p.148). The anorexic woman can then speak directly, rather than through her body, as Orbach concludes: "In allowing herself to feel and to act, she reverses some of the key features of socialization towards femininity. She becomes a person with legitimate desires and demands which she can now openly express" (Orbach, 1986, pp.179-180).

In conclusion, Orbach makes a valuable contribution to a feminist understanding of anorexia by highlighting the issue of 'needs' in anorexia and locating anorexia as an aspect of the social control of female desire. However, it remains debatable whether Orbach has provided a thorough going feminist analysis or simply added on a feminist perspective to the individual pathological standpoint of object relations theory and psychiatric orthodoxies and standard psychosomatic theory. While Orbach argues that political struggle as well as individual therapy is needed if the social structure producing anorexia is to be changed, collective feminist action is downgraded in favour of "encouraging individual anorexic women to accept their needs" (Orbach, 1986, p.179). Taking up this issue, Macsween (1993) asks "How is the ex-anorexic woman who accepts and acts on her desires as legitimate to deal with a patriarchal society which emphatically does not" (p.82). Furthermore, by suggesting that the therapist as benign mother can cure anorexia through a positive presentation of female desire, assumes

that mothers cause anorexia, and that correct mothering can alleviate it. In this fashion, Orbach psychologizes and domesticates the social control of woman assuming that personality is created in one relationship and underplays the influences of other social relations. Macsween (1993) thus argues that "there is little point in replacing the isolated Oedipal triangle floating in 'unsocialized ether' with an equally isolated mother-daughter dyad" (p.81).

Such tensions and critique of Orbach's theory highlight the need for an understanding of anorexic embodiment that intertwines the individual and the social at the level of bodily existence, whereby the individual is not seen simply as a product of social relations, nor overemphasised, whereby social relations become fragmented and disintegrated. Merleau-Ponty's dialectical theory recognizes the individual simultaneously as an individual, yet also as a social being. It is argued that this approach is best able to balance the opposition between the individual and the social that Orbach struggles to reconcile.

2.3.2 Kim Chernin: The Anorexic Body and the Hidden Struggle for Self-Development

Chernin (1986) argues that eating disorders should not be seen simply as illnesses but as a hidden struggle for self-development. In analyzing the issue of women and eating disorders, Chernin (1986) identified four main areas: the search for identity and selfhood; the separation struggle between mothers and daughters; food and its meaning for women; and the concept of the rite of passage.

2.3.2.1 The search for identity and selfhood

Chernin argues that it is only recently that women have claimed the right to participate in the public sphere in such large numbers:

"We are a unique generation of women - the first in history to have the social and psychological opportunity to surpass with ease the life choices our mothers have made. We come of age, we leave home, and we enter a world in which most social and political institutions have thrown open doors that for thousands of years were closed to women".
(p.12).

Chernin argues, however, that women who suffer from eating disorders and anorexia in particular can't say "Yes" to this offered opportunity. Chernin (1986) writes that:

"At that very moment when we might expect to step forward and harvest the fruit of a profound struggle for female liberation, many of the most gifted among us fall prey to a severe suffering that gradually consumes more and more of our life energy and finally causes what in many cases is a severe breakdown".
(p.17).

An obsession with food is chosen in place of freedom at a turning point in the individual woman's life itself and in women's history as a whole. Terrorized by female development, eating disorders prevent movement into the public domain, indicative of a collective female refusal of self-development.

2.3.2.2 Separation struggle between mother and daughter

The mother-daughter relationship is, for Chernin, the most significant factor in the failure of self-development. The background to this separation is a historically unprecedented separation of values and way of life, between the mother and modern daughter, "a progressively growing crisis in the institution of motherhood" (Chernin, 1986, p.88). The pressure of women's political struggle in the 20th Century ushered in a collapse of the need for women to sacrifice their lives to domesticity, especially motherhood:

"Suppositions that were taken for truths, that women should live through their families, be confined to the domestic sphere and give up the longing for their own development and sacrifice it for their children have been gradually broken down".
(Chernin, 1986, p.79).

Crucially, however, the traditional idea of necessary motherhood was not substituted with any new idea of womanhood (Macswen, 1993). Unable then to accept the necessary sacrifice of individuality in domesticity, mothers of the post-war era were also unable to enter a world of larger possibilities. The mothers of the post-war era were left very discontented. A new type of mother-daughter relationship emerged:

"Mothers and daughters of the modern era face one another as beings in a struggle for a self - the older woman having already failed in this quest as the younger starts out on it".
(Chernin, 1986, p.81).

The mother thus becomes ambivalent about her daughter's new opportunities: she wants her daughter to have what she lacked, but also envies and resents her potential to do so. Conversely, the daughter fears the surpassing of her mother, in her quest for

self-development and self-assertion. This fear of independence Chernin aptly described as the 'Cinderella Complex', which was in reality a pervasive worry about mother's life.

The daughter, plagued with the guilt of surpassing mother, blames herself, rather than the culture, for her mother's wasted life. The daughters come to feel that they themselves have drained and depleted the other with their needs. Here, Chernin (1986) draws on the work of Klein, arguing that this is the "seeds of this hidden mother-rage and mother-guilt which are at present restricting our development" (p.118). Chernin argues that there is a propensity for daughters to feel guilt about their potential to surpass their mothers: "the idea that they drained their mothers in reality - an unconscious Kleinian memory - is reactivated in later crises of growth and development" (p.91). For Chernin (1986),

"the terrible guilt observed in women with an eating disorder, although focused on the number of calories consumed and the number of pounds gained, arises from the fact that the woman afflicted with this obsession cannot forgive herself for having damaged her mother in earliest childhood. Consequently, she cannot allow herself to move into the next stages of development, to turn her back on the older woman and leave her behind to the depletion and exhaustion she believes she has inflicted upon her". (p.125).

2.3.2.3 Food and its meaning for women

The daughter is trapped by the guilt over growth, food, and eating. Eating in this scenario is "an act of violence against the mother" (Chernin, 1986, p.128), and this feeling is reinforced by a culture, which, Chernin argues, fears and dislikes large

women. Not eating thus resolves many guilts, principally, however, the "primal crime of imaginary matricide" (Chernin, 1986, p.132).

The daughter fears that food will turn her into what her mother is; ambitionless and shameful: "with every bite she has to fear that she may become what her mother has been" (Chernin, 1986, p.42). Anorexia, then, is an attempt to remake the female body: it is "symbolic gender transformation" (Chernin, 1986, p.52). The hope is that in developing the lean male body, she will "escape from the mother's destiny without enduring all that remorse of leaving the mother behind and will be able to surpass her mother with the serenely cruel and self-referring attitude of a son" (Chernin, 1986, p.56). This, however, is impossible. The body regains its natural weight and contours, and confronts the anorexic woman with "the fact of being fundamentally and irrevocably female" (Chernin, 1986, p.53). She is trapped; she can neither retreat nor go forward.

2.3.2.4 The concept of rites of passage

Eating disorders should be seen, Chernin argues, as attempts to evolve 'rites of passage' in which the traditional female identity of self-sacrificial mother can be transformed and women can enter the culture. This, she argues, is "the purpose of 'tribal' rites of passage, but because the ritual here is not recognized socially, it is unable to do this, its 'self-destructive excess' is not controlled, and ritual thus remains split off from its collective significance" (Chernin, 1986, p.185). The anorexic woman "cannot get beyond those trappings of transformation, remaining stuck in the repetition and

elaboration of dietary ritual without experiencing the transformative power of the true rite of passage" (Chernin, 1986, p.175).

For Chernin, what is needed is a collective ritual through which a new female identity can be created, an "intentional ritual rather than ritualized obsession" (Chernin, 1986, p.185). Chernin argues, "We are in urgent need of a ceremonial form to guide us beyond what may well be the collective childhood of female identity into a new maturity of female social development" (p.169). Only then will a 'new woman' who can enter the public world without the finally impossible transformation into a 'pseudo-man' be born; a woman in whom female creative and nurturing power are integrated in, rather than separate from, her identity (Macswen, 1993).

In sum, drawing from Klein (1975), Chernin focuses on guilt in the mother-daughter relationship as the main explanatory factor in anorexia. Differing from Klein's idea that the child's phantasy to appropriate the contents first of its mother's breast, then of her whole body, leads to a belief that it has really destroyed her, Chernin argues that this is not an *a priori* universal truth, but rather an *a posteriori* maxim, dependent on the oppression of women in the institutions of motherhood.

Chernin furthermore provides fruitful insights into the importance of ritual in anorexia, the disjunction between femininity and individuality, the problem of feminine appetites, and the opposed orientations of men and women towards the public sphere (Macswen, 1993). Macswen (1993), however, argues that Chernin's analysis of anorexia is effective only if "we accept that the patriarchal oppression of women is effectively over,

and that the 'masculine self' is the proper goal of women" (p.64). Failing this, Macsween continues, "We will be forced to look outside of the mother-daughter relationship to the wider social forces which continue to oppress and constrain women - as mothers and daughters certainly, but also as wives, girlfriends, workers and citizens" (Macsween, 1993, p.64). In so doing, Macsween argues that the analysis of anorexia can be liberated from "its dependence on a particular type of mother, i.e. the discontented woman, ambivalent about her daughter's growth, and the control of feminine appetite can be understood as social rather than self-inflicted" (1993, p.64).

Chernin's discourse attempts at greater inclusivity of the social factors in the production of anorexic pathology highlighting the dominance of the social construction of guilt in anorexia. In this stance, the social dimension of anorexic guilt is overemphasised, whilst the intentional dimension of the individual that is directed towards the social suppression of woman is underscored. The guilt of the anorexic cannot be fully articulated as a mechanical, socially determined process alone, nor is the guilt to be understood as simply a type of subjective thought and experience alone. The guilt, as embodied by the anorexic, requires a theory of the body that understands the manner in which the anorexic is both the bearer of guilt, simultaneously to being open to an intersubjective world that constructs the guilt.

Such a discourse would deepen Chernin's insights by providing a basis for not having to overemphasize the social construction of anorexic guilt at the expense of the underemphasis of the intentional dimension of this phenomenon. In this regard,

Merleau-Ponty's understanding is of utmost importance, and the need for an appropriate theory of the body becomes all the more transparent.

2.3.3 Marilyn Lawrence: The Anorexic Body and the Psychic Shell

According to Lawrence (1984), anorexia is a double-pronged stratagem of control. On the physical level, through food denial, size and shape of body are controlled. On the moral level, through self denial, the anorexic tries to control desires, needs, and appetite. The former offers proof that the latter is successful. These attempts to achieve absolute control are motivated by feeling out of control physically as seen in obesophobia and morally in their self concept as debased women (Lawrence, 1984).

For the anorexic woman, rigid boundaries separate her from an environment which tends to regard woman as "an aspect of the environment of others" (Lawrence, 1984, p.94). An anorexic girl succinctly describes her need to be "closed up for a while, and very small. Not receptive, not there for others." (Lawrence, 1984, p. 100). Fearing that her feelings and needs will overwhelm others and herself, she resorts to self denial, a societally approved virtue, particularly for women, stereotyped as "inherently prone to badness and moral weakness" (Lawrence, 1984, p.95). Lawrence thus seems to regard both the methods and goals of the anorexic as equivalent to those of medieval female ascetics.

Due to the relative powerlessness inherent in women's subordinate position in society, Lawrence (1979) argues that the areas of food and the body are then chosen as the

sites of control and denial, because food and the body are two of the few areas open and accessible to female control, and partly through a lack of alternatives. Food and eating are major female concerns, and anorexia is viewed as an extension of the difficulties all women have with eating:

"it (anorexia) is in fact at one end of a continuum of confused and conflictual responses, which we women have towards ourselves. We do not just eat: we slim, we worry, we weight-watch. We also spend an inordinate amount of time absorbed in the business of food: feeding others as well or instead of ourselves, shopping, cooking, and cleaning-up the waste. Food in our society is regarded as the responsibility of women. It is one of the few areas of life in which we are expected to be in control."
(Lawrence, 1984, p.12).

The control and manipulation of the body is also a major facet of female existence. Lawrence (1984) argues that appearance is central to women's acceptability and today sexual acceptability demands slimness (p.33). Weight control is, therefore, commonplace in women's lives, both in the attempt to conform to a cultural stereotype, and as an expression of the idea that if women experience problems, they should change themselves rather than their society in order to deal with them (Lawrence, 1979), which may be the case with men as well, but not in equal measure.

Although the lay feature of anorexia is the desire to control both food intake and weight, the underlying conflict for Lawrence (1979) is a conflict over independence and autonomy. The conflict is between two courses of action: pursuing individualistic success which is seen to involve a rejection of affiliation and femininity; or abandoning this course to become fully feminine and therefore subordinate, defining the self in relation to the needs of others.

Anorexia is a way to avoid the conflict, and is seen by Lawrence (1984) as a retreat from independence. The conflict for Lawrence, however, is social rather than individual. It is not the anorexic girl herself that is confused due to individual inadequacies, but it is the social world which is filled with conflicts over how adult women should behave. Anorexia is thus "a disorder which springs from the very midst of women's experience of the world" (Lawrence, 1984, p.21).

Lawrence (1984) distinguishes the aim of anorexia in which the anorexic girl tries to retreat from confusion and conflicts between success (primarily educational) and dependent femininity, and the method used to achieve this aim, physical and moral control strategies, to construct a shell around the self:

"We can think of the symptoms of anorexia as a kind of protective outer shell. The shell is not the real person, but it hides and protects the real person. It did not need love, it did not need friendship, it did not need food. It had no connection with anyone or anything in its environment. It was complete and contained within itself. It had declared its independence"
(Lawrence, 1984, p.22).

The anorexic solution, however, cannot be permanent or total, since:

"most anorexic women eat at least something; the body can never come absolutely under moral control; the anorexic lives with a constant need to increase control by decreasing intake; the anorexic woman lives with the terror of her appetite overwhelming her and therefore needing to eat uncontrollably; finally, the anorexic process itself becomes unmanageable, and instead of the anorexic controlling the eating, it seems to control her. Put simply, the anorexic strategy does not work because it is a solution which is symptomatic of the desperate situation it seeks to rectify. It is a solution which is essentially self-destructive"
(Lawrence, 1984, p.100).

In sum, by viewing anorexia as a product of the social position of women, in pointing out the importance of food, and the body appearance in the female gender role, in questioning how far independence is a real possibility for women, and in arguing for a connection between the anorexic strategy and women's relative social powerlessness, Lawrence provides an effective explanation of how the anorexic experience becomes meaningful almost exclusively to women (Macswen, 1993).

However, Macswen (1993) argues that in spite of Lawrence's feminist stance in accurately linking self-denial and gender, she fails to comprehensively link individuality, desire and gender in a specifically bourgeois culture. Macswen (1993) argues that:

"the active pursuit of self-interest and satisfaction of desire are central facets of the bourgeois construction of the individual. In patriarchal ideology and practice, however, women are constructed as the passive objects of the desires of the masculine subject, rather than the active pursuers of their own desires. Feminine desire, feminine behaviour, is constructed as responsive to masculine action, as dependent upon it. Independent, unresponsive desire is expected of individuals but sanctioned in women, through, for example, the construction of autonomous female desire as dangerous, voracious and potentially overwhelming".
(p.72).

It is not simply a lack of confidence, as Lawrence would have it, that prevents women from controlling their own destinies. Independence and appetite, dependence and denial are inextricably linked (Macswen, 1993). Feminine appetite and appearance still requires articulation as it is embodied in bourgeois and patriarchal culture.

In affirming a link between the anorexic body and gender, without resorting to biological differences, Lawrence provides an understanding of the anorexic body that is culturally and historically contextualised. However, even though our bodies are not fixed foundations, this does not mean that our bodies are merely cultural constructions. Lawrence underplays the inextricable boundedness of the body in both cultural and natural ways. The constant situatedness of the body in an already present cultural and natural world is reduced by Lawrence to the situatedness of the body in a cultural world alone. With the help of Merleau-Ponty, the aim of this thesis is to present a paradigm of the body that is neither purely culturally relative, nor solely biologically determined, so as to cater for the natural-cultural relational field that the anorexic body demonstrates as its home ground.

2.3.4 Morag Macsween: The Anorexic Body as Desiring Enemy and Desireless Ally

According to Macsween (1993), the feminine body is constructed around three dominant social meanings in a bourgeois patriarchal culture, namely, objectification, discipline, and chaos. Regarding objectification Macsween argues that the feminine body is created as an object on which the masculine subject acts, and which he owns; women maintain their bodies as objects through dietary, cosmetic and behavioural practices as caretakers rather than owners. The notion that women have a phenomenological possession of their body (Turner, 1984) sits uneasily with Macsween's understanding of the feminine body being alienated from women, as objects of masculine sexual desire and the site of uncontrolled reproduction. Discipline is regarded by Macsween as an essential feature of femininity and of women's relationship with their bodies; women

watch what they eat, how they dress, talk, sit, walk, and behave. Finally, there is the other side of the coin of discipline, fear and disgust at the appetites which necessitate that control, in that women are seen to have the potential to overwhelm the boundaries of femininity and restricted feminine space (Macswen, 1993).

Anorexia, for Macswen, represents the reproduction and reworking of these concepts of the feminine body. In anorexia, ordinary expectant feminine self control takes on new dimensions. Weight-watching becomes the major and eventually the sole activity of the anorexic woman. Macswen argues that anorexic ritual attempts to create secure defences against appetite, and that the ultimate goal is "the construction of the body as desireless and inviolate. Eating nothing, allowing nothing into the body, is therefore the end towards which anorexic rituals aim" (Macswen, 1993, p.194).

The enemy of anorexia control is appetite. Appetite is the chaos which makes discipline so necessary. Appetite is the force which undermines anorexic self control and makes such discipline so precarious. Through an analysis of anorexic womens' descriptions of eating, Macswen argues that the concept of feminine insatiability is translated, in anorexia, from sex to food, and the characterization of feminine desire as non human intensified. Further, Macswen argues that:

"the danger of feminine desire encroaching into masculine space, its construction is antithetical to patriarchal order, is expressed internally in the anorexic body as appetite (feminine) threatening self (masculine), a transformation of a public and social inter-gender conflict into a private and individualized intra-gender struggle".
(p.194).

Macswheen's central argument is that in anorexia the body and its appetites are transformed in an attempt to eradicate desire. Such splitting results in the body, or food, or the anorexia itself to be seen as alien. The sense of control by an external force is actualized in hospitalization where the anorexic woman becomes the object of medical control. The body, says Macswheen, is split in two: "the desiring body, in which appetite is lodged; and the desireless body, which needs nothing and wants nothing" (Macswheen, 1993, p.194).

Thus, following Macswheen, anorexia represents the social construction of the feminine body through objectification and the discipline/chaos dichotomy taken to its logical conclusion. Anorexia, however, is not simply an expression and transformation of social meanings. For Macswheen, it is also an attempt to resolve their contradictions. Through ritualized eating patterns, the anorexic aims "to create the surface of the feminine body as an absolute barrier and the body itself as an absolute object" (Macswheen, 1993, p.195). In anorexia, the concept of receptivity/penetrability as weakness and incompleteness is overcome by creating the body as a self-contained object which takes nothing in from the external environment.

Penetrability, argues Macswheen, must not just be understood as incompleteness but also voraciousness and potential encompassment. In anorexia, both meanings are reworked in the split between the body as 'desiring enemy' and 'desireless ally' (Macswheen, 1993). The ultimate aim of anorexia is the "destruction of the desiring body in which dangerous appetite is lodged, and the ascendancy of the object-body.

The aim is to create the body as an absolute object-inviolate, complete, inactive and initiativeless, wholly owned and controlled by the self" (Macswen, 1993, p.197).

The ultimate irony, for Macswen, however, is that the object-body comes to control the self. Starvation as a conscious strategy is itself transformed into an oppressor. The anorexic woman feels powerless to stop a process she herself began. The anorexic intends to be a fully individual subject, acting on the environment through the vehicle of the needless and inviolate anorexic body. Instead, the anorexic body remains "a mirage which she continually sees in front of her but never reaches. In the end, her individual transformation of the social meanings of the feminine body is no such thing. The object-status of femininity is reasserted. It returns with a vengeance" (Macswen, 1993, p.246).

The ultimate strategic failure of anorexia is for Macswen the attempt to resolve at the level of the individual body the irreconcilability of individuality and femininity in a bourgeois patriarchal culture. This very individualization of the anorexic solution is its failure.

Macswen (1993) clearly highlights that one cannot fully understand the anorexic symptom without an analysis of the structures of social meaning and social practices in bourgeois patriarchal culture. Macswen calls for a collective feminist engagement with those meanings and practices as 'social', in order to transform the oppression of women which leads to anorexia.

One of the major problems for feminist theorists, according to Robertson (1992) is that "we describe the oppression of women and the limits of medical discourse, then proceed to discuss the woman and her symptoms within parameters drawn from that discourse" (p.52). Robertson argues that feminist clinical practice must address the political and epistemological implications of these theoretical notions.

Critiques of feminist analysis and its use of psychoanalytic theory have also come from Marxists such as Wilson (1987). Wilson is critical of feminist psychoanalytic theorists such as Mitchell for remaining silent on the question of what political action women should take against their oppression.

For Robertson (1992), feminist critical scholarship on anorexia nervosa needs to be considered in terms of the questions raised by Foucault's work. Drawing from Foucault (1982), Robertson (1992) asks, "How can feminists challenge the power structure of male-stream knowledge without at the same time becoming entangled in reductionist concepts of the object, i.e. the anorexic?" (p.53). Robertson acknowledges that while the work of Orbach, Chernin, and Lawrence, have attempted to increase the knowledge about anorexic women in the face of mainstream psychiatric knowledge that mostly omits consideration of gender and power, and in so doing challenging the discourse within psychiatry, they do not challenge the fundamental assumptions about the form and function of these discourses themselves.

Foucault (1982) has documented the manner in which power and knowledge operate in a mutual relationship to define reality. Knowledge about subjects and objects in

culture is a function of a totalising process which accumulates information on particular groups in society, e.g. the anorexic, and then defines reality for that group (Foucault, 1982, p.213). Robertson (1992) thus asks: "How is it that there is a single, unitary group of women, with ascribed symptoms who are called 'anorexics' and analysed by feminists?" (p.54). Robertson answers that the totalised object, 'the anorexic', becomes netted down by some feminist theorists and therapists. Feminist theory, continues Robertson:

"assumes that 'anorexia' exists as a discreet entity and that it can be re-codified from a feminist perspective, thus giving the feminists the right to blow the whistle on the treatment of 'anorexics' and offer an alternative treatment for the totalised 'anorexic' object".
(p.54).

According to Foucault (1982), however, authorship gives the writer certain rights and privileges. The authority even of a critical knowledge exerts power over the object of that knowledge. Robertson is thus not arguing against the feminist theorists' desire in helping the anorexic understand that her individual problem is part of the oppression of women generally and a function of power imbalances between the genders in society. Robertson, however, is arguing that feminist theorists and therapist could benefit from a strategic use of the Foucaultian understanding of the process of totalising an object, in this instance, the anorexic, by warning that:

"We must be careful not to get caught in the juggernaut of speaking for the woman being treated for anorexia, who is seldom the originator of the discourse, but is instead its silent object".
(Robertson, 1992, p.54).

In 'What is an Author', Foucault (1979) argues that the truth of a discourse lies in the strategies which it brings into play, not simply in what it says. It is not sufficient, argues Foucault, to measure the value of a discourse in terms of what it explicitly states as truths. A discourse should also be evaluated in terms of the possibilities it creates for particular types of thought or action. Writers within a discourse establish their own theoretical validity in relation to the work of the discourse's founders. In this way, argues Robertson, the subject of the discourse does not become its originator but is analysed as a variable in the discourse. Thus Foucault's (1979) question in relation to a discourse is "What difference does it make who is speaking?" (p.160). In the literature on anorexic nervosa, Robertson (1992) maintains "that the voice of the woman who starves herself is rarely heard. Instead, others speak about her and for her".

The value of feminist exploration of language as the means of conceptualizing the self, is to highlight the insight that the woman who is diagnosed as anorexic is expressing herself in a language that is not neutral: "The meaning she finds for her weight loss is part of a lay and medical discourse dominated by male meanings" (Robertson, 1992, p.67). Language and the entry into the symbolic are based, for women, upon the adoption of a male view of the female body. Irigaray and Cixous challenge patriarchal ideology by proposing a feminine imaginary and plurality of femininity. Such a deconstruction of femininity helps in understanding the anorexic body as part of the code of meanings in Western patriarchal society. This code links the feminine body and its embodiment in culture to a construction of knowledge which relegates women to a subordinate position in society, simultaneously to depoliticizing gender and embodiment. Robertson (1992) claims, "the possibility of a woman's experiencing

anorexia nervosa is as much a result of her place within language and patriarchy as it is an indication of her 'pathology'" (p.69).

2.4 EXISTENTIAL VIEW

2.4.1 Ludwig Binswanger: The Anorexic Body and the Dread of Existence

Although Binswanger's (1958) report of Ellen West does not belong with feminist analyses of the anorexic body, it is placed here since his detailed account of the existential modes of the anorexic could be argued to fall under the heading of the denaturalization of the anorexic body.

In an extensive case study, Binswanger (1958) examines the underlying existential dilemma of anorexia. Drawing from personal contacts, previous medical history, extensive diaries, and poetic writings, Binswanger reconstructs the psychological development of a young woman whom he called Ellen West. Despite the fact that this famous 'Case of Ellen West' is not reported as an example of anorexia, it represents a detailed account of the existential modes of the anorexic.

The first datum which Ellen West's case history provides is the fact that "at nine months she refused milk, so that she had to be fed on broth" (Binswanger, 1958, p.270). This peculiarity and stubbornness in regard to eating runs throughout her entire life-history beginning in infancy. Binswanger argues that this is a peculiarity of 'sensory communication', not in the sense of a 'reflex' but of a behaviour toward the 'world'.

Thus, in this early refusal of milk, a line of demarcation is drawn between bodily *Eigenwelt* (own-world) and *Umwelt* (world around), a 'breach' in the uniting with the *Umwelt* in the sense that the former is set in opposition to the latter. Concurrently to this opposition to the *Umwelt*, there existed a resistance to those persons who tried to oppose Ellen's idiosyncrasies, showing that the upbuilding of the *Eigenwelt* proceeded quite clearly in sharp disjunction with the *Mitwelt* (with world).

With anorexia, there exists a resistance to the *Umwelt* and the *Mitwelt*. The *Eigenwelt* does not travel trustingly over into the *Umwelt* and *Mitwelt*, "to let itself be carried, nourished, and fulfilled by it, but separates itself sharply from it" (Binswanger, 1958, p.270). The anorexic experiences the *Umwelt* and *Mitwelt* as oppositional to the *Eigenwelt*.

Furthermore, whilst the anorexic's rigid assertion of the *Eigenwelt* may present as an expression of the fullness of existence, it represents in reality a constriction of the spectrum of existential possibilities. Such a stance towards existence is defined by Binswanger as defiance, which for him is always an expression of an existence that is not "open to the world" but is "fixated ("own-willed") once and for all, locked against or in opposition to *Um-* and *Mitwelt*" (Binswanger, 1958, p.271). The anorexic being-in-the-world as defiance and willfulness is therefore "no independent, authentic, or free self, but a self that is defined, though negatively, by the *Mitwelt*, a non-independent, unauthentic, and unfree self-in-a-world, a defiant-violent self" (Binswanger, 1958, p.271).

It is not only from the direction of the *Mitwelt*, however, that the anorexic is constricted, oppressed, and emptied out, but also from its own self, namely from that of its actual thrownness (*Geworfenheit*) into the role of woman. The open defiance and rebellion of the anorexic attempts at exchanging this fated role for an assumed role: "Ellen West plays only boys' games until her sixteenth year, likes best to wear trousers (at a time when this was not nearly as usual for young girls as it is today), and at the age of seventeen, still wants to be a boy, in order to be able to die as a soldier, sword in hand" (Binswanger, 1958, p.271). Here, the anorexic does not simply create a rift between *Mitwelt* and *Eigenwelt*, but a real though artificially bridged rift between the *Eigenwelt* and the "world-of-fate". Here, anorexic existence experiences a further much more incisive limitation in the unfolding of possibilities. Instead of assuming the role into which she is cast, the anorexic deceives herself and the *Mitwelt* as to this role: "Being is replaced by illusion" (Binswanger, 1958, p.271). The anorexic dodges her own burden. With the self-willed separation between the *Eigenwelt* on the one hand, and the *Umwelt*, *Mitwelt*, and *fate-world* on the other, "there go a certain own-worldly self-sufficiency, expansiveness and aggressiveness" (Binswanger, 1958, p.271).

In her eighteenth year, Ellen West expresses the wish to be petite and ethereal as her chosen girlfriends are. This wish casts its spell not only on the *Umwelt* and the *Mitwelt*, but also on the *Eigenwelt*. The *Eigenwelt* is the realm which Binswanger states "offers the most powerful resistance to etherealization by its very gravity, solidity, and compact filling of space, by its massiveness and opaqueness, that is, the body sphere" (Binswanger, 1958, p.277). Ellen's wish for the ethereal world cannot escape her existence in the body. The body for Binswanger represents "the identity of worldly

condition, my body, and of inner body-awareness, existence-in-the-body" (Binswanger, 1958, p.277).

Binswanger distinguishes between two senses of the word body: *Leib*, meaning the body as living, in the sense of the living body of a human being, and *Körper*, which refers to the body in its physical sense, the animate object on which the surgeon works. The anorexic's wish for the ethereal, anorexic existence overstrains itself by its own weight. Such an overstraining wish, Binswanger refers to as "off the beam", for here existence gets "off the beam" (Binswanger, 1958, p.277), not in a moralistic sense, but in an existential sense, into a situation from which actually no way back seems possible.

Of decisive importance at this point is the falling apart of "the world" into two irreconcilable worlds: "a bright, light, wide, non-resisting world, the world of ether, and a dark, massive, heavy, narrow and resisting world, the world of the earth or the tomb" (Binswanger, 1958, p.280). The body, in contrast to the soul, has historically always been assigned to the latter world. In anorexia, however, this assigning is, for Binswanger, not the outcome of a logical system, nor a result of a religious dogma, but is of an existential nature. Corporeality, as the quintessence of the material mode of being-in-the-world, linked to both matter and desire, is experienced in anorexia as a heaviness and as prison. Corporeality thus represents the sharpest contrast possible to lightness or ethereal existence. The ideal of slimness is for Ellen West basically the ideal of being bodiless. The dread of becoming fat, which manifests in her twentieth year, in Sicily, is seen by Binswanger not as a beginning but an end:

"It is the end of the encirclement process of the entire existence, so that it no longer opens for its existential possibilities. Now they are definitively fixated upon the rigid existential contrast between light and dark, flowering and withering, thin equalling intellectual, and fat equalling the opposite".

(Binswanger, 1958, p.281).

This gestalt loss moreover leads to a disturbed "temporalization". Temporality for the anorexic no longer runs into the expanse of the future but moves in a circle. The preponderance of the future is now replaced by the supremacy of the past. The anorexic's existence no longer points to the future, but circles in a present closed off from the future, ruled by the past, and therefore empty, as is symbolically embodied in Ellen West's life history in which she:

"keeps circling around her girlfriends who have stopped at a scenic point. Ellen West does not walk ahead and then return, since she cannot enjoy the present; nor does she dance in a circle around her companions which would represent a meaningful movement in the present, but she walks, that is, moves, as if she were striding forward, and yet she keeps going in a circle all the same".

(Binswanger, 1958, p.281).

In this connection, Binswanger notes that from her twenty-fifth year along with the dread of getting fat, goes an increased urge for sweets, such as seems to have existed in early childhood, even at that time probably opposed by a tendency to ascetic self-denial. Here too, demonstrates Binswanger, the existential maturing in the sense of authentic self-realization (*Selbstigung*) determined by the future, is replaced by the supremacy of the past, the movement in a circle and the existential standstill.

Ellen West's desperate defiance in wishing to be herself, reveals itself not only in revolt against her fate (her being-a-woman, her home, her social class, her desire for sweets, her tendency to get fat and, finally, her illness), but also in revolt against temporality.

Binswanger argues that insofar as the anorexic refuses to become old, in a word, fat, she tries to stop time, or, as the saying goes, "refuses to pay her tribute to time" (Binswanger, 1958, p.299). In the anorexic's stubborn adherence to her separate self, which Binswanger argues is not her real self but a "timeless" ethereal wish-self, the anorexic does not escape the ground of her existence, since this is not possible, but runs into it, as into an abyss. For Binswanger (1958): "Man can no more escape from his ground than he can escape from his fate" (p.299). However, with the anorexic, as is the case of Ellen West, the circular movement of existence is lived away from its ground, and back into it as into an abyss, then the existence exists in the mode of dread (Binswanger, 1958, p.299). The place of authentic maturing in the sense of becoming oneself, of the self-possessing of the ground, is replaced by the destructive mode of dread.

Thus, in the case of Ellen West, as with the anorexic, existence is ruled more by the past. The past weighing down the existence, depriving it of a future, encircling it in an empty present, robs existence of its authentic life meaning and existential opening. For Binswanger, when the life which is yet to be lived is ruled by the past, "we speak of old age".

As a young woman, the anorexic already becomes old: "The life-meaning of this *Dasein* had already been fulfilled in early years" (Binswanger, 1958, p.295). Existential aging hurries ahead of biological aging. The untimely suicide of Ellen West is explained by Binswanger as the necessary-voluntary consequence of this existential temporality. The being-a-corpse among people had hurried ahead of the biological end of life.

Binswanger's account is a refreshing analysis of the constriction and oppression of anorexic existence. Employing an existential analysis, common themes, such as the experiences of lacking in autonomy, power, and control, emerge as fundamental to the anorectic syndrome. However, the notion that anorexia represents a fight against one's fate, or thrownness, implies that the anorexic should let-herself-be-met by existential givens and forge an identity within them. This implies that it is the individual anorectic's distorted stance towards existence that is problematic, whilst ignoring the tensions and incompatibilities inherent in the social reality itself.

Moreover, given that the overwhelming majority of anorexics are women, Binswanger cannot account for why the existential dread of being-in-a-female-body should be so consistently expressed by the 'psychophysical garb' of emaciation, when men just as surely suffer from being-in-a-body and existential givens although in a different way (Dittmar *et al*, 1987).

2.5 CONCLUSION

Feminist discourses of the anorexic body have worked to redefine the anorexic body as a product of cultural meaning. These discourses are critical of the hierarchical binary relation between nature and culture in which bourgeois patriarchal culture freely imposes meaning on nature, rendering it Other. The claim that the anorexic body is a passive medium for cultural inscription falls into the very natural/cultural dichotomy that the feminist discourses oppose. Whilst it is feasible to argue that the anorexic body is historically and culturally contextualised, the reduction of the body as a whole to a purely cultural phenomenon, unwittingly perpetuates the dichotomy of nature and culture. Whilst it is correct to argue that there can be no pure body prior to culture, the feminist solution to the myth of a purely biological state prior to culture, is to posit a purely cultural state prior to nature, which is equally a myth.

The feminist critique of the metaphysical foundations of bourgeois culture and the attempt to free gender from the modern conception of a biological fixed body is important in attempting to understand the anorexic body. The privileging of culture over nature, however, reinforces the very same phallogocentric metaphysical structures that have contributed to the domination of women and nature.

This approach Merleau-Ponty (1968) terms the "bad dialectic" (p.94). The primary pattern of the bad dialectic is to create and maintain the I-other dichotomy. the movement of the bad dialectic defines one term as positive, another as negative, and a third term as the absolute suppression of the negative, as a new positive term. The dialectic is 'bad' from Merleau-Ponty's perspective, in that the first and second terms are

so distinct from one another that the only movement possible is an ambivalence, a static swinging back and forth that goes nowhere: "No third term can actually be posited, no new positive term can be established" (Merleau-Ponty, 1968, p. 94).

The bad dialectic accurately describes the historical actuality of discourses of the anorexic body. Both the naturalized and denaturalized discourses of the anorexic body is characterized by the I-other opposition. Allen (1982) describes this opposition as an "ontological catastrophe" (p.246), whereby two distinct discourses, the naturalized and denaturalized, confront each other across an ontological abyss, with the former privileging nature over culture, and the latter privileging culture over nature.

To better grasp the anorexic body, the body has to be 'renaturalized' so as to release it from a dichotomized nature and culture. A new discourse of the body is required that transcends and is prior to both the fixed biological body of the naturalized discourses and the culturally inscribed body of the denaturalized discourses. Towards this end, the "good dialectic" (Merleau-Ponty, 1968, p.95) that attempts not to solve but to transform the division of the I-other, needs to be adopted. The good dialectic is named by Merleau-Ponty (1968) a "hyperdialectic" (p.95) that is centered on a being "lying before the cleavage operated by reflection, not outside us and not in us, but where the two movements cross" (Merleau-Ponty, 1968, p.95).

The purpose of the present research is to demonstrate that Merleau-Ponty's work is useful in overcoming the difficulties inherent in the bad dialectic of the dominant discourses of the anorexic body. It is the aim of this research to demonstrate that his

work exemplifies the spirit of the hyperdialectic, and provides the grounding for describing an incarnate genderized body.

A meaningful discourse of the anorexic body, freed from the bad dialectic, that can articulate the anorexic body, neither just as a biological entity nor purely as a fleshless cultural construction, but as a hyperdialectic, as a flesh of the two movements, is needed. It will be argued that Merleau-Ponty's work can meet this need.

In order to achieve the goal of articulating the anorexic body in a language beyond the bad dialectic and provide a discourse that embraces the hyperdialectic, the research methodology most suited to this goal is that of grounded interpretive research. Grounded interpretive research is presented in the chapter that follows, as offering a method that is able to go beyond the subject data of the private subject by actively acknowledging the role of interpretation in its philosophy and is able to go beyond the objective data of the quantitative method, by acknowledging the involvement of the researcher in the research process. This methodology gives credence to the natural-cultural relational field within which the human participates, and is best suited to exploring the anorexic body that requires an acknowledgement of the cultural field of influences as well as the interconnected web of relations between the natural and the social. In this manner, the choice of method of investigation is congruent with the problem to be investigated, and fits the goal of the research.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 STATEMENT OF THE PROBLEM: THE FORESTRUCTURE OF PROJECTION

Historically in the West, vision has been a primary route to scientific knowledge. We speak of "knowledge as illumination, knowing as seeing, truth as light, throughout Western thought. The illumination that vision gives has been associated with the highest faculty of mental reasoning (Schievelbusch, 1986, p.159). Recently, however, the role of vision has come to seem problematic. Some have singled out reliance on vision as a key culprit in the scrutiny, surveillance, domination, control and exertion of authority over the body, particularly over the bodies of women (Oakley, 1984). Anthropologists have claimed that privileging of the visual mode of knowledge is particularly likely to lead to forms of representation impoverishing the complex whole that actually exists (Oakley, 1984).

In anthropology, a growing concern with the ways in which visual knowledge dominates the sciences, and how it affects the nature of what is known, has led to a new emphasis on hearing as a mode of perception. While 'visualism' has been castigated for objectification, the aural has been suggested as an alternative mode of perception which might avoid some of the problems associated with the visual. For Ong (1958),

a move to auditory metaphors would mean a move to more personal, existential, and human forms of knowledge.

Research in psychology has recently begun to pursue this line of thought. There has been increased questioning of the notion that research in psychology can be value free (Packer, 1985). Serious consideration has also been given to the possibility that traditional quantitative research in psychology can no longer be considered the panacea it was once believed to be (Stones, 1986). A fundamental reason for the increase in interest in qualitative methods is that standard quantitative methods have not been able to generate adequate understanding of the complexities of human experience (Polkinghorne, 1989).

Given the limits of the 'visualism' inherent in both causal empiricist and formal rationalist views, the present research aims to be more descriptive rather than explanatory, expressing its data in words, not in numbers, focusing not on the incidence and frequency of the anorexic body, but on the rich concepts and categories that will be generated by attending to the voices of the subject of the anorexic body. Towards this end, hearing will be privileged over seeing as the primary mode of taking in knowledge, and the participant observer will be replaced by the participant auditor, that now attends to voices that are multiple, comprising a polyphony of different sounds: "Polyphony is a better metaphor because it evokes sound and hearing and simultaneity and harmony, not pictures and seeing and sequence and line. They comprise a heteroglossia" (Michelson, 1987, p.432).

It is demonstrated that, for the purposes of the present study, a quantitative research approach which gives priority to the methodology as opposed to the phenomenon, is based on an inappropriate ontological reduction. The present research methodology finds its conceptual roots in Heidegger's (1927) hermeneutic understanding as documented in his seminal work, 'Being and Time', and the procedure for gathering and analyzing data for the purpose of generating a theory in the qualitative methodology called Grounded Theory as developed by Glaser (1978). Borrowing from Addison (1989), the present research methodology can best be termed grounded interpretive research. It is demonstrated that this combination addresses the inadequacies of traditional quantitative research methods, whilst grounded theory also benefits by grounding itself in Heidegger's interpretive framework. Furthermore, as is discussed in the present chapter, this combination is shown to be the most appropriate methodology to fit the problem and goal of the study.

3.2 AIMS OF THE RESEARCH

The present research is not only an attempt to add to the literature on anorexia nervosa. Whilst the phenomena of anorexia have been explored in the literature review and the medical and feminist responses to it have been demonstrated, the aim here is broader, namely to highlight the ways in which the contemporary discourses of the anorexic lack a comprehensive theory of the phenomenology of the body, especially important in the case of anorexia where the symptomatology is expressed and experienced at the level of the body. With this in mind, attention is drawn to the work of Merleau-Ponty (1963) who has perhaps contributed most to our understanding of the phenomenology of the

body. Merleau-Ponty attempts to recover a non-cultural, non-linguistic body that accompanies and is 'intertwined' with our cultural existence. His dialectical theory of the intertwining of subjectivity and the body is posed as an alternative to the Cartesian philosophy of the body. He provides the groundwork for understanding "embodiment" (Toombs, 1988) and for understanding the dialectical tensions between self and body which collapse when the meaning of body experience is 'split off' from awareness and the body and its practice become unconscious and symptomatic. His conceptual framework provides the groundwork for understanding the relation between body and meaning, and the present research aims at using his conceptual tools which he provides to deepen our understanding of the specific form of contemporary experience, namely the anorexic body.

More specifically then, the first goal is to obtain rich, accurate descriptions of the experience of the anorexic body from participants who have been diagnosed as anorexic and experienced the phenomenon. In order to illuminate the complex meaning of the anorexic body, the present research adopts the qualitative and exploratory approach of Seidman's (1991) in-depth phenomenologically based interviewing method which will be elaborated on shortly.

The second goal is to rigorously analyze this data so as to yield a general structure and account of the anorexic body experience. The interview protocols are analyzed by various coding procedures which form the bases of the grounded theory approach originally developed by Glaser and Strauss (1967) which are explained in the present chapter.

The third goal is to interpret the above general structure with reference to the already established body of ideas about the anorexic body (i.e. psychoanalytical, behavioural, psychodynamic, family systems, and feminist discourses) on the one hand, and in relation to Merleau-Ponty's (1963) notion of the 'lived body' on the other. It is hoped that this will lead to the advancement of new ideas about anorexic embodiment which will be more faithful to the experience of the anorexic body and better represent the difficulties which the anorexic has in attempting to understand/speak her symptoms. It is also hoped that such analysis will provide new treatment directions for psychotherapists.

3.3 PROCEDURES: SEIDMAN'S IN-DEPTH PHENOMENOLOGICAL INTERVIEWING

The word interviewing covers a wide range of practices. There are tightly structured interviews with pre-set, standardized, normally closed questions. At the other end of the continuum are open-ended, apparently unstructured, anthropological interviews that might be seen almost, according to Spradley (1979) as friendly conversations. The present research employs Seidman's in-depth phenomenological based interview. This method combines life-history interviewing and focused, in-depth interviewing informed by assumptions drawn from phenomenology and especially the work of Schutz (1967).

In the present research, open-ended questions are primarily used. The major task is to build upon and explore participants' responses to those questions. The goal is to have the participants reconstruct their experience of the anorexic body, and the meaning their experience had for them.

An important motive for using this model of in-depth phenomenological interviewing is that it provides a series of three separate interviews with each participant that allows both the interviewer and participant to plumb the experience of the anorexic body and to place it in context. Without context, there is little possibility of exploring the meaning of an experience (Patton, 1990). The first interview establishes the context of the participants' experience. The second interview allows the participants to reconstruct the details of their experience within the context which it occurs. The third interview encourages the participants to reflect on the meaning the experience holds for them.

3.3.1 Interview One: Focused life history

In this interview each anorexic participant is asked to describe her life up until she became anorexic, going as far back as possible. The specific question here is: "Could you describe in as much detail as possible your past experiences up until you became anorexic?" Here the participants are asked to reconstruct their early experiences that may have been significant in the evolution of their anorexic body.

The task here is for the participants to ground their experience of the anorexic body in the context of their life history.

3.3.2 Interview Two: The details of experience

The purpose of this interview is to concentrate on the concrete details of the participants' experience of their anorexic bodies. The aim here is not to elicit opinions

but rather details of their experience upon which their opinions were built. To this end, the participants are asked the following questions: "Could you describe in as much detail as possible the experience of your anorexic body?"; "Could you describe a typical day and weekend in your life?"; "Could you describe a typically bad day as an anorexic?"; and "Could you describe a typically good day as an anorexic?" Various other questions were prepared and asked according to the flow and tempo of this second interview.

3.3.3. Interview Three: Reflections on meaning

In this interview the participants were asked to reflect on the meaning of their experience.

The question of meaning addresses the intellectual and emotional connections between the participants' experience of their anorexic body and work and life. The question was phrased: "Given what you have said about your life before experiencing the anorexic body, and given what you have said about the experience of your anorexic body, how do you make sense of it all now?"

This making sense of making meaning required that the participants look at how factors in their lives interacted to bring them to their present situation. It also required that the anorexic looked at their present experience in detail and within the context it occurred. The combination of exploring the past to clarify the events that led the participants to their anorexic experience, and having described the concrete details of their anorexic

body, established the conditions for reflecting upon what the meaning of the anorexic body had for them. Thus, the third interview was only productive conditional upon the foundation of it having been established in the first two.

It should be noted, however, that even though it was in the third interview that the focus was directed to the anorexics' understanding of their experience, through all three interviews the participants are making meaning, as Vygotsky (1987) states that the very process of putting experience into language is a meaning-making process. However, in the third interview, meaning-making is the centre of attention.

3.3.4 The strengths and weaknesses of in-depth phenomenological interviewing

In-depth phenomenological interviewing allowed for questions to be repeated, enabled the interviewer to probe for additional information on pertinent themes, and allowed access to a wide array of verbal and non-verbal stimuli. The chances of misunderstandings were also lessened by the three-part serial nature, in that the interviewer and participants were able to adjust to the topic, the interview situation and develop good rapport. Having developed a sense of rapport with the participants and vice-versa, insight could be gained into the more sensitive areas of the participants' life. In brief, the in-depth phenomenological interview allowed for an exploration of the depth of the experience of the anorexic body, and provided a wide variety of perspectives.

From a critical stance, it was difficult at times to adhere to the three-interview structure as outlined by Seidman (1991). Whilst each interview serves a purpose both by itself and within the series, at times participants would give data that was the focus of another interview, and it was both tempting and difficult to maintain the focus and avoid forsaking the structure of the interview.

3.3.5 Spacing of interviews

The three-interview structure was spaced a week apart, allowing time for both interviewer and participant to reflect over the preceding interview but not allowing too much distance to avoid losing the connection between the interviews. Participants were involved with the interviewer over a period of two to three weeks, participating in a minimum of three interviews, and, at times, more than three interviews, as the situation demanded.

3.3.6 Selecting participants

Participants who were deemed pre-eminently suitable for participating in this research were those who:

- (a) have had experiences relating to the anorexic body, i.e. who are or have been diagnosed as anorexic;

- (b) were verbally fluent and able to communicate their feelings, thoughts and perceptions in relation to the anorexic body;
- (c) were of the same home-language as the researcher;
- (d) expressed a willingness to be open to the researcher.

A crucial aspect of the research process is "gaining entry" (Johnson, 1990). Once a potential participant had been identified in the various psychiatric institutions, and by colleagues who were able to provide assistance with identifying suitable participants, an appointment was arranged to explain the aim and process of the research. The researcher was careful to explain the aim of the study in a simple way without divulging information that might influence the informant's responses in any way. It was highlighted that the interest was in exploring how the participants experienced their anorexic body in the present and past, including milestones and crises in this process. Confidentiality was stressed, and the opportunity to work through painful issues that emerged, was also offered. It was in addition stressed that there were no expectations of right or wrong answers. If the participant agreed to be involved in the research, an appointment for the first interview was set up. After the initial interview, the process of coding the data was initiated.

Three participants whose ages ranged from early adolescence to late thirties and early middle-life respectively, who fitted the above criteria and who were seen to be able to provide data across the developmental stages, were chosen.

3.4 THE ANALYSIS OF THE DATA

The method of analysis used in the present research is essentially an editing style of analysis (Miller and Crabtree, 1992), and is based on the grounded theory approach which was proposed by Glaser and Strauss (1967), and further combined by Addison (1992) with Heidegger's (1927) ontological hermeneutics, to form what Addison (1992) calls grounded interpretive research.

3.4.1 Grounded interpretive research

The aim of grounded interpretive research is to build or construct a theory that is grounded in the data that emerges. In this process, data collection and the analysis of the data occur simultaneously. The core of the theory that emerges is an explanation of the social and psychological aspects of the phenomenon under study (Beck, 1990). The researcher is guided by initial hypotheses and is then continuously involved in a process of 'checking' or 'testing' these ideas as new data emerges (Schatzmann and Strauss, 1973, p.108). This circular process links for Addison (1992) grounded theory and hermeneutics.

For Addison (1992), as was the case in the present research, grounded theory was intriguing and attractive as a systematic inductive procedure for gathering and analyzing data for the purpose of generating a theory or account.

Although grounded theory addresses some of the inadequacies of positivist research methods, it does need to be complemented by the hermeneutic approach to allow it to mature as a more consistent interpretive and hermeneutic method of research. By briefly analyzing certain tenets and practices of grounded theory, its interpretive strength and limitations can be elucidated, and its usefulness for the present research can be demonstrated.

Both grounded theory and interpretive research adopt a procedure of constantly questioning gaps, omissions, inconsistencies, misunderstandings, and 'not-yet' understandings. This is a central feature and strength of both grounded theory and hermeneutic research, and very useful in understanding the participants' experience of the anorexic body.

An important contribution that both grounded theory and interpretive research can make to the understanding of the anorexic body is their recognition of the importance of context and social structure. Although Glaser (1978) is emphatic about the recognition of the importance of the context and conditions that contribute to social situations and their effect on social structure, Addison (1989) sharply notes that grounded theorists still employ a language of causes, contingencies, consequences, and co-variance terms, that connote a more mechanised view of social interaction than a fully interpretive approach.

A further complement that interpretive research can provide grounded theory is that interpretive research adds the pre-understanding of the researcher to the process,

making theory building a co-constitutive process. Although Glaser and Strauss (1967) stress that the process of theory construction involves being open to emerging data and not imposing a framework on this data, interpretive research maintains that it is impossible to approach research with no assumptions. The interpretive researcher is encouraged to make explicit a preliminary framework which, in accordance with the grounded theory, is revised as the research progresses. The important point for the interpretive researcher is not to impose meaningless, irrelevant observations on to the research. The interpretive researcher prevents this by integrating the preliminary framework with flexibility and theoretical sensitivity.

The argument against the grounded theorist, from the hermeneutic standpoint, is that grounded theory is an inductive process whereby the theory grows out of the data and is grounded in that data. In this manner, argues the hermeneutic researcher, theory becomes just the construction of the researcher. Here there is no recognition of the researcher's pre-understanding affecting perception and selection of data.

For Heidegger (1927), understanding is circular. The circularity of understanding is the foremost and most useful contribution that hermeneutics can make to grounded theory and to the present research in particular. For Heidegger (1927) any study of a new phenomenon always involves being thrown forward into it. This means that it is simultaneously understood and misunderstood. The phenomena is inevitably shaped to fit a 'fore-structure' that has been shaped by expectations and preconceptions, and by lifestyle culture and tradition, as is clearly the case with the anorexic body.

Understanding, for the hermeneuticist, always takes place within this horizon or framework that is 'projected' by human being, *Dasein* (Heidegger, 1927, p.17).

This does not mean, as Heidegger puts it, that the circle is a vicious one, simply confirming prejudices, but it is an essential one, without which there would be no understanding at all. Critics of interpretive research are concerned that interpretations should not turn out to simply reflect the prejudices and biases of the interpreter. This concern stems from a recognition of the potential for the hermeneutic circle to turn in on itself and atrophy into 'fore-structure' prejudice. This critic is a valid one, and raises a vital question for hermeneutics: How can the circle be both open yet complete? The answer lies in conceiving of the hermeneutic circle as comprising dialectically interacting 'arcs': a forward flexing arc and a backward reflexing arc (Packer and Addison, 1989). The forward and backward arcs continually inform each other, thereby keeping the circle complete but open. Establishing a point of view, a perspective, is the forward arc, and evaluation forms the reverse arc. It is in the dialectical interaction of these two arcs that the 'validity in interpretation' (Hirsch, 1967) question is addressed. What is emphasized here is the importance of appreciating both arcs of the hermeneutic circle: the forward arc of projection, and the return arc which shall be explicated as a movement of uncovering. The former makes understanding possible and the latter provides the possibility for evaluating an interpretive account.

Given the nature of the hermeneutic circle, the interpretive researcher would critique the naive realist assumption of the grounded theorist that claims to inductively discover some 'basic social process' that 'emerges' to accurately describe, at a theoretical level,

something that corresponds with 'reality' (Addison, 1989). Interpretive research emphasizes that the circularity of understanding implies that the researcher cannot act value-free, who can objectively see things as they 'really are', or that the data is collected independently of the researcher (Addison, 1989, p.47). Interpretive research takes into account the impact of the researcher's pre-understandings in reporting the 'theory' that emerges. This is of particular importance in attempting to understand the experience of the anorexic body.

Whilst grounded theorists admit to changes in the perspectives of the researcher while doing research, this change is limited to the researcher's learning about the world of the participants rather than examining changes in the horizon of pre-understandings. Following Gadamer (1976) in interpretive research, the researcher's understanding of the situation transforms the researcher, the participants and setting in a widening of horizons.

Despite the abovementioned shortfalls, grounded theory provided the present research with a method of systematically developing a processual contextual account of the anorexic body. This method, combined with the hermeneutic back-up of Heidegger (1927), collectively coined, grounded interpretive research, was the method of choice for the present research, deemed most fitting to research the complex issue of the anorexic body.

Grounded interpretive research was chosen for the present research because the research is concerned with laying the groundwork for the development of a theory of the

anorexic body. The research thus begins with a fore-structure, a preliminary framework provided by the theoretical constructs and categories underlining the theory of the body as expounded by Merleau-Ponty (1962). The aim, however, is not to prove the existence of these categories but rather to allow them and other categories to emerge in whatever form or content, from the data, so that important themes and processes pertaining to the anorexic body can be identified.

3.4.2 Data reduction through open coding

Grounded theory is based on the comparative method of analysis (Glaser and Strauss, 1967). The basis of comparative analysis is the coding of data. The purpose of coding is to identify the underlying patterns or themes that emerge from the data (Beck, 1990). Coding involves two vital processes, namely making comparisons and questioning the data. As the researcher codes the data questions such as: What is this? What does it mean? How important is it? are asked, and the data is compared to identify similarities and differences (Strauss and Corbin, 1990).

This process of editing the data to make it more meaningful has been referred to as "data reduction" (Miles, 1983). Data reduction begins with the researcher attempting to make sense of, and organise, the many pages of transcribed interviews (Patton, 1990). In the present research, this process began with the transcribing of audio material into the written form, and reviewing the transcripts a number of times. Edwards (1993) suggests a number of other points concerning data reduction relevant to the present study. This includes removing repetitious material from the transcript and

synthesizing similar material from different sections of the transcript. It also involved purposefully selecting data without intentionally omitting material, and rendering of the data in a manner that is as "economical and succinct as possible" (Edwards, 1993, p.15).

An important step in data reduction is clustering or grouping concepts that have similar characteristics or patterns (Miles and Huberman, 1984). An important feature of grounded theory is to first label incidents or events in the protocol and then group the incidents together into higher level categories (Strauss and Corbin, 1990).

The categories in the present study were generated by 'in-vivo' coding (Strauss, 1987). These are words and phrases used by the participants themselves which form various categories. The main criteria for coding is the relevance these categories have for the anorexic body. Coding was also used for the manifestation of any other 'marker' events.

3.4.3 Developing the theory through axial coding

The initial coding of data is followed by a more thorough and comprehensive axial coding. Axial coding involves adding richness and density to the categories by more thoroughly defining the characteristics of the category. Through this process, changes and differences in the emergence of categories, as well as the relationship between categories, is explored (Strauss and Corbin, 1990).

As in the initial coding, questions and comparisons such as the following are an integral part of the process: Is there evidence for the relevance of this category and other categories? What conditions, and what is the context, that lead up to the emergence of this category? How does this category change over time? What variables can be identified that have given the category variation? (Strauss and Corbin, 1990).

Axial coding as used in the present research involves writing a synopsis under the heading of each category that emerges, taking into account the abovementioned questions. Axial coding is also done by comparing the categories of each informant's protocol so that similar themes, as well as differences, are identified.

3.4.4 Grounding the theory through selective coding

As the conceptual framework develops, the researcher begins to collect data in a much more selective way, so as to fill the gaps in the emerging theory. The researcher is then faced with the task of integrating all the data into a grounded theory.

Simply put, integration of the data involves the identification of a story. Again, the researcher is guided by such questions as: What is the central process in the structure of the anorexic body that integrates the who, what, where, when, and why, of the participants' experience? To understand the story, analytically, the researcher establishes a story line which entails stipulating a core category. This core category is the central phenomenon that encompasses the whole story. Once the properties of the core category have been stipulated, the other categories called subsidiary categories

must be related to it. "The core category must be the sun, standing in orderly systematic relationship to its planets" (Strauss and Corbin, 1990, p.124).

A central task of analysis is to uncover the patterns and relationships that exist between categories and properties of categories. Any statement regarding relationships among categories must be validated by establishing whether the statement applies to each participant in the study.

In the present research, the emerging theory is continually tested with the data that emerged from the interviews. The core category in the present research is the anorexic body. The subsidiary categories are all the important categories that emerge from the interviews with all the informants.

3.5 FRAMEWORK FOR ANALYSIS

The framework for the analysis of the data in the present study is adapted from Seidman (1991), and attempts to be consistent with grounded interpretive research. This framework involves five stages:

- Developing a narrative account;
- Developing an interpretive account;
- Refining of the interpretive account;
- Collective interpretation;
- Comparative interpretation.

3.5.1 Stage 1: Developing a narrative account

The narrative account is purely descriptive, and describes the evaluation of the participants' life in the context of the anorexic body. This account refers to the nature and dates of marker events in their development of the anorexic body. As such, it provides the context that highlights crucial points in this process, and is similar to Seidman's (1991) Part 1 interview content.

3.5.2 Stage 2: Developing an interpretive account

In this stage, extensive use is made of open coding to reduce data to a more manageable form. Observations and insights relevant to the anorexic body are noted in the left-hand margin of each protocol.

The researcher is specially aware of important changes in the narrative that relate to the life structure. This could be a feeling expressed by the participant, a sentence communicated with much emotion, or a comment on a crisis or turning point.

3.5.3 Stage 3: Refining of the interpretive account

In this stage, more comprehensive axial coding is used, which involves the construction of an interpretive summary of each participant's life. At this level, the analysis is done per participant.

3.5.4 Stage 4: Collective interpretation

The aim of this stage is to develop a collective interpretation of the anorexic body by comparing each participant's protocols and looking for similarities and differences. Here category development does not occur per participant, but involves the development of a model of anorexic embodiment which represents the integration and explication of categories as they emerge collectively.

3.5.5 Stage 5: Comparative interpretation

The fifth stage involves a comparative interpretation of the present theory with reference to Merleau-Ponty's (1962) notion of the lived body on the one hand, and the already established ideas about anorexia (i.e. psychoanalytic, behavioural, psychodynamic, family systems, and feminist discourses) on the other hand. This comparison does not occur per participant, but compares the theory of anorexic embodiment that collectively emerges from the previous stage, with already established theories.

3.6 EVALUATING GROUNDED INTERPRETIVE RESEARCH

Within grounded interpretive research, validity is not a matter of correspondence between a theory or account and the way things 'really are'. Heidegger (1927) provides a new interpretation of what truth is that strips away metaphysical notions, and is grounded in practical concerns. Heidegger demonstrates that the truth of an interpretation, a theory, or even a practical activity, is a matter of uncovering. This

uncovering of an entity is the return arc of the hermeneutic circle; it is the response to our inquiry (Addison, 1989).

For Heidegger, a good interpretation does not show things as they really are. What is uncovered in the course of a true interpretation is a solution to the problem, the confusion, the question, the concern, and the breakdown in understanding that motivated the inquiry in the first place. In Heidegger's view, a good interpretation will not provide "validated knowledge, or timeless truth but instead an answer to the practical or existential concern that motivated our inquiry" (Packer and Addison, 1992, p.279).

Rationalist and empiricist critics of interpretive research have questioned the methods used for determining "validity in interpretation" (Hirsch, 1967). The worry here is that the interpretation should not land up reflecting the prejudices and biases of the interpreter. This concern stems from the recognition of the potential for the hermeneutic circle to turn in on itself and atrophy into 'forestructure' prejudice. This criticism is valid and begs the vital question for hermeneutics: How can the circle be both open yet complete?

The answer lies in conceiving of the hermeneutic circle as comprising dialectically interacting "arcs": a forward flexing arc and a backward reflexing arc (Packer and Addison, 1989). The forward and backward arcs continually inform each other thereby keeping the circle open but complete. The former makes understanding possible, and the latter provides the possibility for evaluating an interpretive account.

Based on the above, the present grounded interpretive research borrows its framework for evaluation from Sandelowski (1986), and considers four factors: truth value, applicability, consistency, and neutrality.

- (a) Truth value in the present research will concern itself with the accurate description of participants' experiences as they are lived and perceived in the research. The effects of maturation and experience are irrelevant, because a change-over time is assumed, and the present research observes change in its historical context.
- (b) Applicability in qualitative research is the equivalent of generalizability in quantitative research. While the sample size in the present research was typically small, applicability can be achieved when the results of the research shed light on or fit into contexts outside the research situation. In grounded interpretive research, the exemplars and paradigm cases may shed light on other situations that have quite dissimilar objective characteristics. The representativeness of the sample is replaced by the representativeness of the recurring themes and patterns identified by the study.
- (c) Consistency replaces reliability in the present research. For the grounded interpretive researcher, the fact that subjects exist in time means that a study can never be replicated exactly just as history can never be recreated exactly. The consistency of the present research is

established by the presentation of sufficient data from the text analogues to enable the researcher reader to participate in the consensual validation of the data.

- (d) **Neutrality** - The present researcher approached the study with an interest in both the works of Merleau-Ponty and the being of the anorexic that was informed by his own reading and psychotherapy practice. Such horizons of interest were not denied, but made explicit through self-awareness and checking with participants whether interpretations made of their data were not distorted totally by the researcher's bias, interests, and purposes. In quantitative research, the researcher is assumed to have an objective, disinterested stance with regard to the study. In grounded interpretive research, it is assumed that there can be no detached objective position from which to study human beings. The researcher is a self-interpreting being thrown forward into the research, as is the subject.

3.7 SUMMARY

The present chapter has outlined the research methodology to be used in this study, including the procedures used for gathering and analysing the data. In the chapter that follows, the results are presented, and a discussion of these results form the content of the final chapter of the thesis.

CHAPTER 4

RESULTS AND DATA ANALYSIS

The results of this study are presented in this chapter, in the form of a narrative account of each participant that captures the nature and dates of marker events in their development of the anorexic body. This is followed by the presentation of an interpretive summary of each participant's experience. Following the framework proposed for analysis in the methodology section, the next stage is a collective interpretation of the participants' data whereby the data is compared by noting differences and similarities in their experience of anorexic embodiment.

The process of anorexic embodiment and explication of categories as they emerge from the data and analysis are presented.

4.1 NARRATIVE ACCOUNTS

4.1.1 Narrative Account of Participant D

Identifying Information

Participant number	:	D
Age	:	40 years
Marital status	:	Married
Children	:	4 sons
Family of origin	:	Middle child, older and younger sister, both parents deceased
Socio-economic background	:	Upper class
Language	:	English-speaking
Highest Educational Qualification	:	Matric
Occupation	:	Personnel Consultant
Referred by	:	Colleague in Clinical Practice
Diagnosis	:	Anorexia Nervosa
Age when diagnosis was made	:	19 years old

Introduction

D was located through a friend of the researcher. Five interviews were held over a period of four weeks, at the researcher's office. D was chosen for the research, as she had been diagnosed with anorexia nervosa and was very willing to discuss her experience. Prior to the second interview, D provided the researcher with drawings and growth exercises that D had produced during her year-long hospitalization. D felt that these drawings captured her experience, and they formed the content of the second interview. D displayed a high level of psychological intellectual insight into her illness,

and was a very eager participant. The data produced by D revealed that D had experienced a severe form of anorexia nervosa and had received intensive treatment.

Biography: The life of D

D is a 40-year old, observant Orthodox Jewess, married, with four children. D is English-speaking from a middle socio-economic background, and runs her own private personnel consultancy. D is married to a practising clinical psychologist. Both her parents are deceased, and D is the middle child in a family of three daughters.

At the age of 19, D was hospitalized for a period of one year. At the time of admittance, D weighed 32 kilograms, had ceased menstruating, was in the routine of disposing food and was no longer able to cling to her assertions that she was indeed perfectly well and not too thin. D had developed an intense aversion to chewing or swallowing food herself, which induced a crisis whereby D's condition had reached critical proportions where D was near death.

Intravenous therapy and tube-feeding was administered for a period of three weeks. During this period, D developed a very special reaction to her nasogastric tube and was quite prepared, even happy, to accept food given to her through it. During her hospitalization, D presented sufficiently depressed to warrant treatment with anti-depressants, and anti-psychotic medication was also administered to treat her delusional thought process.

Initially, D was placed in a general ward but, due to her intense avoidance and aversion to eating, that resulted in D developing a critically low weight, D was moved to a private room and monitored on a strict behavioural management programme. D spent three months in this room and was denied basic privileges, such as bathing, washing hair, visitors, and mail.

D had grown resentful at the isolation she had imposed upon herself, and was angry at the nursing sisters for denying her basic rights. D realised that this isolation was self-imposed as a result of her food-refusal, and understood that she needed to comply with the treatment demands. D desired to be allowed to wash her hair, wear her own clothes, receive visitors, receive mail, and be given a weekend at home. Given this motivation, D began to voluntarily chew and swallow food. With the concomitant weight gain, D was permitted to participate in art therapy, occupational therapy, growth games, and finally was allowed a weekend at home.

After a one-year hospitalization, at the weight of 52 kilograms, D was discharged from hospital and instructed to leave her home of origin and live independently. D was able to move out of home and to another province as a result of the support she received from the Orthodox Jewish community with whom D had become aligned. D's increased interest in Orthodox Judaism began in the latter half of her hospitalization, motivated by the constant input of the hospital Rabbi who would visit D during her hospitalization.

D describes her anorexic process as a gradual, slow process over a period of three years that was precipitated by the sudden loss of her father due to a heart attack. At

that stage in her life, D was 17 years old and was busy preparing to write her Matriculation examinations. D experienced an intense period of mourning and grieving for her father, characterized by suicidal ideation and depressive symptomatology. D could not come to terms with the fact that her father 'was just a body that could be put in a box and buried'. When it rained, D would fear that her father was getting wet, and expressed a desire to 'join him'. D reported that she was not the personality type that could relieve her pain at this loss through drugs, alcohol or suicide, and began expressing her grief through food restriction and wearing black clothes.

Following her father's death, D now moved into her mother's bedroom, and shared that living space with her. In the absence of her eldest sister who was studying medicine and living at the University residence, D became the caretaker of the home. D was forced to get her driver's licence as her mother never drove, and was pressurised into completing her Matric. D experienced tremendous anger and resentment towards her mother for not being able to 'steer the boat', as she put it. For D, the 'boat was rudderless', and 'I had to become father / mother / husband in the home'. Simultaneous to these added responsibilities, D was experiencing suicidal ideation and depression at the loss of her father.

Prior to her marriage, D was involved in one heterosexual relationship with a member of her synagogue, who was twelve years her senior. D reported that this relationship was terminated when her partner refused to continue playing out a parental role, and sought a more mature adult interaction. Until the age of seventeen, D experienced a sense of satisfaction by remaining in the embrace of the relationship with her father and

not venturing out of home to participate in extra-mural activities or with peers of her own age. D also reported a sense of rivalry between her and her mother, for the attention of her father.

It was the intensity of the overprotective quality of the dependent relationship between D and her father that rendered the loss so severe for D to overcome. Focusing on her family relationships, D described her mother as a weak, helpless and inadequate personality, exhibiting behaviour more like that of a child than a mother and wife. D identified her mother's upbringing in an orphanage and her lack of socialization as the contributory factors in this personality style. D reported a very poor relationship with her mother, who favoured the eldest daughter, due to her academic functioning and independent conduct. D, on the other hand, did poorly scholastically and was diagnosed as epileptic at a young age. D reports that her mother would refer to D as a 'shame and embarrassment to the family'.

Given the sense of rejection D experienced in relation to her mother, D developed an intense sibling rivalry with her sister and a very dependent relationship with her father. D described her father as a strong, successful, domineering character, both at work and at home. D's father spent a lot of time doing homework with D and helping her to overcome her feelings of low self-esteem and inadequacy. D's father was supportive of her and sided with her in family conflicts. D describes her relationship with her father as emotionally supportive and all-encompassing. D describes her elder sister's relationship with her father as more competitive and intellectual.

Within this family context, D acknowledges that she developed an inadequate and dependent personality similar to that of her mother. She reports never having experienced teenage years, like her sister, in that she did not date, sleep-over at friends, or rebel at all, like her sister.

Following the loss of her father, D assumed the role and responsibility as caretaker of the home, with much resentment. Faced with the responsibility of mothering/fathering her mother, unable to overcome the grief at the loss of her father, D turned to food restriction as a means of expressing her suicidal intent. D reports that she did not set out to become anorexic, but found herself there through a gradual process of restricting caloric intake, abuse of laxatives, and excessive exercise.

D put into symbolic form her state of mind, through various drawings, which captures the process of anorexic embodiment as D experienced it. These drawings were produced during an occupational therapy session, during D's hospitalization, and were presented to the researcher after the first interview.

D describes her body as that of a woman in a foetal position (See Appendix). D explained that whilst this may sound very confusing and illogical at first, this figure describes her experience of anorexia. D describes her body as that of a foetus, totally helpless, dependent, and unaware of her feelings, reporting that when she was finally hospitalized, she had reduced her body to such proportions that she was unable to do anything for herself. At this stage, the foetal nature of D's body was described by D, whereby the tube-feeding was experienced by D as the umbilical cord, and the sisters

on the ward were experienced as her mother's. D was totally dependent on them for being washed, fed, even turned side-to-side every hour on the hour to prevent bed-sores.

Simultaneously coexisting with this foetal body, D describes the woman in a foetal position. The woman aspect of this figure was described by D as the responsible compliant daughter who compensated for the absent father due to the latter's death by running the home, closing down the family business, and compensating generally for her mother's inadequacies. In this regard, D reported experiencing intense anger at the accusations made towards her body as being that of an infant:

"How could anyone accuse me of being an infant if I had been such a support to my family after dad died? The cheek of it!! Hadn't I successfully managed to replace dad in the home? Everyone had told me what a model daughter (or should I say "husband/father"!!) I had proved to be, and here I had the staff and my therapist denying that!!! I was so blady angry at the time but I was only a child, a very small, helpless child".

Regarding her recovery, D reported that this started very slowly, the day the helpless child was hospitalized. Her hospitalization is cited as the first step in her recovery. As she began to grow strong physically, as a result of the behaviour programme and her 'mothers' in the hospital, D began to work on her emotional growth by leaving home and functioning independently. In order to do this, D reports that,

"I had to admit to a lot of painful truths, a lot of concealed and crushed anger towards my parents, and, of course, the painful realization and eventual acceptance of my womanhood."

It was her discovery of Orthodox Judaism and sense of belonging to a community of people, other than her immediate family, that created the 'space for me to breathe and grow'.

Currently, within her marital relationship, D still continues to restrict her food intake, adhering to a strict vegetarian diet and excessive coffee-drinking to inhibit her appetite. Being an integral part of a Jewish Orthodox community, D entertains others excessively and is known to refuse reciprocal invitations and is unable to dine out. D continues to attend daily aerobic classes and runs a busy personnel consultancy.

D maintains that although she is no longer in physical danger of requiring hospitalization for her disorder, she remains, in thought and behaviour, anorexic. The factors preventing a relapse are her responsibilities as a wife, mother and career woman. The risk of a relapse emerges when D is 'burnt-out' from her responsibilities and many activities, desiring then to return to her previous anorexic state of a helpless child. In this instance, D begins to increase her food restriction, exercise, and withdraws. D, however, has never needed any further hospitalization, but does attend intermittent psychotherapy sessions, when she becomes aware of her anorexic pattern starting to own her.

4.1.2 Narrative Account of Participant B

Identifying Information

Participant number	:	B
Age	:	38 years
Marital status	:	Presently separated for past three months
Children	:	4 sons
Family of origin	:	Only child, father deceased
Socio-economic background	:	Middle class
Language	:	English-speaking
Highest Educational Qualification	:	B.A. Honours degree in Psychology, Honours degree in English
Occupation	:	Free-lance market researcher
Referred by	:	Colleague in Clinical Practice
Diagnosis	:	Anorexia Nervosa
Age when diagnosis was made	:	27 years old

Introduction

B was located through a colleague of the researcher. Four interviews were held over a three-week period. B was chosen for the research because of her unusually late diagnosis of anorexia nervosa at the age of 27, and, unlike the other research participants, B did not require hospitalization. At the time of interviewing, B weighed 47 kilograms, was well-groomed, wearing thick make-up, and noticeably tanned even though it was the winter season. It was clear that B paid attention to her appearance.

Rapport was easily established, and B reported being able to articulate and reflect on aspects of her past, for the first time.

Biography: The life of B

B is a 38-year old married female, mother of four children, who has currently been separated from her husband for the past three months. B's father passed away when B was 22 years of age, after suffering a long-standing organic brain disorder. B's father had a short occupational career as a clerk in a financial business, but was boarded early in his career due to his organic condition.

B's mother worked as a housewife. The family were able to maintain a high standard of living based on an inheritance and money they received from a disability pension.

B's father was described by her as a submissive and physically ill figure, who was dominated by her mother and absent in the father-daughter relation. B's mother was described as a very selfish, manipulating figure who was intent on spoiling B's plans and development. B described a very poor non-communicative marital relationship between her parents. B reported receiving the message from her mother that she had disrupted the household, in particular her parents' marital sex life, following her birth.

During the course of marital therapy, B's weight of 40 kilograms was apparent to the clinical psychologist, and she was referred for psychiatric intervention, where she was diagnosed with anorexia nervosa. Denying the seriousness of her current low body

weight, B refused hospitalization, but undertook intensive outpatient treatment. At that time B was 27 years old and exhibited typical anorexic behaviour that manifested in: ritualistic running every morning that eventually became addictive for B; peculiar behaviour at meal times, whereby B would cut her food into small pieces and spend a great deal of time rearranging the food on her plate, pretending to eat, and attempting to survive each meal-time without food-intake; markedly decreased interest in sexual relations both with her husband and lover at the time; and an inability to relax or enjoy free time, filling her day with activities surrounding her children and working through the night as a free-lance market researcher, surviving on coffee and intake of tablets to sustain her attention and concentration.

In this regard, B described her inability to enjoy or partake of any comforts:

“Human needs, or the meeting of human needs were way out of my agenda; food, sleep, comfort, soft comfortable chairs, a place at the dinner table, tucking up in bed, rubbing aching muscles, soothing cuts and grazes, were all things I tirelessly provided for others, almost forced on others, but certainly had no need for myself”.

The most gratifying moments for B were described as those moments spent in energetic activities,

“mostly running, as far as I could, in the early hours of the morning, rain or shine. There is never time to stop and feel the moment. Those were years spent running”.

In describing her experience of anorexia, B describes it as:

“the single-most powerful experience of triumph. Anorexia gave me a new identity. An identity that pleased me. An identity that put me on a par with ordinary girls. Ordinary girls

were thin, athletic, energetic, and I was now being labelled anorexic which surely epitomizes these qualities in the extreme. Despite overt denial, I knew I had something, some powerful secret inside me”.

B reported that this pursuit of 'ordinariness' had its roots in her early childhood and upbringing, where B experienced herself as extraordinary. Unlike most of her neighbours, B was born to elderly parents, was an only child, and attended the catholic school, rather than the public school in the area. B reports that 'I had to wear this different uniform and they all went to the government school wearing the same uniform, doing the same things, playing the same sport, and I was at this strange place behind high walls.' B further reported that she was 'fatter' than her friends in primary school, an issue her mother reinforced by refusing B delicacies and luxurious foods at an early age. A further contributory factor to B's extraordinariness was her academic excellence at school which allowed her to skip two grades. She was placed in a class where she was the youngest pupil by two years.

The first attempt at ordinariness for B occurred in her Standard 9 year. B attempted to fail that year by refusing to answer the examination questions. The teachers reported that B was experiencing a bad spell, and B was promoted to Matric where, at the young age of 15, she was made head girl.

B describes a poor social life during her schooling years, being unable to entertain friends at her home due to her father's illness. The friends she did have at school were described by her as 'the rebels of the class', and she experienced pleasure in this association.

Following her Matriculation, B was offered a scholarship as an Exchange Student. Despite all the arrangements being confirmed, B's mother would not allow this opportunity, offering B a vacation with her parents overseas. Here, B spent four months with her maternal grandmother and parents. Upon returning home, B arranged a job as an air-hostess, and this was again prohibited by B's mother, describing this vocation as a 'career only for whores'.

Having unsuccessfully attempted her own choice of career, B complied with her mother's request and enrolled as a BA student in Drama and Psychology, which was a far more 'normal' choice for B in the eyes of her mother. The advantage for B, however, was that she received a bursary from the University and was able to leave home by taking up residence at the University.

During her second year of study, B was refused a role in a play, and told that she was 'too overweight'. Living on her own at the University residence, B began restricting her food intake by missing meals and surviving on fruit and coffee. B also began attending regular aerobic classes, at times twice a day. By the end of her third year studying, B was awarded the title of Rag Queen of the University.

Unlike her parents who married late and bore one child, B married an accountant, at the age of 22, and in quick success had four children. B now immersed herself in being a mother, and completed an Honours degree in psychology as a part-time student. B also involved herself in working part-time as a free-lance market researcher.

B described the first two years of her marriage as satisfactory, but complained thereafter that her husband was emotionally absent and not meeting her needs. All her achievements as a mother, student and career woman were not acknowledged, and B reported feeling lonely and detached from her spouse. B's spouse was diagnosed with major depression, and a course of anti-depressants was prescribed. B experienced tremendous disappointment when her husband disclosed that he was homosexual and desiring a relationship with a member of the same sexual orientation.

During a renovation of the house, B began having an extramarital relationship with the building contractor, that triggered her anorexic behaviour. B described him as a 'fit healthy man who loved jogging'. A major part of their relationship involved running together during the week, and participating in the various arranged races on the weekend. B enjoyed the compliments and acknowledgment she received for her achievements as a runner, and enjoyed his admiration of her success in her career. In order to remain attractive to him and secure his compliments, B began to diet excessively, pretending to eat at meal-times, restricting her intake to vegetables and fruit. B also developed an addiction to running, whereby she would not miss a day and was compelled to cover more kilometers each day.

B's overactivity was depleting her energy. She was unable to maintain the pace she demanded of herself. At the risk of 'burn-out' and at a weight of 40 kilograms, B voluntarily sought treatment, although presenting the issue as a marital problem. B described the insights she gained from individual psychotherapy as the decisive contributory factor in her healing. Through visualization exercises, B gained insight into

the dangers of her behaviour pattern, the self-indulgence it demanded, and the price the family were paying for her ambition. B was made aware that she did not have to go to such great lengths to experience a sense of ordinariness.

Currently, B is still jogging and enters weekend races. She partakes of food as a strict vegetarian. B intends enrolling for a Masters degree in psychology. Regarding her marital relationship, B reports intentions of filing for divorce. For a period of three years, B ritualistically followed this rigid diet and jogging schedule, achieving in her own words, 'a body that was hard as a nut', and a weight of 40 kilograms. This triumph for B was the ability to be anorexic in thought and behaviour without requiring hospitalization, nor having to resort to laxative abuse, diuretics or self-induced vomiting.

The laxatives in B's life, as she reported, were a:

“relentless involvement in activities requiring superhuman power, that had no time for gluttony, no sloth, no idleness, no self-indulgence. The pursuit never ended - not during sleep, not during meal-times, not social times or ever. I was constantly driven”.

Regarding her extramarital affair, B has become aware that she was involved in a relationship of control, conditional upon a certain type of body and way of being, which in essence was not dissimilar to her early experiences with her mother. This relationship has thus been terminated, and B lives as a single parent with her children. B experiences a sense of tremendous gratitude at being able to experience an existence that is less driven.

4.1.3 Narrative Account of Participant C

Identifying Information

Participant number	:	C
Age	:	21 years
Marital status	:	Single
Children	:	None
Family of origin	:	Single child, both parents still living
Socio-economic background	:	Lower class
Language	:	English-speaking
Highest Educational Qualification	:	Matric
Occupation	:	Secretarial / Administrative
Referred by	:	Colleague in Clinical Practice
Diagnosis	:	Anorexia Nervosa
Age when diagnosis was made	:	19 years old

Introduction

C was located through a colleague of the researcher, and was interviewed on three occasions over a period of three weeks. During these interviews, C was able to be open regarding her experience of anorexia which was 'still fresh' in her mind, as she described it, volunteering information in a non-defensive and compliant manner.

At the time of interviewing, C weighed 57 kilograms, and reported to be in a recovery phase, although 'fearful of hitting the big 60-kilogram mark'. C came across as a fragile and timid young girl, wearing baggy clothing to all of the interviews, and spoke in a soft

voice. C reported that she was pleased to be participating in the study, expressing a desire to use her experience to benefit others suffering from the disease.

The arrangements for the interviews were all done by participant C's mother. C was further requested to phone home on arrival and departure from the interviewing venue.

Biography: The life of C

C is a 21-year old English-speaking female who currently lives with her elderly mother and father in a small home in a working class neighbourhood. C is an only child. C's mother works as a receptionist, and her father has retired from his employment as a technician in the telecommunications industry. C is currently employed in the administrative section of a rental company working in close liaison with her mother.

C was diagnosed with anorexia nervosa at the age of 19, and was hospitalised for a period of six weeks at a specialised psychiatric unit. At admission, C weighed 45 kilograms and was unable to control her dieting. At this stage, C reported feeling terrified of gaining weight, and would only eat a bit of toast in the morning and a spoonful of food at night. If C did eat, she would experience tremendous guilt that was relieved by abuse of laxatives.

C's food restriction began by eating less at dinner, whereby C would mentally create a boundary with her knife and draw a line where she would eat, and hide the rest of the food in her pockets, which she would later flush down the toilet. The food that C was

unable to flush down the toilet was kept in a container in her cupboard and was thrown out in the dustbin while her parents were asleep. Such eating behaviour soon generalized to breakfast meals and all food intake, resulting in a loss of nine kilograms over a four-week period. Once C had dropped from 57 kilograms to 48 kilograms within a month, it became a 'challenge' each week for C to lose another kilogram. C reports experiencing 'an unexplainable high, standing on the scale and seeing the needle drop and drop'. C now aimed for the 46 kilogram weight as her goal, achieving this goal in a month through further stricter food restriction, as well as laxative abuse that increased from eight tablets a day to thirty tablets a day, to ward off the guilt she experienced when she did indeed eat.

At this stage, the anorexic behaviour pattern had 'sunk in', as C describes it. C would read every book and article, and watch every programme on the subject. She describes envying those girls who weighed 40 kilograms, and would aim for their 'disaster weight'. C started to exercise daily, weighing herself before each aerobic class that she attended without fail. C would also assess her weight loss by the diminishing size of her arms and thighs. C's clothes began to 'hang on her', and C reports that her work-clothes had to be altered to fit her anorexic body.

At this point, tension mounted in the home between C and her mother. Fellow colleagues at work began noticing her drop in weight and her thin appearance. C was now being questioned about her behaviour. Though C could wear 'tights and clothes for thin girls', C was still afraid of gaining weight and terrified of eating. C was finally

hospitalised after fainting during an aerobics class, and spent six weeks in an eating disorder unit.

During family therapy sessions, C became aware of the impact that her behaviour was having on her family, and realised that it had the potential to cause a breakdown in her relationship with her mother, which at the time of hospitalization was very tense and argumentative. By observing the social and occupational functioning of fellow patients in the anorexic ward, C became further aware of the dangers of anorexia, realising that: 'their lives just don't function. A lot of them were forced to leave school during Standard Eight, never completing Matric, and spending their days, just walking and walking'.

Initially, C felt very proud to be anorexic. 'I cannot explain in words what it feels like to be thin, you feel so good, so attractive, to feel your bones sticking out, you feel so proud.' Although C claimed that 'anorexia became my only reason for living', she soon began to realise that 'anorexia's claims on me became more than I had bargained for'. C described being 'locked in a web of confusion, starving for food and too scared to eat'. C became aware that 'I was making myself mentally very ill'.

Based on the above insights gained from her experience of family therapy, from interacting with other anorexic patients, and by reflecting on the destructive path she was carving for herself, C began to eat and slowly put on weight. The eating and weight-gain was initially motivated by her desire to heal the damaged relationship with her mother, but more significantly because, 'I wanted to get on with my life. For the first

time I started to see what I was doing to myself and I became frightened about where I was heading.'

Once C had started to gain weight and had contracted for out-patient treatment, she was discharged from hospital. Currently, C is involved with a family church, has returned to work, and reports that :

"I'm still struggling but anorexia is not my main priority in life. In fact I try to focus as little as possible on my weight, which is difficult because I am so insecure with regards to it."

C has become involved with a member of the opposite sex in what she describes as a very supportive and caring platonic relationship.

C describes an extremely isolated sheltered home environment, identifying her father's severe drinking problem as the most predominant event that shaped her isolation from an early age. Due to her father's drinking problem, C was brought up by her maternal grandmother with whom she lived in an independent flat adjoining the house. Being an only child, C was extremely dependent on her grandmother, who she experienced as an important caretaker, creating for her a very meaningful childhood by initiating in her a joy for reading and writing, attempting to create for her the innocence of childhood, undisturbed by an awareness of her father's drinking.

From an early age, C reports being aware of her father's drinking, and perceived that 'this was something very secretive, a shame, something bad'. On many occasions C reports being tearful and feeling humiliated due to her father's irresponsible behaviour

when intoxicated, forgetting, at times, the lift-scheme and parental duties. C reported having to go to school with a 'brave front, putting on a new face, an act that C became very good at'. Embarrassed and fearful of her father's unpredictable behaviour, C never entertained friends at her home, and would seldom visit friends, being concerned about events at home. C reports that these circumstances laid the foundation for her 'anorexic personality and withdrawn, shy, insecure character'.

When C was 12 years old, her grandmother died from natural causes. C was both traumatized and relieved at this loss. Regarding the former, C had lost her best friend upon whom she was very dependent for support and wisdom. Regarding the latter, C was relieved of the burden on the family that her ailing grandmother had caused due to her irrationality and loss of functioning as she aged. C's mother now moved into the flat and shared a room with C.

C now developed an extremely close relationship with her mother that revolved around homework and academic achievement. C reported that her mother placed her under extreme academic pressure, forcing C to study excessively, memorizing her work by heart, and repeating this to her mother at night. This style of learning became a habit for C, and a ritual in the mother-daughter relationship.

C became totally focused on memorizing her work perfectly, and would experience feelings of rage and depression when she could not achieve a perfect re-telling of the work she had learned. C reported that this aiming for perfection was a further contributing factor in her developing anorexia. This devotion to studying did result in C

obtaining good academic marks. However, as C progressed to higher standards, and the work-load became more demanding, C could not maintain this style of studying. During her Matric year, C felt that she could not cope with the work-load and her habit of having to memorise everything perfectly to the word.

C cites her Matric year as 'the trigger which put the ball of anorexia rolling'. C reported that she:

"gave the first term my all, and then I just collapsed emotionally. I couldn't cope. I felt so helpless, so alone, so frightened, so anxious. I knew all I had to do was study, yet I couldn't. I just couldn't. It seemed such an easy simple requirement, but I couldn't".

C started to think desperately, and reported suicidal ideation. The thought that she was:

"on the brink of a new life and all of this lay in my hands to achieve, which meant passing Matric, not just passing but achieving a University Entrance and the last thing I felt like doing, was opening a book and studying".

C desired to starve herself and reported 'wanting to die'.

At this point, C began restricting her food, started taking laxatives. C began to lose weight, but not significantly. C experienced tremendous pressure from her mother, teachers and friends, following her poor performance in the second term of Matric. C had dropped from being a scholar that achieved a 70% average to 50%, and just managed to pass her preliminary exams. C did achieve a University Entrance exemption, but well below the grades expected.

Following her Matric year, C underwent two major leg operations, and began working at her mother's place of employment. Based on her mediocre performance in Matric, and following her leg operations, C reports experiencing a major depression. The remedy suggested by her mother and her boss was to enroll for a Bachelor of Commerce that she could study on a part-time basis. C was reluctant to enrol, but eventually did and was able to complete the first two assignments. Having failed to complete a third assignment and now faced with a tremendous work-load, C overdosed on Indoral and was hospitalised for four days. C reported feeling dirty because of the overdose, and felt that she had lost her innocence. The overdose was C's attempt to persuade her mother that she needed help for her depression.

C describes the overdose as the turning point in her relationship with her mother. C's mother lessened the pressure on C to achieve her Bachelor of Commerce, but became hypervigilant regarding C's behaviour in the flat. C discontinued her studies, and began to secretly drink alcohol. This behaviour threatened to interfere with C's responsibilities at work, and C began to express her suicidal ideation through food restriction, since:

“by starving yourself you are in control and it doesn't influence any other areas of your life. It's something you have. It's your secret that nobody else knows about. It's something you have that makes you feel better, you reinforcing it the whole time, losing weight. It's something to focus on, something to really look forward to. I still could not bear the fact of living, but this made my life so exciting”.

C describes her life at this stage as 'suicidally depressing'. C was fearful of taking an overdose again, reporting that she had changed since the overdose:

"I felt older, I felt dirty, I felt that all my innocence had gone and that I was scarred forever".

C further could not cope with the depression she was experiencing, and felt that her mother couldn't understand, simply placating her by telling her that everyone goes through depression. C reported that she was needing help desperately, and feeling utterly destructive, needing to hurt herself.

C reports that anorexia was her help. C experienced her anorexia as an 'outlet, a door which opened to a new person, a new world, an inner life to help living in the real world.' Anorexia for C was her biggest secret.

"It was mine, it was deep, it was comforting when I needed to feel secure, it was exciting, an adventure, when life was dull and monotonous".

C reports that anorexia had become "my suicidal crutch. I could push myself to the limits and no one could stop me." Anorexia was for C her control in a life which was so out of control. "I could live again".

With her anorexia, C felt that she had replaced her depression: "From the moment I made up my mind to starve myself, I never saw the face of that depression again". C reported that she now started to become another person, 'the thin me, the successful me, the new me". This thought process, with the concomitant weight loss, eventually culminated in C's hospitalization and treatment.

In a letter to the researcher, C reported feeling recovered because:

“my body distortion is almost non-existent, it doesn't matter to me anymore. I have come to realise that it is okay to have thighs, and thighs don't make the person”.

C reports though that she still becomes more critical and weight-conscious when she is going through a depression or is anxious about a new task or challenge. C reports suddenly feeling like, “I need to lose weight, and feel fat all over”. In suggesting advice to recovering anorexics, C maintains that “you almost have to split yourself into two people, the recoverer, and the little sly, cunning voice which keeps nagging at you to follow your old pattern.”

4.2 INTERPRETIVE ACCOUNTS

4.2.1 Interpretive Account of Participant D

At the age of 19, Participant D was hospitalized due to a critically low weight of 32 kilograms. Immediate intravenous hydration and tube-feeding was administered. Due to her low weight, intense fear of gaining weight even though under-weight, and inability to grasp the seriousness of her low body weight, D warranted a diagnosis of anorexia nervosa. Evidence of depressive features with psychotic thought patterns warranted treatment with a course of anti-depressants and anti-psychotic medication during her year-long hospitalization.

As reported by D, it was never her intention to become anorexic. This process was a slow gradual one over a period of three years, initiated by the trauma of the sudden loss

of her father due to a heart attack. D reacted to this loss with severe depression and suicidal ideation. D reported that she desired to "commit suicide with a revolver but lacked the guts".

D further admitted that her personality was too inhibited and socially immature to partake of alcohol and drug abuse. Already experiencing a lack of desire to eat, D turned to food refusal as an expression of her desire not to live. In this sense, D's anorexic body allowed for an expression of D's suicidal intent, and signified her method of integrating the trauma associated with the loss of her father.

D's significantly close relationship with her father and the personality she developed within the context of her family can be identified as the possible source for D experiencing her father's loss so traumatically and resorting to her body, unintentionally, to express this loss. D grew up with a very dominant father-figure and an equally inadequate mother-figure. Due to her own personality shortcomings, physically in her epileptic condition, and psychologically in her lack of independent functioning, scholastically and socially compared to that of her older sister, D experienced herself as inadequate. D furthermore never experienced the rebellious teen years due to her immature and inhibited personality, that restricted her venturing out the home. The mother-daughter relationship was of a devaluing quality and competitive in the arena of gaining father's attention. Experiencing and expressing herself as a helpless victim, D's father became the rescuer by developing a very special caring, protective and supportive relation with D. D's father provided her with acknowledgement and confidence. With the loss of D's father, D found herself abandoned, helpless, with little

inner resources to cope with the loss. This situation was further exacerbated by D's mother's inadequacy at coping. Of significance in this regard was D's mother's inability to drive, having never obtained her driver's licence. This incapability bespeaks her mother's lack of independent functioning, revealing the extent of her dependency on other caretakers.

At this stage, D was suddenly thrown into the role of caretaker of the home, which entailed attending to funeral arrangements, clearing out of her father's clothes, closing down his business, obtaining a driver's licence, and writing Matriculation examinations. The assumption of this role of father / husband in the home was clearly materialized by D's sharing of the parental bed with her mother. In the face of these responsibilities, D was forced to live the life of a responsible woman who could not afford to attend to her loss in an overt manner. D thus mourned her father's loss secretly, through food refusal, and consequently through her body. Furthermore, by refusing to eat as an expression of her desire not to live, D gained a tremendous sense of satisfaction in the ensuing weight loss and control over her body. It now became important for D to maintain this habit and the focus that this project entailed in its demands for constant weight-watching, counting of calories and exercise, provided a meaningful project in the face of her loss.

To describe this predicament in symbolic form, D produced a drawing which she had done during her hospitalization (see Appendix). D describes that her body is that of a woman in a foetal position. The foetal position signifies D's feelings of total helplessness and frustrated, unmet dependency needs, following her father's loss. D had to resort

to acting out these feelings through food refusal, which eventually reduced her body to such proportions that she was unable to function independently. By developing an anorexic body, D was finally able to re-experience the symbiotic relation she had enjoyed with her father. The tube-feeding was experienced by D as the umbilical cord, and the sisters on the ward were experienced as her 'mothers'. In D's own words:

"I was the foetus, totally dependent on the sisters in the ward for being washed, fed, even turned over from side to side every hour on the hour to avoid bedsores".

Simultaneously, coexisting with this foetal position, D describes a 'woman' in a foetal position. The woman aspect of this figure was described by D as the "responsible, compliant daughter, stuck at home", who compensated for the absent father-figure due to the latter's death, and for the mother-figure due to her inadequate coping.

Over a period of three years, D lived out this paradox of the 'woman in a foetal position'. The woman dimension took care of the home and mourned the loss of her father secretly through food refusal. In this dimension, D began to feel adequate, powerful, and in control. What first began as an expression of loss resulted in an anorexic body. With the anorexic body, D was able to now bring the foetal position to the foreground and with her year-long hospitalization able to engage in physical and symbolic feeding of this aspect of her being. In this regard, D experienced her anorexic body as a renaissance, whereby she was able to relinquish, for a year, the role of caretaker and experience a re-birth. The hospitalisation experience allowed D to express her foetal position and become re-born as a more functional adult. Through her growth both physically in terms of weight-gain, and psychologically, in terms of D's newly-found spirituality, D was re-born. The renaissance expressed itself in D's ability to lay to rest

her father's death, by couching this event in a spiritual philosophy that made the loss more acceptable. The renaissance further expressed itself in D's ability to leave home and function independently with the support of her newly-found Orthodox Jewish community.

Presently, as a mother of four, married to a nurturing supportive husband, and a career woman, D continues to embody the paradox of the woman in a foetal position but is able to avoid resorting to the extremity of an anorexic body. This is achieved by D being able to balance her need to be the absolute 'woman' caretaker, with the need to feed her 'foetal position'. The 'woman' is able to articulate a neediness and experience a form of dependency; the foetus is able to be mature and experience a form of independence.

4.2.2 Interpretive Account of Participant B

Participant B developed anorexia in the context of a poor marital relation. B was married to an accountant who experienced discomfort in participating in heterosexual relations and in demonstrating affection. B's husband did also disclose, during their third year of marriage, confusion regarding his sexual orientation. B experienced a sense of aloneness and lack of acknowledgment within the marriage.

B also avoided the marital relationship by being too occupied in a daily schedule of mothering four children, free-lance work in the evening, and furthering her education. The marriage was focused on the facilitation of a home, with both partners, functional

in the role of father and mother, and unable to participate in an adult relationship of husband and wife.

Within this context, B developed an extramarital relationship that provided B with the acknowledgement and mirroring absent in her marriage. This relationship was B's first experience of real recognition as a person, in particular, as a capable woman.

The extroverted, outdoor, sporty and alive characteristics of her lover were particularly attractive to B. In order to maintain and secure the relation, B began to participate in similar activities as her lover, in particular running. In this activity, B discovered an excellent mechanism to both lose weight, gain a thin body, and receive acknowledgment from her lover. Running became an important activity to be added to B's already full day and, to cater for this, B would awaken early in the morning. Running became addictive for B.

Furthermore, in the secretive dining-out that characterised this newly-found relationship, B developed the ability to eat very slowly, cutting her food into small pieces, thereby decreasing her food intake. Between these meals, B would busy herself with feeding her family, and restrict her own food intake. This behaviour, together with her addictive running, resulted in B developing a very fit, strong, and thin body. It was the achievement of a thin, athletic and energetic body that now gave B a tremendous sense of satisfaction and achievement. Within this context, B had become narcissistically preoccupied with her body, and the satisfaction she experienced in her extramarital

relationship itself became secondary to the satisfaction experienced in achieving an anorexic body.

In her own words, B's anorexic embodiment was experienced by her:

"as the single-most powerful experience of triumph. Anorexia gave me a new identity. An identity that pleased me. An identity that put me on a par with ordinary girls. Ordinary girls were thin, athletic and energetic, and I was now being labelled anorexic, which surely epitomizes these qualities in the extreme."

Being acknowledged as a separate person and achieving a sense of ordinariness, were important values in B's life. Having experienced a childhood of 'extra-ordinariness' and lack of acknowledgment from her parents, B was driven by these two values.

B's experience of extra-ordinariness began in her family of origin. With an absent father-daughter relationship, and an overbearing mother-daughter relationship, B developed a drive for separateness and independence at an early age. In the shadows of this drive for independence was B's inability to experience a sense of healthy dependence. Based on the unhealthy forms of dependency that B experienced in her home, particularly with her mother, B developed a negative stance to experiences and expressions of dependency.

B's drive for independence manifested in B completing Matric, as head girl, at the young age of 15. This achievement was, however, experienced by B as a further instance of extra-ordinariness, and by implication not feeling ordinary like other peers in her

neighbourhood. B's intelligence, capability and independence of functioning were evident when offered an opportunity overseas as an Exchange Student. This opportunity, however, was thwarted by B's mother. B's desire to be away from home further manifested in her successfully obtaining an offer to work as an air-hostess. These opportunities would leave her mother without a function, and B was taken overseas with the family instead.

The overseas trip with her family, living with her maternal grandmother, served to frustrate B further, and proved to be the last form of dependency she would experience and allow with her family of origin. Following this trip, B's urgency to leave home and express her independence was finally realised when B moved to residence and married in her third year of study. In her spouse, B had chosen a partner who was submissive, unassertive, and not demanding of her intimacy and affection.

Within quick succession, B had borne four children. Here B demonstrated a need to avoid any similarity with her family of origin. Where her mother had married late and bore one child, B married early and gave birth to four children. Within the marital relation, B demonstrated her inability to form a healthy dependent relationship by simply pursuing her own needs to be a mother, a career woman, and further her studies. Within this context, B's spouse served more as a means to her goal of 'ordinariness' and differentiation from her family of origin.

Given B's drivenness for independent functioning and inability to form a healthy dependent relation, the marriage did not survive, culminating in her separation from her

husband. Furthermore, B's extramarital relationship also dissolved once B had achieved a sense of independence in her anorexic embodiment.

B turned to her body as the ultimate venue for her to give expression to her desire for complete independence and avoidance of dependency. B's anorexic body signified a sense of complete differentiation from her mother, in that she was now the creator of her own body. In her self-discipline regarding food, B demonstrated that she was in total control of her nurturance. In her early morning running prior to sunrise, B demonstrated her ability to be beyond time and season, being able to run whether it was raining, cold, clear, or hot. Even in her anorexic state, weighing 40 kilograms, B avoided any hospitalisation and was able to receive treatment that did not involve extreme dependency on medical staff or therapists. These achievements were for B the ultimate triumph.

B's marriage, her mothering of four children, her achievements in her career and studies, were not substantial enough expression of her desire to be separate and different from her experiences in her family of origin. Only by creating her own body, as anorexic, could B experience a sense of individuation that allowed her a sense of ordinariness, acknowledgement, and difference.

Through the experience of a healthy dependent relationship with a psychotherapist, B was now able to recover. Having gone to the extremes in her expression for independence, this desire and drivenness was tapered by a re-learning of dependency through psychotherapy. B entered psychotherapy with the presenting issue being that

of marital discord. Physically, however, B had become fatigued and drained by her drivenness and full schedule. Furthermore, B was experiencing a sense of guilt at her failed relationships and lack of focus on quality of mother-child relations. These factors, her sense of physical fatigue, and guilt at failures in her relationships, opened up a path for B to start experiencing a less extreme independent existence, and submit to a less driven, dependent existence.

B's anorexic body thus gave expression to her desire for complete independence from her origins, from human need, and relatedness to others. Paradoxically, in its extreme expression, it brought her to the therapy room where she could learn healthy dependency. Presently, B remains a highly motivated and ambitious person, still running and dieting. However, resulting from her therapy experience, she is able to incorporate 'being' into her existence rather than existing only by 'doing'.

4.2.3 Interpretive Account of Participant C

C experienced her anorexic embodiment as an 'outlet, a door which opened to a new person, world and inner life to help living in the real world'. Anorexic embodiment as an open door, an outlet, signified the sense of joy, security and invitational character of her anorexic experience. This is in direct juxtaposition to the isolation and seclusion C experienced within the closed doors of her life prior to her anorexic embodiment. C's family life was characterised by the experience of isolation and seclusion, a closed door, shut by the shame and humiliation experienced in living with an alcoholic father, being an only child, her own physical problems with her legs, her mother's inappropriate need

for her, and her dependency for stimulation on her grandmother who eventually aged and died. For C, the home was not a venue where she could entertain friends, and her main source of entertainment was the special relationship she shared with her grandmother who lived on the premises. Her other source of entertainment was excessive studying.

Prior to her anorexic embodiment, C used obsessive studying as a means of avoiding the conflicts at home, and as a perfect excuse to avoid the demands of socializing with her peers. The discipline, self-control and perfectionism that was required for C to know her work by heart and the consequential satisfaction at this achievement, together with good academic marks, provided the training ground for the necessary character traits that C would employ in her later development of anorexia. Prior to her anorexic embodiment, C employed obsessive studying as a means of coping with her life-circumstances. Obsessive studying allowed C to experience a sense of control in an important area of her life. Together with the academic achievement that resulted from such endeavours, C gained acknowledgment from her mother, and confidence in herself. In her studying, C experienced a similar outlet, an open door, to the outlet she experienced with her anorexic embodiment.

With the loss of her grandmother, C was to share the independent flat adjoining the home with her mother. The mother-daughter relationship revolved around academic achievement, which required a constant focus on studying and homework. C was forced to focus on her school-work and avoid any signs of mourning or vulnerability. C's mother perhaps desired that C achieve a good Matriculation Exemption and proceed

to establish a sound financial career and a future that would be different from that of C's mother.

C was able to succeed academically, achieving an average of 70% overall, and classified within the top five of her class. However, during the pen-ultimate year, matric, the defensive nature of her obsessive studying was exposed and collapsed. With the increase in work-load, C could not maintain her study method of obsessively knowing all the work by heart.

Having become used to this habit that was entrenched in her from the age of 13, that fueled her relation with her mother, gave her confidence and placed her within the top five of her class, C was now faced with the frightening possibility of failure during the very year when she needed to maintain her study habit. On the brink of leaving school and entering the next developmental stage of increased independence and tertiary education, C's method of existence collapsed. There occurred a significant drop in grades, and C just managed a University Exemption, contrary to the expectations of her teachers, others and herself.

Although undiagnosed, it is clear that following her second term in Matric, C suffered a reactive depression, precipitated by her academic underachievement, according to her own standards. The symptoms of her depression manifested in a loss of interest in usual meaningful activities, loss of concentration, apathy, and suicidal ideation. During this period, C experienced a tremendous sense of aloneness and failure, and unable to elicit support from her mother as to the gravity of the situation. Following her Matric

year, the situation was further exacerbated by C having to undergo two major knee operations, and was furthermore enrolled for a Bachelor's degree in Commerce, without the sufficient energy or motivation for such an undertaking. Unable to cope with such stressors, C overdosed and was hospitalised.

Realising that an overdose did not help matters, nor did alcohol or drug abuse since these strategies interfered with work, C required another strategy to cope with the sense of failure she was experiencing, her suicidal ideation, and the demands made upon her. C turned to food restriction, laxative abuse, and control of her body as the most functional method to allow her a sense of coping. C turned to anorexia as a means of replacing her depression and helplessness with 'control in a life which was so out of control. I could live again. Anorexia was my friend.' Initially, anorexia served for C the function of replacing her depression and provided her with a:

“permanent destructive mechanism. I knew I could feel better by restricting my intake, depriving, by starving my body of food. So anorexia took away my depression because I placed all my focus on standing on the scale every day, three to four times a day.”

Through her years spent in obsessive studying, C had furthermore developed the necessary discipline, control, and desire for perfection that rendered these habits a suitable fit, for this disorder. By developing anorexia, C was able to maintain her job, live with her mother, and give expression to her suicidal destructive desires in a manner that would allow her to live. Just as she gained acknowledgment and confidence in her academic achievements by means of obsessive studying, C now gained

acknowledgement and confidence in her 'newly created thin body' by means of her anorexic behaviour.

Unable to be heard regarding her depression and struggling to establish a career, C discovered a haven of safety and freedom in her anorexic embodiment, whereby "anorexia became my only reason for living". The ecstatic experience of once again being in control, fitting into thin clothes, and no longer feeling depressed, became addictive for C. During her hospitalisation, upon observing the consequences and poor level of functioning of other anorexic patients, C became aware of the destructive nature of her habit, and began a process of healing.

C resorted to anorexia as a means of overcoming a suicidal depression. Anorexic embodiment allowed her to be extremely destructive, simultaneously to functioning adequately at home and at work. Anorexic embodiment was C's secret, a way of silently asserting her desire for independence, while remaining extremely dependent on her mother. However, upon realising that this method was becoming out of control, developing into a habit that was more threatening than C had envisaged, and destroying her mother, C had to seek treatment.

Having been brought up essentially by her grandmother, then her mother, in the absence of input from a fatherly figure, C developed a personality fearful of the 'outside', and experienced a sense of confidence only when achieving academically as a result of hours of isolated obsessive studying. C's excessive study was not motivated primarily by a love for schoolwork, but rather by a need to remain occupied in an

unstimulating home and avoid the conflicts therein, as well as the challenges of a social life.

During the year that marked the transition from school to tertiary education and adulthood, C experienced a depression and inability to cope with this demand. During her first year out of school, C also overdosed. The depression and overdose can be seen as strategies that perhaps express C's anxiety and fear of being incapable of independent functioning. Only through the experience of anorexic embodiment could C experience a sense of independent functioning that she described as an 'adventure, as a friend'. C, however, realised that anorexia, as a means of expressing independence, was a 'dangerous game' and was an inauthentic assertion of independence. Employing the familiar habits of discipline, control and willpower, C consciously eats, exercises, has joined a family church, and has begun to control her anorexic habit.

4.3 COLLECTIVE ANALYSES

4.3.1 Family dynamics

With all the research participants, the pull towards independence was suffocated by the participants having to compensate for their parents' own shortcomings and dissatisfaction in the marital relationship of their parents. Participants B and C grew up with parents who had an extremely submissive attitude to themselves and the outside world. That is, both participants experienced parents who themselves were frightened

by the outside, and struggled to survive. In both situations, the father-figure was a poor role model as breadwinner, and absent as father. With Participant D, the family were well-off and comfortable, but it was the mother who was inadequate and unable to confront the external world. In all these families, the interaction between parents was one of rescuer and victim. Participant D's father was the domineering rescuer, who seemed to have saved her mother from an impoverished existence in an orphanage, and continued this type of interaction throughout their relationship. This type of marital interaction became mirrored in the father-daughter relation, whereby D experienced an extremely symbiotic relation with her father, from which she struggled to recover following his loss. Participant B witnesses a marital relationship with her mother rescuing her physically-ailing father. Participant B is terrorized by the potential engulfment of her mother, who expresses her dissatisfaction and lack of investment in her marital relationship by controlling B's investment in her own development, attempting to vicariously live through her daughter. In the presence of an alcoholic syndrome in her father, C is witness to an abusive marital relationship, and drawn into a claustrophobic relationship with her mother.

This all suggests that the participants as children were far too involved with their families and home problems, so that too little energy was spent on focusing on the demands of the outside world of school and friends. The participants were raised in families operating with highly enmeshed patterns. The families of participants were characterised by overprotectiveness, lack of privacy, and the inability to foster the individuation process.

What seemed to be happening in these households was that the participants were encouraged, from a very young age, to be grown-up and mature, to think, act, and be like adults. Unable to conform, do well, and manage outside, Participant D is drawn into an intense caretaking relationship with her father, who wishes her to become independent and adequate like her elder sister. Following his death, D is then drawn into the role of caretaker of the home, and finds it difficult to mourn the loss of her father. Participant B is an only child, and functions independently from a young age. She starts school early, matriculates early, and marries, bearing four children at an early age. Participant C is not allowed to show any signs of vulnerability following the loss of her maternal grandmother, and is forced into a life of studying hard, achieving academically, with little room for anything else.

The participants all seem forced to live not only with their own distress, but with that of their families. The participants are taught to focus on their parents, their problems and their anxieties. The parental role is reversed, with the child caring for the parent. This leads to a deep desire in the participants to save their parents. In this context, Participant B is driven to self-sufficiency from an early age. Fearing any expression of vulnerability, Participant C buries herself in academia, avoiding entertaining friends at home, thereby protecting herself and her family from the shame she experiences in being the daughter of an alcoholic father. The result of this family set-up is that all participants neglected their needs, just as their parents did. Participant D was unable to attend to her early need for mourning and depression, following her father's loss. Participant B was unable to attend to her early signs of being overtired and overworked.

Participant C was unable to attend to her burn-out in studies. All participants ignored signs of breakdown in favour of continuously coping for their parents' sake.

Within their family context, the participants see their worlds predominantly through the demands of their parents. The participants therefore do not view themselves as individuals with rights of their own. With Participant D, loyalty and fatherly protection took precedence over autonomy and self-development. With Participant B, all her goal-directed activity, such as matriculating at a young age, leaving home, marrying early, were fuelled not by an expressive sense of competence, but by an attack against the fear of being trapped at home and developing a similar personality like her mother. With Participant C, her obsessive studying was not driven by a love of knowledge, but by a need for entertainment, approval, and love.

The participants grew up in homes where the ability to depend on parental support was replaced by an overwhelming urgency to function independently. Having never experienced a healthy sense of dependency that allowed for the expression and meeting of needs or vulnerabilities, participants also realised the false sense of their independent functioning when having to face the outside world. Both Participants D and C experienced a lack of confidence, a sense of aloneness, a lack of personal growth and maturity, in coping with the academic and social demands following their Matriculation. Both were diagnosed with anorexia, and hospitalised at the age of 19. Participant B's sense of independent functioning carried her through to a point of marital breakdown. She seemed to have developed better coping mechanisms and resources.

Her sense of independent functioning, however, collapsed during her marriage when faced with the dependent demands of a marital and mothering relationship.

In sum then, all the participants were raised in family contexts that were characterised by poor marital relations among their parents, resulting in the participants developing a fragile sense of independence together with an inability to allow for healthy expression of dependency needs.

4.3.2 The pre-anorexic personality

Having outlined the structure and dynamics of the participants' homes, the dynamics and behaviour of the pre-anorexic personality will be outlined.

The world of the participants can be described as a limited one. The parents of the participants are completely dominant. For both Participants D and C, the father and grandmother/mother, are the only source of feedback, comfort, security and stimulation. They tend to be the only people in these participants' life. Participant B's excitement and stimulation is found in avoiding the claustrophobic nature of the mother-child relation. Outsiders are not entertained in these homes. In this manner, the participants were systemically cut off from the influences of the outside. This sense of isolation engendered feelings of being extraordinary, as was the case with Participant B, and feelings of seclusion, as was the case with Participant C.

With the lack of participation in extramural activities and development of relationships outside the home, the world of the participants was restricted to contacts with the parental caretakers. The main events in their lives revolved around activities in the home. Participant D's home revolved around the homecoming of her father from work. The competitiveness involved in being the first to meet him and serve the snacks became an important activity. In Participant C's home, the main interpersonal engagement was around the checking, doing, and repeating of homework with her mother. Within this home-centered focus, both Participants D and C were not exposed to the winning or losing of a sports game, or the ebb-and-flow of emotions involved in the initiation and betrayals of friendships. Both D and C developed a phobic sense for the outside world, and feared the challenges of entering the adult world. For Participant B, the flight from the home-centered focus allowed her to develop a sense of mastery and adequate functioning in the world of work and public domain. Her shortcoming was her inability to experience a sense of dependency and intimacy.

The pre-anorexic personality is shaped by the manner in which the participants coped with dependency and independence within the framework set up by their parents. Both Participants D and C traded in expressions of their independent needs for an extremely dependent relationship on their parental caretaker. Participant B traded in expressions of dependency for an independent existence as different as possible from that of her home of origin. Consequently, Participants D and C developed extremely dependent personalities that would shift their initial dependency on parental caretakers to other caretakers and situations in their lives. Participant B developed an extremely capable

independent personality that would succeed in areas that required independent functioning but fail in areas of dependency and intimacy.

4.3.3 The world outside home

In the varying interactions with the world outside the home, all participants transferred their experience achieved as individuals at home onto the interactions outside the home. Both Participants D and C retreat from contact with peers, avoiding extracurricular activities at school, to the security of the familiar world of their home and parents. Participant D finds herself with little energy available to focus on schoolwork and relationships, being caught in the home with the tasks of mourning her father's loss and caring for the family. The overwhelming nature of the family needs, together with D's inability to engage socially outside the home, render her trapped 'inside' with her mother. D is unable really to focus on developing peer relations. Academically, D does manage to matriculate despite stressors at home, and enrolled for tertiary studies which she never completed. D's participation outside her home was always mediocre, with D being unable to overcome the symbiotic dependency she learned at home that rendered her passive and dependent on tasks and people outside home. Participant C also spent her adolescence retreating into the home and, through her excessive studying, was able to live even deeper in the family, avoiding and terrified of socializing, shameful to entertain friends at her home. C's entertainment at home was her excessive studying, and in this focus C was able to get her teachers to treat her and care for her, as her mother did. C's adolescence was study-focused, and when C was unable to maintain her habit, she became terrified and depressed. Participant B, unlike the other two

participants, experienced a life outside of the home. Determined to be other than her mother, Participant B's outside world was also defined by the home but in an escape from home. In her drivenness to be outside the home, B was able to overcome and avoid the symbiotic union experienced by the other participants. Unlike the other participants, B matriculated as head girl at the young age of 15.

Regarding the world outside the home, both Participants D and C were unable to pierce the symbiotic dependency on their homes. Lacking an ability to assert themselves and functioning independently according to their own needs, both participants spent their adolescence entrenched in their homes, and were deprived of any learning outside the home. Interestingly, in this regard, both Participants D and C required hospitalisation for their anorexic disorder, and their healing depended on the discovery of other arenas outside the home where they could shift their dependencies.

Participant B never required hospitalisation and, in her well-learned independence of functioning, healed through out-patient treatment. Whilst D and C functioned dependently and struggled in areas that demanded independent functioning, B was able to function independently and struggled in areas of intimacy and dependency. In this regard, both D and C retreated from the outside world and lived entrenched at home. B retreated from the home and lived outside in the world. Once again, in their interactions with peers, school performance, and development, all the participants demonstrated a one-sided dimension that was extremely developed at the expense of the other. D and C were too dependent and fearful of independent functioning. B was too independent and fearful of dependent functioning. Because of the extremities of

one style or the other, all participants were unable to engage in mature dependency and independence within their homes and outside world.

4.3.4 The anorexic crisis

The crisis that precipitated the anorexic process was, for Participant D, the loss of her father; for Participant B, the breakdown of her marriage; and for Participant C, the eventual collapse of her studying as a solution to her home problems. The crisis that precipitated the anorexic process, in all cases, involved the final collapse in the participants' style of coping. With Participant D, the loss of her father was an external event beyond her control that shattered her symbiotic relation with him, and forced her to develop a new method of coping both at home and outside in the world. Participant D's safe cocoon and avoidance of the challenges of independent functioning now was called into question, and required solutions. Participant B's style of functioning outside the home eventually threatened her marriage and limited her functioning in the role of mother. Realising that her style was about to destroy her family and was depleting herself, Participant B was forced to question her self-sufficient independent process, and was forced to return to her roots in the home. Participant C's studying for mother, and studying as an avoidance of the outside world, as well as a defence against her sterile home, could no longer be maintained, and C was called to answer for herself by developing an identity of her own and functioning more adequately in the world-at-large.

The anorexic crisis is precipitated when the attempt of the participants to remain absolutely dependent or cocooned at home breaks down, or when the attempt at

absolute independence from the home breaks down. In these instances, all participants experience a crisis and realization that absolute dependency is no more normal or viable than total independence. To function, the participants learn that human embodiment entails a flexible, fluid alternation between independence and dependence, according to the demands of the situation. Healthy functioning requires a constant flux between functioning on one's own independently, actively and assertively, as well as functioning dependently and passively, as the situation demands.

4.3.5 Anorexic embodiment: The resolution of crisis

The participants experienced their anorexic embodiment ambivalently; on the one hand, it was experienced as a renaissance, an extraordinary triumph, an outlet; on the other hand, it was a terrifying experience that almost cost D her life, and warranted a year-long hospitalisation; that threatened to get out of hand for B and destroy her family life, and was rendering C dysfunctional, socially and occupationally. D experienced her anorexic body as a renaissance, in that it allowed her to become completely dependent, during her hospitalisation, and work towards healthy forms of dependency and strive towards more independent functioning. B experienced her anorexic embodiment as an extraordinary triumph in that it signified the achievement of total independence and denial of any human need or dependency. For C, anorexic embodiment was experienced as her friend, as an outlet, in that her anorexia replaced her depression, and gave her a sense of identity and independence.

For all the participants, anorexic embodiment provided a resolution to their conflictual experiences of dependency and independence. All the participants had experienced unhealthy dependent relations which rendered Participants D and C fearful of independent desires and ambitions, and Participant B driven to independent functioning. Anorexic embodiment allowed for a transformation of dependency needs by creating a body which was owned, inviolate and needless. The anorexic body, as a personally owned object, now becomes the possession of an active subject that behaves independently.

The anorexic body transforms the dependent open quality of the intersubjective dimension of existence, that has the potential to be acted upon, into an independent functioning body that is absent and closed to the demands of others. Anorexic embodiment provides D with the opportunity of relinquishing her role as caretaker of the home, and attend to her own loss and need to mourn. Participant D in fact experiences re-parenting from a state of helpless foetal dependency to a position of expression of maturer dependency and independent functioning. Participant B is able to express and experience total control, triumph, and the ultimate expression of independence in her anorexic embodiment. Anorexic embodiment provides her with a sense of mastery, acknowledgment, and recognition, necessary mirroring experiences that she was denied in her upbringing. However, in the shadow of this achievement, Participant B faced the breakdown of her marriage, depletion of her own energies, and neglect of her role as mother to her children. Resulting from her achievement of anorexic embodiment, C is able to move out of her mother's bedroom, literally creating a new space for herself, and finally able to discontinue studies in a course that she was not ready for, nor wanting to

pursue. This project, however, proved to be temporary and precarious, in that the desire for total independence and attempted denial of dependency proved to be illusive.

4.3.6 The body as the locus for the anorexic solution

The body becomes both the arena and instrument that the participants employ to resolve their conflict between the dependent and independent dimensions of human existence. The body ontologically signifies the coexistence of the dimensions of dependence and independence, and is thus the arena most suitable for participants to express this conflict and exert control over either dimension.

Participant D resolves the crisis of being a 'woman in a foetal position' through anorexic embodiment. Anorexic embodiment allowed D to temporarily relinquish her adult role, become a helpless foetus, and experience re-parenting, arriving at a more functional balance between her dependency and independence needs and striving. By D's own admission, her personality was too passive, dependent and immature to choose the route of substance-abuse or suicide. Through her body, D was able to give expression to her extreme dependency needs, as well as her struggle with becoming an independent functioning adult.

Participant B's struggle was the attempt to deny any form of vulnerability, dependency and submissiveness in the service of an independent, inviolate and controlled existence. B's anorexic embodiment represented a triumph for her, in that her thin, hard, tanned body signified a triumph over the neediness of her family of origin, and her own human

neediness. By expressing the independent function of human bodilyness, and repressing the dependent dimensions, B's anorexic embodiment is almost an attempt at being the creator of her own body. That her anorexia took this form, lacking hospitalization, reveals the extent of ambition and will B demonstrated in her project of total independence. Participant C, similar to D in personality, turned to her body to express her need for overcoming her helpless and depressive dependency. Through her anorexic embodiment, C was able to discover an identity and sense of self.

4.3.7 The crisis within anorexic embodiment

Beginning as an attempt to deny dependency and human needs, as revealed in the refusal to eat, the anorexic process violently attempts an existence of complete independence. However, with the ensuing weight loss, threat to physical existence, and breakdown of relations, the result is paradoxically a return to the state of dependency in the form of hospitalisation, as was the case with D and C, or with outpatient treatment, as was the case with B.

In reaction to pathological experiences of dependency, the participants attempt an existence of complete independence. Realising the impossibility of this task through life-threatening experiences or inadequate functioning socially and occupationally, the participants are forced to discover a means of integrating dependency striving into their existence.

4.3.8 Healing

The term healing is used here to describe the process of recovery from anorexia, i.e. the normalisation process. This term captures the experience of a process of recovery together with the implication that the wound remains, always ready to manifest.

In order to heal, Participants D and C required hospitalization, while B was able to recover through outpatient treatment and intensive psychotherapy. Both Participants D and C were able to heal through shifting their dependencies onto areas outside of their family of origin. Participant D was able to join a supportive and caring Jewish Orthodox community, where she discovered a sense of spirituality, and found a husband. D's husband was a clinical psychologist, and experienced by her as kind, considerate and tolerant of her anorexic behaviour. Participant C, similarly, was able to discover meaning in a family church and a caring, supportive relationship with a fellow congregant.

Having realised the detrimental effects of food refusal, both D and C engaged in food intake, although in a limited manner, and always focused on dieting. Exercise remains for both an activity of great importance. For D, the threat of relapse occurs. When faced with the enormity of her adult responsibilities, she wishes to escape and avoid life by becoming the helpless foetus once again. D continues to find living a struggle in terms of the demands made on her by husband, children, and career. By increasing her exercise and decreasing food intake, D still is able to find meaning in this method. The difference now is her ability to realise what she is doing, and seeking treatment. When

C experiences the meaninglessness and futility of her existence, she also turns to her anorexic patterns as a means of gaining control once again. However, with her newly-found spirituality and experience first-hand of the consequences of allowing her pattern to become habitual, C, similarly, through self-will, seeks the necessary assistance in psychotherapy and in her support group at the church.

Participant B's recovery is the result of her insight into the extent of her avoidance of life, by hiding in marriage, children, career, and running. B became aware that she was unable to be vulnerable, submissive, and participate in areas of her existence, and was therefore missing out. Presently, B functions as a single mother, not involved in any heterosexual relationship, but more able to enjoy her activities like running, mothering, and career. B's anorexic focus was able to cover up her sense of boredom, emptiness and dissatisfaction in her life, to the detriment of her participation in her marriage, role of mothering and existence in general. B does not describe any relapse, and presently experiences having finally individuated from her family of origin. Her separation from her husband seemed to symbolise more her individuation finally from having to run from her home of origin, than the leaving of an intimate marital relationship.

Ultimately, all the participants had to face the impossibility of their maintaining their anorexic resolution. The participants had to come to terms with the fact of human embodiment being the coexistence of vulnerable dependency and violent independence. The denial of the one in favour of the latter has life-threatening consequences. Healing is the consequence then of being able to balance the need for dependency with the ability to assert one's independent will, as the situation demands.

Having experienced pathological forms of dependency, the participants were not given to the ability to express mature forms of dependency, and, by the same token, mature expressions of independence. Anorexic embodiment is a renaissance, a triumph, a friend, only insofar as it provided the participants, for the first time, with a sense of independent functioning. However, lurking in the shadows of this achievement, was the call for mature dependent functioning. Anorexic embodiment seemed the only method possible for these individuals to learn the ambiguity of existence that human embodiment requires the ability to tolerate the ambiguous coexistence of vulnerable dependency and independent challenges.

4.4 CONCLUSION

In this chapter, the various narrative and interpretive accounts of anorexic embodiment are presented. A collective interpretation of anorexic embodiment is also presented under the core categories that emerged from the data and analysis. In the chapter that follows, the final stage of analysis that compares the present research findings with that of other theories in the field, and Merleau-Ponty's notion of the lived body, are presented.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

The final stage of analysis is called the comparative analysis. This involves a comparative interpretation of the findings from the present study with the already-established naturalized discourses of anorexic embodiment (i.e. the biological, behavioural, psychoanalytical, object relations and family systems theories), and the denaturalized discourses of anorexic embodiment (i.e. the various feminist discourses). Similarities and differences in the findings of the present study with those of the abovementioned discourses are highlighted. The findings of the present study are then compared with reference to Merleau-Ponty's phenomenology of the body.

With the help of Merleau-Ponty's phenomenology of the body, a paradigm of the renaturalized body is presented. It is then argued whether Merleau-Ponty's phenomenology of the body does indeed provide the methodological and philosophical grounding in the task of describing the anorexic body. The theoretical and treatment implications of Merleau-Ponty's paradigm are then discussed. This chapter concludes with an account of the limitations of the present research and suggestions for further research.

5.2 COMPARATIVE INTERPRETATION

5.2.1 A comparison of research findings with the naturalized discourses of anorexic embodiment

Findings from the present research indicate that when starvation had gone too far or when the participants faced doing serious harm to themselves as a result of food refusal, hospitalisation was necessary. In this context, the various medical treatments such as force-feeding and use of drugs, as well as the behavioural reinforcement programmes proved to be valuable life-savers. However, once the participants were out of danger, and no longer requiring hospitalization, it was the use of other methods of treatment such as insight-oriented therapy that proved valuable. Participant D's recovery was undoubtedly initiated by medical intervention and behavioural therapy. The most significant factor identified by her, however, was the experience of a renaissance, an experience which was initiated by her hospitalisation but included her discovery of spirituality and a new sense of self. Participant B's recovery and treatment did not warrant medical and behavioural programming as her disorder did not reach the proportions that threatened her physiological make-up. Participant C was able to initiate a process of recovery following her experience of hospitalisation.

The anorexic embodiment of the participants can only in its severe manifestation be treated or articulated as a physical dysfunction of a mechanistic body. Only at the point of risking death itself through starvation were the paradigms of the biological and behavioural discourses useful. The body-as-machine is susceptible to mechanical interventions and, at the point of risk to life, the biological and behavioural discourses

proved successful in many ways. However, in the long-term, these paradigms proved incomplete. The anorexic embodiment of the participants could only initially be treated as a physical dysfunction of a mechanistic body. The process of recovery required a broader focus on the disorder as a disorder that encompasses the body as well as the self and the relational world. Findings from the present research indicate that the participants' experience of anorexia is more accurately experienced as a disruption of their lived-body rather than primarily a dysfunction of their biological body. Lacking an appropriate understanding of human embodiment, the biological and behavioural discourses are successful in the treatment and articulation of the dysfunctional body, but are unable to conceptualize the broader issues that the anorexic struggles with, and demonstrate through their anorexic embodiment.

The family dynamics in the present study were characterized by over-involved, enmeshed family relationships. As argued by Palazzoli (1974) and Minuchin (1978), the families in the present research were characterized by a strong spirit of self-sacrificial behaviour, poor conflict resolution, refusal to take on responsibilities, and marital relationships that demonstrated a facade of unity, concealing profound disillusionment. The problematics of a domestically dominant mother and emotionally distant father were also implicated in creating anorectic pathology. However, the case of a domestically dominant father and emotionally distant mother needs to be considered, as was evidenced in the present study.

Systemic discourses accurately identified the covert coalitions crossing generational boundaries that were present in anorexic families of the participants. Viewing anorexia

as a form of rebellion against the enmeshment in the family provides an accurate depiction of the anorexic process of the participants. All participants were engaged in a battle against their family dynamics. Absent in this discourse is an explanation of the anorexic's employment of their body to embody this conflict.

There is further no explanation given as to how control of bodilyness by the anorexic is able to exert such power within the family context. The issue of how the body can be the bearer of the family conflict simultaneously to being used by the anorexic as transformative of their family and themselves, remains unarticulated and taken for granted.

Focusing more specifically on parental relations, findings from the present study indicate the possibility of intense father-daughter relations and ambivalent relations with mothers as nurturers as causative in anorexic pathology. Early psychoanalytic discourses (Freud, 1895, 1896, 1905) and Jungian discourses (Woodman, 1980; Caskey, 1986) focus on articulating the nature of the father-daughter relations. Focus on the ambivalent mother-daughter relation is the province of the Kleinian (Hughes, 1985) and object relations theorists (Bruch, 1973; Palazolli, 1974; Lerner, 1988).

Freud (1905) traces the anorexic's disgust at food, to regression from adult sexuality to forbidden wishes for oral sex with the father. Food refusal in this instance is the result of food being equated with sex, on account of this regression. Findings from the present study indicate that when the father-daughter relation was one of enmeshment and symbiotic in nature, the poor social, occupational and sexual functioning of the

anorexic can be languaged in this manner. There is evidence from the study that the intensity of the father-daughter relation was primarily causative in the formation of anorexic pathology.

Elaborating further on the intensity of the father-daughter relation as causative in anorexic pathology is the Jungian view. In the participants' drive towards academic achievement and 'life of the mind', there is evidence of the participants' obsessions and special focus on logos (Caskey, 1986). That anorexics are caught up in a relationship toward the animus, as Woodman (1980) suggests, is evidenced in the participants' attempts at rejection of the other and mother's body in favour of a delusional relationship with the pure adolescent spirit. The drive among the participants was to achieve the spiritual attributes of divine masculine youth.

The anorexic process highlighted in this study does provide evidence of the anorexic's drive for a spiritual union with the *puer*. The experience of triumph, feelings of purity that the participants found so enticing, can be understood to result from the eroticised, spiritual union with the *puer*. Their lack of development sexually, socially, and intellectually, as experienced by the participants, can be viewed as a result of the *puer* being balanced by its opposite, the *senex*, the negative old man. The participants' anorexic embodiment, experienced as a renaissance, a triumph, a friend, can be understood as their discovery of unity with the *puer* and holy *puer* that accounts for the experience of elated feelings. Such achievements and the precarious nature of anorexic embodiment, can be understood by the *puer* being shadowed by the daunting presence of the *senex*. The drivenness to remain pure as expressed in food refusal

and excessive exercise, can be understood in the drive to meet the standards of the *puer*. The withdrawal from food from the outer world, and inhibited sexual development, explains the desire to purify the body so as to live up to the standards of the *puer*. The failure of this project can be understood to result from the criticism of the *senex* that balances out the absolute standards of the *puer*.

The development and failure of anorexic embodiment can be understood as the anorexic's emphasis of one pole of existence, namely the *puer*, that inevitably constellates the opposite pole of existence, namely the *senex*. Too great a search for the *puer*, as expressed in the participants' drivenness for purity and independence, brings with it the presence of the *senex*, with the absolute standards of impeded development.

The psychoanalytical and Jungian discourse provides insights into the father-daughter relation, and the anorexic's special focus on the animus, respectively. Evidence for these discourses were present in the study whereby an intense father-daughter relationship was cited as causative in the anorexic process. The participants further did display an intense focus on logos, and sought a union with the *puer*. The failure of their attempts at being the *puer* can be articulated by the presence of the other pole of *puer aeternus*, namely the *senex*.

The particular nature of human embodiment that allows the anorexic to employ her body as the grounds for regression, remain taken for granted and unarticulated. Similarly, regarding the Jungian account, there is no explanation of how the body is able to be

shaped so as to signify the embodiment of union with the *puer aeternus*. The use of the body, as being the fertile soil for such embodiment, remains to be articulated.

The viewpoint that anorexia expresses infantile ambivalence towards the mother is the focus of Kleinian followers (Boris, 1984; Hughes, 1985; Dunbar, 1987). The Kleinian model is able to explain the mechanisms involved in creating the mother to be fantasized as the internal persecuting object. For Klein (1946), the infant's ego is driven by the instincts toward both love and hate of the mother. The infant's ego is, however, so fragile and precarious, it fears annihilation by its own hatred. This feeling is therefore expelled out of itself into the mother. The mother is now experienced as hating and persecuting the baby. Re-internalized, she is experienced as a persecuting internal object. During adolescence, the fantasy of the other as an internal persecuting object is exacerbated. The female bodily changes of puberty render the pre-anorexic similar to mother. This explanation explains the age of onset, the extreme fear the participants experience of being enmeshed with mother, and the extreme drive for independence that the participants achieved through their anorexic bodies that they experienced as their own creations.

Through food refusal, the participants did act out their persecutory fantasies with their mother. Food refusal was a direct attempt at expressing rejection and independence of the mother's feeding role. Food refusal was an attempt at displaying a separateness from the dependency on their mother-figures. The Kleinian model is further useful in explaining the issues of greed and envy as experienced by the participants. Regarding the former issue, the presence of greed and longing triggered by differentiation from

parents in adolescence were important aspects of the participants' anorexic process. Regarding the latter, the use of superlative academic and athletic achievements as a means of evoking envy of others, formed an important dimension in the development and maintenance of the anorexic body.

The Kleinian discourse explains the age of onset, the extreme fear of being enmeshed with mother, and the extreme drive for independence, as expressed by findings from this study. Absent, however, in this discourse is an articulation of the particular nature of human embodiment that allows the anorexic body to be the bearer of the internalized persecutory object, and the means of expressing differentiation and distantiation from the feared other.

Object relations theory (Bruch, 1973; Palazolli, 1974; Goodsitt, 1985), unlike Kleinian discourses, focuses on the real failure of the mothers of the participants to respond to the needs of their children during infancy. The inability of the participants to meet the challenges of independence during puberty is articulated by object relations theory as resulting from early faulty learning. This explains the compliance, dependency, and immaturity of personality, as gleaned from the histories of the participants' upbringing. As expressed by the participants, the need to comply with parental needs resulted in the development of a lack of sense of self, because of an obsessive focus on the external desire and wants, particularly of their caretakers. As witnessed in the participants' experience, this lack of a sense of self was particularly challenged when, during adolescence, the demands on the participants to become adult and develop an identity separate from their parents was too threatening. This failure in being able to meet the

challenge of adulthood is described by Bruch (1982) following Kohut (1971) to be a consequence of the parents' failure in their capacity to act as 'self-objects'. The result, as embodied by the participants in this study, is a development of an inauthentic and insecure sense of self. Bruch highlights the role reversal evident in the histories of the participants, whereby, instead of the parental being, the self-object that the anorexic needs, the anorexic is called upon to be a self-object to the narcissism of their parents. Likewise, Lerner (1986), adopting the work of Winnicott (1958), attributes anorexia to failure in the maternal holding environment.

Anorexia in this discourse is viewed as a struggle for identity and selfhood, precipitated with the onset of adolescence that calls for a transition to independence and maturity of which the pre-anorexic personality is incapable of answering. This model is accurate and congruent with the research findings in its emphasis on the age of onset and the inability of the participants to develop a secure, independent sense of self. However, the nature of human embodiment that allows the anorexic body to incarnate a failed holding environment and embody an insecure sense of self, remains to be expressed.

The naturalized discourses of the anorexic body implies that the anorexic body is understood to rest as the firm foundation of a 'natural' body, where 'natural' means ahistorical and cross-cultural, and thereby fixed. Ignored in these discourses of anorexia is an understanding of the body as it is lived. In order to capture the experience of anorexic embodiment, the body needs to be viewed more than primarily as a biologically functioning entity. To conceptualize the anorexic embodiment, a model

of the body is required that incorporates but goes beyond the biologically fixed body, implied in the naturalized discourses of anorexic embodiment.

The naturalized discourses of anorexic embodiment highlight the problematics of enmeshed parenting, poor coping mechanisms in the family of anorexics, and the anorexic's struggle for a separate sense of independence and identity. There is, however, no articulation of how the body, particularly in the case of the anorexic, becomes the bearer of self-consciousness, consciousness, and relationship to others. Stating the issue more accurately, the question as to how the absent father, overly enmeshed mother, and poor sense of self, as experienced by the anorexic, become prefigured in the body, remains unanswered in these discourses.

The naturalized discourses of the anorexic body describe the biological object-body. By viewing the body as a physical entity in a world external to it, the biological and behavioural discourses explain only the objective pole of experience. By viewing the psyche as the active subject of experience, the psychoanalytical, Jungian, object relations and family systems theory, explain only the subjective pole of lived experience. Anorexic embodiment, because of its extreme nature, demonstrates most clearly that the body is the incarnation of their relations to others, to their world, and finally to themselves. That the body can be used to express these relations is only possible if understood as the lived body. Further critics of the naturalized discourses of anorexic embodiment stem from the feminist discourses which forms the content of the next section.

5.2.2 A comparison of research findings with the denaturalized discourses of anorexic embodiment

Feminist discourses aim at the denaturalization of the anorexic body, re-defining anorexia as a product solely of cultural construction. These discourses take issue with the naturalized discourses that posit a purely natural state prior to culture, and argue for a purely cultural state prior to nature. Such denaturalization of the anorexic body, however, falls unwittingly into the very nature/culture dichotomy that feminist discourses seek to challenge. As will be argued, the feminist denaturalization of the anorexic body provides useful insights into the cultural construction of the anorexic body. However, similar to the naturalized discourses, the feminist discourse, lack an appropriate theory of the body, that can account for the intertwinement of subjective, objective, and cultural dimensions, as pre-figured in the anorexic body.

Unlike the naturalized discourses of self-psychology and object relation theory, Orbach (1986) denaturalizes the anorexic body and situates the deprivation causative of anorexia within the context of deprivation suffered generally by women in a sexually unequal society. It is clear that the mothers of the participants, and the participants themselves, were brought up to accept an inferior position subserving the needs of others, and were not encouraged to develop an authentic expression of needs or a sense of entitlement for their desires. Orbach's (1986) discourse is congruent with the present research findings in locating the anorexic body as a somatised solution to the feelings of uncontrollable and chaotic neediness, as a defence against the exposure of a very vulnerable sense of self. The participants in the present research were involved

in rejection of the needy self/body (Orbach, 1986, p.89) in favour of a false self/body devoid of needs.

Orbach's (1986) discourse highlights the social roots of the difficulties women experience in expression of their needs and desires, citing the anorexic body as a protest against unexpressed emotions. However, there is no account given as to how the body is capable of acting as the bearer of a protest and a language for problems which cannot be consciously articulated.

Chernin's (1986) discourse, identifying the anorexic body to be the result of a hidden struggle for self-development, accurately portrays the findings of the present study. All the participants expressed a search for identity and self-hood in their anorexic embodiment. Having achieved an anorexic state, the participants described achieving a sense of self, albeit fragile and temporary.

Chernin argues that it is the guilt in the mother-daughter relation that is the single-most important factor in the genesis of anorexia. The participants in the present research did not express a sense of guilt overtly in their mother-daughter relations. The participants, however, in agreement with Chernin, did experience a tremendous separation struggle in this relationship. On the one hand, there was an intense desire to be dissimilar and separate from their mothers, simultaneously to being caught in caretaking roles. For Chernin (1986), this dilemma captures the mother-daughter relation of anorexics, namely, the guilt the daughters experience in surpassing their mothers in their quest for self-development. Congruent with Chernin's (1986) apt

description of the 'Cinderella Complex' that captures the daughter's fear of independence, are the findings of the present research. It may well be that the participants' fear of independence stems from a pervasive worry about mother's life.

Chernin (1986) correctly describes the mother's life as one of discontentment and failure to take up women's opportunities in the public domain. The mothers of the participants clearly displayed a low sense of self-development and inadequate functioning. The mothers of the participants were needy and requiring support from them. Drawing on Klein (1946), Chernin argues that the daughter, plagued with the guilt at surpassing mother, blames herself rather than the culture for her mother's wasted life. Chernin thus denaturalises the issue of guilt, and argues that women are trapped by the guilt over growth, food, and eating, which is not only an act of violence against the mother, but a feeling reinforced by culture.

Anorexia for Chernin (1986) is an attempt to remake the female body: "It is symbolic gender transformation" (p.52). The hope, argues Chernin (1986), is that in the anorexic developing the lean female body, she will "escape from the mother's destiny without enduring the remorse of leaving the mother, and will be able to surpass her mother with the serenely cruel and self-referring attitude of a son" (p.56).

This was similarly the hope and experience of the participants in the present study. Anorexic embodiment was aimed at separation and individuation from mother, and, in their struggle to maintain this process, the anorexic embodiment of research participants revealed a hidden struggle for self-development.

Chernin's (1986) discourse is valuable in identifying the dynamics involved in inhibiting self-development and understanding the anorexic body as the incarnation of a hidden struggle for self-development. However, the manner in which a disturbance in the intersubjective realm of mother effects the subjective realm of self, such that the body is re-created to signify a struggle for self-development, requires an understanding of the body that simultaneously intertwines the intersubjective and subjective, so that the conflict becomes prefigured at the level of the body. This very issue remains taken for granted in Chernin's (1986) discourse and calls for elucidation.

Lawrence (1979) argues that the areas of food and the body are chosen as the sites of control and denial, because food and the body are two of the areas open and accessible to female control, and partly through a lack of alternatives. Findings from the present research indicate that within the overprotective family environments, and the powerlessness that the participants experienced in the positions demanded of them by their parents, food and the body did provide a sense of control, an open door, an outlet, in the face of a lack of alternatives. A sense of power was achieved through control of food and the body. Given that appearance is central to women's acceptability, Lawrence (1979) argues that the body becomes the major component of female existence.

Although the participants were driven to control both food intake and weight, the underlying conflict, in this study, was found to be what Lawrence (1979) identifies as a conflict over independence and autonomy. The participants were engaged in a conflict between two courses of action: pursuing individualistic success, which was seen then

to involve a rejection of femininity or abandoning this course to becoming fully feminine and therefore subordinate, defining the self in relation to others. When the former course of action was chosen, the participants manifested an extreme drivenness to achieve within the public domain, striving for success in careers and sports. When the latter course of action was chosen, the participants chose to remain home-bound and entangled in the demands and needs of the home. The anorexic body, according to Lawrence (1984), represents a retreat from independence. The conflict for Lawrence (1984), however, is social rather than individual. Findings from the present study support Lawrence's (1984) view regarding the conflict that the anorexic experiences. However, anorexia as experienced by the participants was not only a retreat from independence, but also a direct expression of a desire for independence. Findings from the present study suggest that the anorexic is struggling not only with issues of independence, but with the very shadow of independence, namely dependency. Lawrence (1984) correctly identifies the importance of food and the body, in the female gender role, and highlights the issue of how far it is indeed possible for women to achieve independence in a socially unequal society. That all the participants are female, and that the anorexic experience is meaningful almost exclusively to women, is catered for by Lawrence's (1984) explanation.

Chernin's (1986) account, however, does not articulate the particular nature of human bodilyness that permits it to be the surface for the anorexic's expression of conflict between success and dependent femininity. Lawrence (1984) does identify the social role of woman that renders food and the body an area of focus, but the conditions of

human embodiment that allow the anorexic to express her conflict at the level of the body, remain taken for granted.

Macsween (1993) argues that in anorexia, the body and its appetites are transformed in an attempt to eradicate desire. The body, says Macsween, is split in two: "the desiring body, in which appetite is lodged; and the desireless body, which needs nothing and wants nothing" (p.194). The participants in the study were engaged in the struggle to contain the desiring body that sought expression, freedom, and independence. Equally, the participants struggled to maintain the desireless body that attempted to be free of need, others, and family. Macsween (1993) highlights the issue of feminine desire that is not permitted expression, and demands repression. The result is a dichotomy between discipline and chaos. The participants experienced tremendous satisfaction and achievement when acting out in the discipline pole of the dichotomy. The restriction of food intake, low body weight, and superlative achievements in exercise and academics, were experienced with triumph. However, such triumphs were shadowed by the threat of desire and chaos that shadowed the achievement of a desireless body. Breaks in diet, increase in weight that threatened chaos, were immediately treated with severe discipline in the form of increase in laxative abuse and exercise.

Identifying anorexia as the logical conclusion of the social construction of the feminine body through objectification and the discipline/chaos dichotomy, Macsween (1993) identifies the anorexic struggle of the participants in this research. The aim of the participants was to create the anorexic body as an "absolute object-inviolable, complete,

inactive and initiativeless, wholly-owned and controlled by the self" (p.197). Evidence from the present research indicates that the participants were not encouraged to give expression to their desiring body, and that the desiring body was in the hands of significant others, be it their mother or father. The mothers of the participants were also leading lives that involved a subordination of the desiring body. The participants, however, did not articulate the extent of social construction involved in their adoption of typical feminine role stereotypes in their lives. Awareness was only expressed at the level of parental control of their desire and expectations. The social construction involved in creating anorexia was not articulated by the participants, tantamount perhaps to the strength of this force, at a pre-reflective level, that makes Macsween's (1993) articulation of the social control of desire in females vitally important.

The particular nature of human embodiment that permits the cultural control of the natural body, and that is involved in the anorexic's transformation of these meanings, is not articulated in Macsween's (1993) account. The cultural construction of the body and the body's attempt, in the form of anorexia, to resist this construction, requires an understanding of the nature of embodiment that allows for this process. This understanding remains taken for granted.

The cultural construction of the anorexic body emanates from the feminist denaturalisation of the body, viewing the body as a product of cultural meaning. The discourses of Orbach (1978), Lawrence (1984), Chernin (1986) and Macsween (1993) expose the phallogentric nature of the naturalized discourses, and attempt to reclaim suppressed 'women's' history, values and experience.

Of increasing concern to many contemporary feminist theorists (Bordo, 1990; Bigwood, 1991), however, is the use of gender as a means for criticizing the naturalized discourses and for valorizing specific female values. To assume that the term 'woman' denotes a stable, coherent common identity, and to criticize a universal oppressive structure called the 'patriarchy', has recently come to be viewed as a theoretically disastrous move, because it is essentialist, i.e. it pays insufficient attention to historical and cultural diversity, and enforces a hierarchical and heterosexual gender division (Bigwood, 1991).

Bordo (1990) calls this contemporary current in the denaturalized feminist discourses "gender skepticism" (p.134). Gender skepticism holds that "any attempt to cut reality and perspective along gender lines is methodologically flawed and essentializing" (Bordo, 1990, p.134). In agreement with Bigwood (1991), an important feminist task requires finding a means of reconciling the established feminist project to reclaim female perspectives with a renewed attempt to purge feminism of essentialism. A way needs to be found to historically contextualize broad categories, like "female desire" (Macswen, 1993), and "woman", and to use these concepts so that they are "neither exclusionary, nor fleshless abstractions" (Bigwood, 1991, p.55).

In our effort to understand anorexic embodiment, a new discourse of the body that leads neither to the biological determinism of the naturalized discourse, nor to the gender skepticism and cultural relativism of the denaturalized discourse is required. In affirming a link between gender and the body, the naturalized discourse need not resort to fixed biological differences that rest on innate ahistorical differences, and the denaturalized

discourse need not resort to inflexible cross-cultural categories. Anorexic embodiment, in its extreme demonstration of human embodiment, requires an understanding that is cultural and historically contextualised on the one hand, and yet part of embodied givenness on the other. The anorexic body displays most clearly in its lived sense and in the theoretical attempts at understanding that it is neither grasped solely as the product of biological determinants nor purely culturally constructed.

With the help of Merleau-Ponty's phenomenology of the body, a paradigm of the body will be presented that recovers a non-cultural, non-linguistic body that accompanies and is intertwined with cultural existence. The crux of the argument will be to "renaturalise" (Bigwood, 1991, p.61) the anorexic body, thereby releasing it from a dichotomized nature and culture. The anorexic body calls for a natural-cultural discourse of the body, since anorexic embodiment highlights most poignantly its involvement in cultural fields of forces simultaneously to being part of a web of relations with the non-human.

The feminist denaturalization of the anorexic body does free gender from the naturalized discourse of a biologically fixed body. However, in privileging culture over nature, the feminist discourses arrive at a disembodied body that reinforces the very same phallogentric metaphysical structures that have contributed to the domination of women and nature (Lloyd, 1984).

5.3 MERLEAU-PONTY AND THE RENATURALIZATION OF THE BODY

Working within a dialectical framework, Merleau-Ponty exposes the limitations of both the empiricist denigration of the body as a passive receptor, and then active calculator of sense-data and the idealists' disregard of the body in favour of consciousness, which the idealists claim is the truly active performer in the constitution of phenomena (Bigwood, 1991).

In the *Primary of Perception*, Merleau-Ponty (1964) considers the naturalized discourses approach to the issue of recognition of others. Beginning with the concept of psyche and body, Merleau-Ponty investigates the underlying concepts and presuppositions implied in such a discourse. By psyche, the naturalized discourse, following Descartes, argues that it is the private awareness one has of the contents of one's consciousness. The psyche is taken to be the private awareness that one has of one's own feelings, ideas, or imaginings. No one else can directly experience my ideas or imaginings. No one else can, for example, experience my experience of anger or even my perception of greenness (Merleau-Ponty, 1964). Within this framework, the grasping of the other's psyche can only occur in an indirect fashion, "since each individual has a privileged access only to his or her own psyche" (Merleau-Ponty, 1964, p.113).

Merleau-Ponty next considers the concept of the body that is used in the naturalized discourses. This concept is critiqued by Merleau-Ponty (1964) by considering the concept of cenesthesia meaning "a mass of sensation that would express to the subject the state of his different organs and different bodily functions" (p.113). According to this

view, my body is given to me as a mass of introceptive sensations, as an agglomeration of cenesthetic and kinesthetic feelings. For Merleau-Ponty (1964), this makes "my experience of my own body completely private as well as shutting me off from the experience another has of his or her own body" (p.164). Given these presuppositions, Merleau-Ponty argues that the only way that "I can recognize the other person as a person, as a conscious subject, is to project my own internally experienced psyche into a body that I recognize from a point of view outside of it, as similar to my own" (p.115).

Merleau-Ponty has serious difficulties with this approach and the "argument from analogy" (Low, 1992, p.49) that it implies, namely that I recognize the other by first noting his or her body, perceived from the outside, as similar to my own, and then by projecting my subjective interior into this similar-looking vehicle. Firstly, Merleau-Ponty (1964) argues that this argument actually presupposes what it is trying to explain: "the recognition of the other's body as similar to my own already grasps a human body, a body invested with a psyche" (p.352). Merleau-Ponty further elaborates that the child's recognition of the other, and clearly children do recognise the other, cannot be explained by the complicated reflective and intellectual process of recognition, as the naturalized discourses would have it. The infant's recognition of its mother's smile, "allegedly perceived as an object, cannot be possibly associated with an intellectual judgment about its own smile felt from the inside. The infant simply has not yet developed such reflective and intellectual abilities" (Merleau-Ponty, 1964, p.115).

For Merleau-Ponty, the naturalized discourses cannot explain the problem of the recognition of others. These discourses attempt to articulate the problematics of

recognition of others through the use of the terms introjection, projection, and projective-identification without tackling the ontological foundations that allows, in the first place, for the recognition of others. However, it is precisely this recognition of others that forms the basis of the psychoanalytic, Kleinian, object relations, and Jungian perspectives. Merleau-Ponty thus recasts the notion of psyche and, instead of thinking of it as something that is introspectively given only to itself, he defines consciousness as a relationship to the world, as active and turned primarily toward the world. With this notion of psyche, it becomes much easier to recognize the other as another human being, since, as Merleau-Ponty (1964) puts it, "I am not attempting to grasp a private psyche absolutely different from my own, but simply transferring action from one body to another. The other is grasped as a certain way of comporting himself toward the world" (p.116-117). Consciousness is conceived not as the knowing reflective subjective of the naturalized discourses, but as a carnal, prepersonal bodily relation to the world. For Merleau-Ponty (1968), the body is seen as the lived through relation to the world. Since:

"the visible is always between the aspects we see of it, there is access to it only through experience, which, like it, is wholly outside of itself. It is thus, and not as the bearer of a knowing subject, that our body commands the visible for us"
(p.136).

The body is the next concept of the naturalized discourse that Merleau-Ponty transforms. Instead of knowing the body primarily through cenesthetic and kinesthetic sensations, i.e. as a mass of introceptively given sensations, Merleau-Ponty (1962) argues that the human body is best revealed as a "postural" or "corporeal schema" (p.118). The consciousness that I have of my body is really "the perception of my

body's position in relation to the vertical, the horizontal, and certain other axes of important co-ordinates of its environments" (p.117). Thus, when perceiving the other's body, "I perceive a conduct, an orientation toward the world, and there is often an intentional coupling of our bodies' (p.118). Merleau-Ponty (1964) contends that the other's intentional conduct plays across my own body, that "it is this transfer of my own intentions to the other's body and of his intentions to my own, that makes possible the perception of others" (p.118).

In order to cement the argument of the relation between incarnate consciousness and the world, Merleau-Ponty (1968) considers tactile experience. Merleau-Ponty claims that in order to have a tactile experience, my hand must feel from the inside as it moves across a surface, but in order for this to take place, the hand must be capable of being touched from the outside. There is a reversibility or chiasm that is present here that must be grasped in order to understand this simple yet fundamental experience of tactile sensation (Low, 1992). In order for the hand to be able to feel from the inside, it must "pass out into the ranks of the touched, and it is no different for vision, since he who sees cannot possess the visible unless he is possessed by it, unless he is of it" (Merleau-Ponty, 1968, p.134).

For Merleau-Ponty then, experience does not just occur anywhere. The tactile, for example, occurs within, yet a contribution is made to the tactile from the outside, and these experiences blend. Consequently, there is an uncertainty about where the toucher ends, and being touched begins. There is a blend of the feeler, toucher, touching, with that which is felt, touched, being touched. Following Low (1992), the

tactile (an experience) brings together the feeler (the experiencer) with the felt (the object) in such a way that a distinction cannot quite be made between them. The tactile experience has an inside but also a general side, for the tactile extends beyond the toucher and is yet inclusive of him or her. There is thus an anonymous, prepersonal character to bodily experience: "there is the tactile in general or the visible in general of which the perceiver is a part" (Merleau-Ponty, 1968, p.139).

For Merleau-Ponty then, it is the body that is both subjective and objective, it is a lived combination of both. The subjective and objective are both present but blended in such a way that they can not be separated or completely distinguished (Low, 1992). The explicit subjective and objective come out of this original whole. Just as the child's conscious life does not begin with an explicit sense of autonomy, so the lived bodily awareness is not yet individual. Experience is not yet subjective, for it extends beyond and includes the subject. This bodily experience is prepersonal and thus not yet completely individual. It is in this manner that experience is both my own, yet able to be shared by others.

Thus, even though incarnate consciousness is individual, occurring within one body, it is also open to others' experience. The relationship between the self and other is mediated by the world, by an anonymous visibility. Given these structures of the body, there is a prepersonal, anonymous generality to experience, of which both I and the other partake. The individual is surrounded by a halo of generality:

"At the frontier of the mute or solipsist world where, in the presence of other seers, my visibility is confirmed as an exemplar of a universal visibility, we reach a second or

figurative meaning or vision, which will be the *intuitis mentis* or idea, a sublimation of the flesh which will be mind or thought" (Merleau-Ponty, 1968, p.145).

From this statement, Low (1992) argues that the presence of other seers along with the unity of experience within the body, contributes to the formation of my sense of self as an individual. Regarding the relationship of the individual to the other, Merleau-Ponty (1968) makes the crucial point that:

"the factual presence of the bodies could not produce thought or the idea if the seeds were not in my own body. Thought is a relationship with oneself and the world as well as a relationship with the other; hence it is established in three dimensions at the same time" (p.145).

According to Merleau-Ponty then, lived pre-reflective, prepersonal contact with the world is articulated (and makes a particular example of universal visibility) through a reflection on the pre-reflective (a reflection that is motivated by the presence of the other). Following Low (1992), the seeds of the articulation, however, are present prior to the presence of the other,

"for how could the mere presence of the other bring about my own self-awareness and my awareness of the world? How could the mere presence of the other create my own consciousness if it was not in some way prefigured in my own body?" (p.54).

The presence of the other helps complete our reflection on ourselves and the world. It does not virtually create it. The experience of the others, of the world, and of my self are all prefigured in the body, in one sole body.

5.3.1 Merleau-Ponty's notion of the body as a two-dimensional and reversible being

Merleau-Ponty (1962, 1968) thus provides an answer to how the body is the bearer of self-consciousness, consciousness, and relations to others. Self-consciousness (i.e. relation with oneself), consciousness (relation with the world) and the relationship to others, are prefigured in the body because "the body is a two-dimensional being, a whole with two sides or aspects, an obverse and reverse" (Low, 1992, p.55). The phenomenal, lived body is my access to the world, my openness to the world. However, it is also a thing. It is of their kind. The phenomenal body is a sensing sensible. The toucher is capable of being touched. The seer is capable of being seen. This two-dimensionality and reversibility of the body is made explicit, not created, by the presence of the other. I am a seer who is actually seen by another. The turning-back of the body on itself prefigures what comes to be called self-consciousness.

The phenomenal body moreover is not just a thing or a thing capable of being seen from the outside. It is a sensing sensible. The body is an openness or access to other bodies and things. The body as self or consciousness is therefore the other side of the visible. It is that which reveals the thing. Merleau-Ponty (1968) argues that the body as self or consciousness is a negative:

"The negative here is not a positive that is elsewhere (a transcendent). It is a true negative, i.e. an *Unverborgenheit* of the *Vorborgenheit*, an *Urpräsentation* of the *Nichturpräsenturbar*, in other words, an original elsewhere, a *Selbst*, that is an Other, a Hollow. Hence no sense in saying the touched-touching junction is made by Thought or

Consciousness: Thought or Consciousness is *Offenheit* of a corporeity to World or Being".
(p.254)

The body, then, prefigures what comes to be called consciousness, for the body as self is an openness onto being. It is the other side of the visible, that which makes the visible appear but which is itself invisible. The self as experiencer can never be captured or turned into an object by reflective thought because it is always that which is doing the experiencing. This does not make the experiencer transcendental, as it does in idealist thought. The experiencer is the "openness of a corporeity", the "other side of the visible not the consciousness of a transcendental ego" (Low, 1992, p.54).

It can now be seen that the two-dimensional human body prefigures the relationship to the other. It is the original experience of that which is other, it is the "original elsewhere" (Low, 1992, p.55). Contained within the very structure of the human body is a relationship to that which is other. Contained within the body is an experience of a self that is other, a self that is not positive but an openness to the other, a self (the experiencer's own self) that is other, since it only experiences itself as being at the things, as an invisible that reveals the visible. This then, argues Low (1992), is how Merleau-Ponty (1962, 1968) is able to establish the body as the bearer of self-consciousness, consciousness, and the relationship to the other, as all prefigured in the human body.

This fresh model of the body will now be used to help articulate the anorexic body that, in its adopting of a pathological stance, demonstrates the inextricable entanglement of the natural and the cultural. The anorexic position is only possible since we are always

situated in an intersubjective (and thereby already cultural) spatiotemporal fleshy (and thereby already natural) world. Merleau-Ponty (1962) enables us to understand we are never just a factual thing and never a bare transcendent consciousness. Our human body, as described by Merleau-Ponty (1962) with its habits weave things into a human environment and into an infinite number of possible environments, eluding the simplicity of a merely physical bodily life. On the other hand, "there is not a single human cultural configuration or form of behaviour that does not owe something to 'natural' existence, that is not bound up with the rest of the intersensory environs" (Merleau-Ponty, 1962, p.189).

This incarnate natural-cultural situation will be shown to be crucial for the understanding and reconceptualizing the nature of the anorexic body. A renaturalized discourse of the anorexic body understands the anorexic body not as a fixed given untouched by the dominant representational system, but as an anchorage nevertheless in the world, consisting of an interconnected web of relations with the human and non-human, the cultural and natural. It will be argued that the anorexic body calls for an articulation that is neither naturalized nor denaturalized, but renaturalized as a "connatural body" (Bigwood, 1991, p.66).

5.4 THE RENATURALIZATION OF THE ANOREXIC BODY WITH THE HELP OF MERLEAU-PONTY

Merleau-Ponty's analysis can now be applied to the anorexic body. It can be seen that the anorexic is capable of using the body to achieve a temporary, fragile sense of

individuality or independence, because of the unity of experience within the body. The body, understood as the bearer of a relation to the world (i.e. consciousness), a relation to others, and a relation with oneself (i.e. self-consciousness), becomes the ideal grounds for the anorexic to grapple with their conflicts with their world, significant others and themselves.

Furthermore, the body as prepersonal blends in with what it is not, it blends with that which is other than and beyond it. It is against this background of the anonymous visibility that the anorexic body can shape itself. The anorexic solution becomes possible only against the backdrop of a prepersonal, pre-individual horizon. The anorexic goal of striving for an existence of only the dominance of the subjective is possible because bodily experiences blend in a chiasm the subjective and the worldly. The anorexic struggle can be viewed as the battle against this world, and a consciousness that is intimately linked with others. The anorexic body attempts to refuse the dialectical interaction between the self and the other as a system that is capable of defining and forming self and other. That the explicit sense of individuality is dependent on the presence of the other is a source of great discomfort to the anorexic. All the participants attempted to overcome the chiasm of the subjective and the worldly, in an attempt to extricate themselves from the worldly, and reveal themselves only as pure subjects that have severed the dialectical interaction between the self and the Other. The anorexic process of the participants is an attempt to deny the dependency of an explicit sense of individuality on the presence of the Other. All the participants attempted, through their emaciated bodies, to disappear from both the prepersonal horizon and presence of the Other. For Participant D, this meant an

extreme regression to a foetal state. In the case of Participant B, the attempt to deny the prepersonal horizon and dependency on others, took the form of an extreme desire and manifestation of extraordinary independence and self-sufficiency. Participant C remained depressed and frustrated in her link with the prepersonal and her mother by the mere presence of a being a body.

In this sense, anorexic embodiment can be viewed as a disruption of the lived body. It represents a chaotic disturbance between the interactions of embodied consciousness and the world, in an attempt to demonstrate that embodiment is extrinsic to the self. The anorexic strive for a form of bodiliness that is a thing amongst things, and a form of consciousness that is disembodied. To achieve a form of bodiliness that is a thing amongst things, the anorexic engages in food refusal, excessive exercise, and experiences a sense of satisfaction when the body is reduced in weight and size. To achieve a form of consciousness devoid of bodiliness, the anorexic seeks unrealistic freedom and independence from need and desire. All the participants are most ecstatic, although short-lived, when pushing their bodies to the limits either through excessive exercise or starvation. In this regard, Participant D describes an addictive high in pushing her body to the limit during aerobic classes. Participant B experiences a tremendous sense of satisfaction in her jogging, when pushing her body to achieve greater distances. All the participants experience a sense of heaviness and depression when once again they have to face the facticity of their bodiliness, following an escape from the body, through exercise. The anorexic body attempts to mirror the Cartesian vision by separating bodily acts as purely mechanical from acts of cognition and volition as purely mental.

Findings from the present research indicate a desperate power struggle between research participants and their parents over ownership of their body. The participants' early initiatives toward self-directed activity and self-ownership were discouraged, stifled, and replaced by parent-directed activity. A primary deficit in individuation, self-awareness and self-ownership resulted. The sense of body ownership was diffused in the family. Participant D felt that her body belonged to her mother and her family of origin. Participant B struggled to free her body from total ownership and dominance by her mother. Participant C struggled to create a boundary between her body and that of her mother, whereby C was unable to assert herself and meet her own needs and desires.

The naturalized discourses identify the cause of this bodily diffusion in the father-figure (psychoanalysis, Jungian theory) in the mother (Kleinian theory), and in the failure of the holding environment (object relations theory). Systems theory identifies the cause in the anorexic family. The denaturalized feminist discourses of anorexic embodiment locate the cause of diffuse bodily ownership in the stereotypical roles that a sexually unequal society imposes on women. Both the naturalized and denaturalized discourses provided meaningful articulations of the problematic precipitants in anorexic embodiment.

However, following Merleau-Ponty, the diffusion of body-ownership in early childhood and adolescence was made possible because phenomenologically 'our bodies' are *a priori*, a more primitive phenomenon than 'my body'. The human being does not enter the world as an individual isolated psyche. The domestically dominant mother,

enmeshed father-daughter relationships, anorexigenic family, and Western society, exploits this *a priori* nature of the human body. The naturalized and denaturalized discourses set out on the wrong foot when assuming the human body enters the world as an individual, isolated entity, because then they are forced to pose the question: How does enmeshment, failure of the holding environment or society's impact on the body take place? Furthermore, the human being does not enter the world in full possession and custody of the body. The 'own body' is a late arrival in the human family (Moss, 1980). The anorexic struggle is to achieve a level of ownership of the body as 'my own body' against the backdrop of a sense of diffused bodily ownership.

Merleau-Ponty (1962) notes that there is a fundamental ambiguity in the structure of the lived body. Whilst the lived body is that which is intimately 'mine', it is yet an object for others being at once the "expression and expressed of my existence" (p.184). As an object for others, it altogether escapes my subjectivity. It is this ambiguity in the structure of the lived body that provides the grounds for the anorexic's subjective control of the body in an attempt to overcome the 'object-ness' of the body. Furthermore, it is the body's capacity as 'object for others' that provides the grounds for control and exploitation by significant others in the anorexic family and culture at large, to the exclusion of the subjective pole of the body. Furthermore, it is this ambiguity in the structure of the lived body that provides the grounds for much of the recent debate in discourses of anorexic embodiment that centre around the relative merits of articulating the subjective dimension or objective dimension in anorexic embodiment.

The question then is raised as to which discourse is given preference in its supremacy in articulating anorexic embodiment. Must one choose the subjective relative truths of the idealist discourse, or the objective truths of the empiricist discourse, or the culturally determined nature of the feminist discourse? Merleau-Ponty attempts to get beyond this debate over the split between the naturalized and denaturalized discourses by shifting the problem of epistemology to that of ontology. Merleau-Ponty considers the question of what it is to be a body before considering questions of epistemology. Once fundamental ontologic notions are clarified, the, at times, acrimonious debate concerning epistemology will be resolved, for as Laudan (1977) notes, a discourse includes both epistemologic and ontologic commitments which are inextricably linked.

In reaction to bodily diffusion and in the struggle to re-appropriate the body-object as their own, the anorexic objectifies the lived body in various ways. Firstly, there is a return of consciousness from its discomfort in the hands of the other, to the body, where the anorexic temporarily attempts to find a home. The usual self-forgetfulness of the body which loses itself in behaviour directed towards the situation, the thing or the other, is eradicated. The lived body is transformed into object-body. Furthermore, under the gaze of the other, be it parents or society, the anorexic perceives the body not only as being-an-object for the other, but also the brute fact of being a biological entity.

Zaner (1981) notes that this "status cannot be gainsaid but must be directly confronted and understood" (p.48). The anorexic desire for freedom from the body struggles with the ability to deal with the issue of morality and materiality of the body. In this sense, the meeting of basic biological needs such as the need for food, sexuality, sleep, and

the menstrual, reproductive, and digestive functions are experienced traumatically and as areas of disgust. The anorexic solution to the struggle with dependency and independence, by creating a body that is totally in the grasp of the subject, must fail since "no sooner does one feel tempted to say 'I am my body' than one realizes 'I am not yet my body'" (Zaner, 1981, p.50).

Zaner (1981) suggests that to experience one's own body as Other is to experience the own body as "uncanny" (p.48), the 'uncanny' being something hidden (repressed) which makes its appearance suddenly. There are four senses in which the body is experienced as 'uncanny': 1) the inescapable/the limitation; 2) chill and implicatedness; 3) hidden presence; 4) alien presence. In the first case, Zaner (1981) notes that a sense of inescapability and limitation are essential to embodiment. While it is inescapable that I be embodied, it is a matter of contingency that I have this particular embodiment, i.e. this particular neurophysiological make-up. This particular embodiment carries with it certain radical limitations:

"In critical ways and whether I like it or not, there are some activities, gestures, postures, sensory encounters and sensory refinements, etc. which are just not within my bodily scope, thanks to my being embodied by this and not some other body"
(Zaner, 1981, p.51).

Thus, the human subject is forced to deal with the limitations of embodiment and is not free to do whatever is willed, since the body must be taken into account. The despair experienced in the anorexic process results from the anorexic's attempt to deny the inescapable limitation of embodiment. The anorexic has to come to terms with this

contingency. The habit of the body of making itself present, intruding and disrupting the anorexic goal to disappear, renders the anorexic helpless and depressed. Whatever impacts on the body impacts on the self. Bodily experiences then are experiences of corporeal implicatedness. The person is bound to this particular embodiment and is irrevocably bound to suffer what the particular body suffers. The recognition of corporeal implicatedness (especially in its most radical form, that of my own going-to-die) is accompanied by a sense of chill. Embodiment is experienced not only as that which is most intimate "mine, but as that which is dreadfully and chillingly implicative" (Zaner, 1981, p.92). It is the sense of chill that awakens the anorexic to the dangers and consequences of anorexic embodiment. The sense of chill brings the anorexic finally for treatment, and represents the turning point in their anorexic process. Only with the realisation through hospitalisation, did Participants D and C realise that they are bound to their anorexic embodiment and irrevocably bound to suffer what their anorexic body suffers. It was this sense of 'chill' that shocked both participants into a realisation that they had gone too far in their anorexic process, and required treatment.

Zaner (1981) notes that the body is also experienced as a 'hidden presence', in that although one may have an intimate knowledge of the body, it involves events, processes and structures over which one has no control and awareness. The body is able to carry on in a hidden manner. In anorexic embodiment, when the anorexic process renders the hidden presence of the body explicit, such as in failure of vital functions, hospitalisation is warranted. Finally, linked to the hidden presence, Zaner (1981) notes that the body has an alien presence in that, despite my desires, the body grows older, becomes tired, or ill. The anorexic attempts to overcome this alien

presence of the body. The anorexic cannot afford illness or tiredness, as these conditions impede their progress and routine. The alien presence of the body awakens the anorexic to the need to deal with issues of mortality and materiality. These are the very issues that the anorexic seeks to deny.

In sum then, anorexic embodiment can be argued to usher in a disintegration in the unity of the lived body. In particular, this loss of unity results in an alienation between body and self. The body is objectified in various ways, and concretely experienced as 'uncanny', Other-than-Me. The awareness of the body as other, directly causes and contributes to the sense of disorder which permeates the anorexic's world, striking at the fundamental features of bodily intentionality, body image, gestural display, lived spatiality and lived temporality.

In anorexic embodiment, the sphere of bodily action and practical possibilities become centered around food intake, and maintenance of a low body-weight. Food and the body, which were formerly grasped as utilizable, now present themselves as obstacles that become effortful and require attention. Bodily intentionality, understood by Merleau-Ponty (1962) as an original 'I can', not as 'I think', is rendered circumspect. The changes in body image are experienced not only in relation to achieving slimness, but also as depression, in the shrinking of possibilities for action and alternative ways of being. In this regard, Participant D's renaissance is overshadowed by her inability to socialise, entertain and partake more fully in religious functions within her community.

Participant B's achievement of extraordinariness is overshadowed by her loss of a marital relation, and having to function as a single parent.

Socialising with friends, and participating at mealtimes, that, in health, centre around food and are experienced as invitational, become for the anorexic arenas to be avoided and challenges to overcome. Such activities become distanced from the anorexic's bodily scope. Ordinarily, embodied capacities provide the background to the figure of worldly involvements, in anorexic embodiment. It is the body itself which becomes the figure of intentions against which all else becomes merely background.

Anorexic embodiment also effects a change in the body's gestural display. Merleau-Ponty (1962) points out that a certain corporeal style is developed which identifies the body as 'mine'. The thinness and verticality of the anorexic body can be seen to be related to their desire for autonomy and attempt to function in the world, unaided. Following Zaner (1981), the anorexic demonstrates that the body displays itself as "value, as being worthwhile, as mattering" (p.28). The anorexic awakens one to the experience of the living body-sphere as "one's integrity, one's integral life" (Zaner, 1981, p.53). In concordance with Merleau-Ponty (1962), the anorexic demonstrates most strikingly that "I inhabit the world through my body which is comparable more to a work of art, than to an object" (p.177).

Since purposiveness and intentionality are essential to embodiment, the lived body exhibits an "if ... then" temporality which is a projecting into bodily action towards a "what is to come" (Zaner, 1981). In anorexic embodiment, the character of lived temporality changes. In health, the individual acts in the present in the light of more or less specific goals which relate to future possibilities. With anorexic embodiment, future goals appear irrelevant, so much so that the anorexic is prepared to sacrifice their

relationships, drop out of studies, and end careers, in the pursuit of the anorexic body. The anorexic is preoccupied with the demands of the here-and-now, confined to the present, and unconcerned about the future. Life projects are set aside, modified or abandoned. The "if ... then" style of strivings, the primordial causality of the body, is interrupted, and the purposiveness is disrupted.

In anorexia, the ability to possibilize, to free themselves from the actual in order to move to the possibly-otherwise, is obstructed. This constriction in the anorexic's world can be seen as a loss of a future. Thus, in the experience of anorexic embodiment, the significance of the past, present and future take on a different character. Firstly, the anorexics are caught in a flight from the meaning of past experiences. The anorexics aim to sever themselves from their childhood and family backgrounds that were experienced traumatically. D desires to escape the dependency of her helpless mother. B is in flight from her overcontrolling mother, and C desires to be freed from the co-dependent relations with her grandmother and mother. This history, however, is embodied in the habits and tasks of their body. Thus the body is attacked as a means of severing themselves from the past. Secondly, regarding the present, the anorexics are preoccupied with the demands of the here-and-now, namely the achievement of low body weight and size, through obsessive control of food intake. Finally, the anorexic is unable to project into the future. All that exists is the immediacy of the now. Blinded by the immediacy of the now, Participant D is unaware of the damage being done to her body. Participant B is driven away from her marital and interpersonal relations, and Participant C is unable to focus on her career.

The anorexic's focus on the temporality of the now ushers in the spatiality of the here. The anorexic body is not dispersed out there in the world. With the obsessive self-preoccupation and isolation, the anorexic body is congealed right here. The body as the site of violating the other's integrity and reciprocally being vulnerable to the ingress of the other, must be made to disappear. Self restriction and world restriction become equivalent. The anorexics present the here-and-now body that is confined to a small world, that mirrors their confinement to a small body.

It has been suggested that the paradigm of the lived body, as described by Merleau-Ponty (1962, 1968) has important insights into the experience of anorexic embodiment. An account has been presented of the manner in which fundamental features of embodiment such as bodily intentionality, body image, gestural display, lived temporality, and lived spatiality are disrupted in anorexic embodiment. Anorexic embodiment is viewed as the disruption of the lived body that renders the body as other. This paradigm of the lived body has important implications in conceptualising the psychological and psychosocial components of anorexic, as well as modes of treatments which are discussed next.

5.5 THEORETICAL IMPLICATIONS

The anorexic body reveals that the body is not merely an object of biologism and behaviourism, or a 'receptacle' of a 'self', but is itself an agent of social praxis. However, as she reproduces the dualities she is transforming, her praxis is simultaneously social commentary and social transformation (Gremillion, 1992). The anorectic reproduces

naturalized and denaturalized discourses, and in her struggle these norms are revolutionised by revealing the rationalization entailed in positing objectivity as 'truth'. This study has explored anorexia as an embodied moment of negotiation, as a site which shows up the naturalized and denaturalized discourse of anorexic embodiment. Whilst recognising the power of discourse to position, the requirement also has been to be careful about collapsing, the very real voices and bodies of the anorexic, into mere matter appropriated by discourse.

Merleau-Ponty's theory of the body is able to broaden those naturalized and denaturalized discourses of anorexic embodiment that cling to the existence of the inner world to the exclusion of the other, or vice versa, in that he denies the existence of inner man simultaneously to seeing the social world as a permanent field or dimension of existence in a way in which the subject is part of the surrounding. Merleau-Ponty restores to the human being the unity refuted by the constraints of inner and outer, individual and social. For Merleau-Ponty, the body is the subject and object and "whether up close or from a distance, directly or indirectly, we are mixtures when it comes to our field of existence, whether as an agent or an instrument" (Merleau-Ponty, 1964, p.35). From this view of sensual body, which is subject-object, 'innerness' cannot exist as a private life, but as an intertwining connecting man to history. The social world is not an object, but primarily a human situation. Merleau-Ponty (1964) argues that:

"The followers of pure philosophy and those who support the socio-economic explanation, change their roles in front of our eyes and we must not enter their perpetual debate. We should not take sides between a false concept of 'innerness' and a false concept of 'outerness'."
(p.163).

The world, in Merleau-Ponty's view, contains our bodies and our spirits (Moreira, 1993, p.144). The world is understood not as the mere sum of things, but as the place for their framing, for their construction. The objective is not to oppose the facts about the anorexic body, ordained by scientific objectivity, with another group of facts, but rather to show that both for the anorexic and Merleau-Ponty (1964, 1968), the being-subject and being-object are formed mutually, and the perceived world is on this side of paradox. This is the fullest meaning of Merleau-Ponty's notion of "reversibility" (1968) in the body - between touching and being touched, seeing and being seen. This expresses the simultaneity of being subject and object in the same act, precluding any possibility of speaking of a subject which constitutes an object or an object which constitutes a subject in an isolated manner:

"There is mutual constitution, not between subject and object, but rather between body (being) and world".
(Merleau-Ponty, 1964, p.43).

Merleau-Ponty can assist the theoretical approaches to not think in terms of victory of the "inner man" over the material, but rather in terms of the re-examination of "subject" and "object" (Moreira, 1993). From this vantage point, discourses of the anorexic body are grounded in the socio-historical world and do not have "the illusion of an absolute bird-eye's view" (Sartre, 1963) by radically imposing the idea that man belongs to the world. As both the anorexic embodiment and Merleau-Ponty (1964) affirm:

"This world which is not me, but to which I cling so intensively, as though to himself, in a certain sense is no more than an extension of my body (being). I have reason to say that I am the world".
(p.63).

Discourses of the anorexic body need to understand that the body is constantly involved with the sensory or historical world, and this world gives the body continuity, existing in mutual constitution with the body. The body needs to be articulated as involved in the world, and this openness to the historical world is "not *a priori*, nor an illusion, but rather a consequence (implication) of being" (Merleau-Ponty, 1968, p.63).

Merleau-Ponty's notion of flesh and the very existence of the anorexic body emerge as metaphors to heal the inherited Cartesian split of our times. Just as Merleau-Ponty's notion of flesh deepens our understanding of the living body, so too does the anorexic body. On this point, Merleau-Ponty (1968) states:

"Our century erased the line of division between body and spirit and sees human life as spiritual and corporeal, together as a whole, always supported by the body, always interested, even in its most 'fleshy' ways, in relationship to people. For many thinkers at the end of the nineteenth century, the body was a piece of matter, a handful of mechanisms. The twentieth century restored and deepened the notion of flesh, or rather of a living body."
(p.248)

Merleau-Ponty's understanding of the body provides the ground for a theoretical and philosophical development of the anorexic body which is not dichotomized, and has a great contribution to offer to the Cartesian discourses of the anorexic embodiment. Such discourses hold on to the idea of dichotomized thinking, which severs the anorexic body from social reality and the world. This anorexic embodiment is always seen as being intertwined with the world, and requires a conceptual discourse that understands the anorexic body as not the centre of the world, but as "flesh", constituting the world

just as much as the world constitutes the anorexic body, in a manner that no centre exists.

5.6 PSYCHOTHERAPY AND THE PARADIGM OF THE LIVED BODY

The understanding of the anorexic body as a disruption of the lived body has important implications for treatment. Firstly, the notion of the lived body means that the biological body cannot be conceived as separate from the person whose body it is. The anorexic body represents the anorexic's particular embodiment, and, as such, this anorexic embodiment intertwines in relation to a particular world and particular self. The notion of the lived body humanizes the treatment process. By refusing to conceive of the anorexic body as exclusively a biophysiological body, treatment grounds the body in the person, other, and the world. The focus then is not primarily on the biological problematics, but also on the problematics of self and world. The anorexic body conceived as a disruption of the lived body forces an inclusion of the disruptions of body, self, and world. This is not to say that the drug therapy used in the first instance is not helpful. The point being made here is that, with the anorexic body understood as a disruption of the lived body, recognition is required of the function and limits of basic medical care, and that attention to the other areas of embodiment require an equal extensive focus.

In addition, understanding the anorexic body as lived body, creates an understanding of an intentional body rather than an impersonal passive object. Such a sense of personal responsibility focuses the attention on the role of the anorexic's participation

in creating the anorexic body and thereby re-creating the body. In this connection, the body cannot be simply handed over to the therapist for treatment. With the notion of the lived body, the therapeutic encounter avoids the objectification of the body. A sense of autonomy is maintained, and the potential to effectively manage the situation is enhanced.

The notion of the lived body suggests that a meaningful healing process, besides attempting to 'cure' the anorexic, would focus on clarifying the contextual horizon of transformation in which the anorectic participates. In this process, the anorexic could reconfigure her praxis as an 'empowered' or socio-culturally informed, body living in a social world that she has helped to shape. Rather than looking for deterministic or mechanistic explanations of causality alone, the notion of the lived body calls for the development of understanding that is based on concerns, commitment, practices, and meanings. This would leave room for transformation in meaning and changes in human concern. Objectivity, then, would no longer be a process of decontextualization or of securing abstract eternal truths, but rather of finding what can show up in agreement among shared common cultural meanings. In essence, the notion of lived body would be congruent with the philosophical assumptions and hermeneutic method of treatment. Understanding the anorexic body requires a circular dialectic process. Consequently, one cannot, as therapist, identify an absolute starting point. Understanding in this sense acknowledges the existence of a shared pre-understanding. Objective or subjective prejudices need not be viewed as obstacles but as inevitable horizons that can be used to construct meaning. The fruitfulness of this understanding demands a sensitivity on the part of the therapist that allows for an acknowledgement of own

desires, needs and ways of reacting in order to imagine what the anorexic could be experiencing. Understanding of the anorexic body takes place then in mutual communication where identifying causality is not the sole aim of the treatment. A hermeneutic psychotherapy opens the way to multiple meanings, and is congruent with the anorexic body which is the site of multiple meanings.

5.7 LIMITATIONS OF THE PRESENT RESEARCH AND SUGGESTIONS FOR FURTHER RESEARCH

The qualitative method used in the present study proved to be a valuable method for exploring anorexic embodiment. Through Seidman's in-depth phenomenological interviewing (1991), and the grounded interpretive method of data analysis and interpretation, rich, in-depth descriptions and themes were generated. It is doubtful whether structured interviews, survey research, or psychometric instruments could have provided such rich data. The valuable information concerning themes, experiences, and processes that Seidman's in-depth phenomenological interviewing was able to access, indicates that this method could have great utility as a research tool in other areas of concern.

Some shortcomings and limitations relating to the research methodology became apparent during the process. Perhaps most striking was the difficulty in keeping the three series interview structure separate during the interview process. There was often an overlap between information and questions of context, with that of the meaning and experience of anorexic embodiment. Furthermore, the research participants

experienced the interviews as evocative, and it was difficult at times to maintain the role of researcher and research participant when the interview threatened to collapse into therapist and patient roles. The point to be made is that the phenomenological method is a very powerful method of inquiry that has the potential to create a very powerful clinical process. As such, this method should rest in the hands of clinically sensitive researchers who are trained to deal with the evocative potential and *sequelae* of this mode of inquiry. In this regard, the importance of offering the opportunity for debriefing or further sessions were offered to the participants who felt that the interview process had evoked unfinished material that required further attention.

A further difficulty experienced in this research related to the psychological knowledge and insight that the participants displayed in the data they produced. All the participants had undergone some form of psychotherapy prior to the research. The information provided was often contaminated by the experience of psychological knowledge and insight around the topic. Given the nature of the anorexic disorder that involves an obsession with studying the disorder on the part of the anorexic, it is difficult to select participants who are free from a knowledge-base or treatment in anorexia.

Pragmatically, a final difficulty of in-depth interviewing and the concomitant analysis of themes in the protocols that emerge is the expense in terms of time and energy, and can be cumbersome. The reliance on a small sample means that the data analysis must be done with care, and individual differences must not be overlooked.

It could be argued that the information that emerged could be limited because it involved a male researcher investigating the lives of adult females. However, it was the development of a trusting and open relationship between researcher and research participants that manifested in the depth of honest material provided and growth experienced in this research by both parties that safeguarded against this problem.

On a theoretical level, there are theorists such as Butler (1989) and Bigwood (1991) who question whether Merleau-Ponty's broader ontology is free of masculine as well as anthropocentric biases. Butler (1989) claims that Merleau-Ponty relies on a 'natural' body of biological subsistence that is removed from the domain of the historical and cultural. Bigwood (1991) claims that a feminist reappropriation of his work is required to re-work many of his notions, since the 'neutral' human body he attempts to describe favours the male body. However, for the purpose of this research, it was argued that Merleau-Ponty's phenomenology of the body is far more developed than any other, and therefore provides a solid base from which to develop a necessary re-working of the anorexic body.

Focusing on suggestions for future research, it would be interesting to explore the anorexic process of males and members of non-Western societies, especially given the marked rise in the incidence of anorexia among the non-female and non-Western societies. Particularly within the South African context, Merleau-Ponty's arguably value-free and neutral paradigm of the body, could be employed in opening up understandings of eating disorders amongst the various population groups that would demand an inclusion of the cultural horizon.

5.8 EPILOGUE

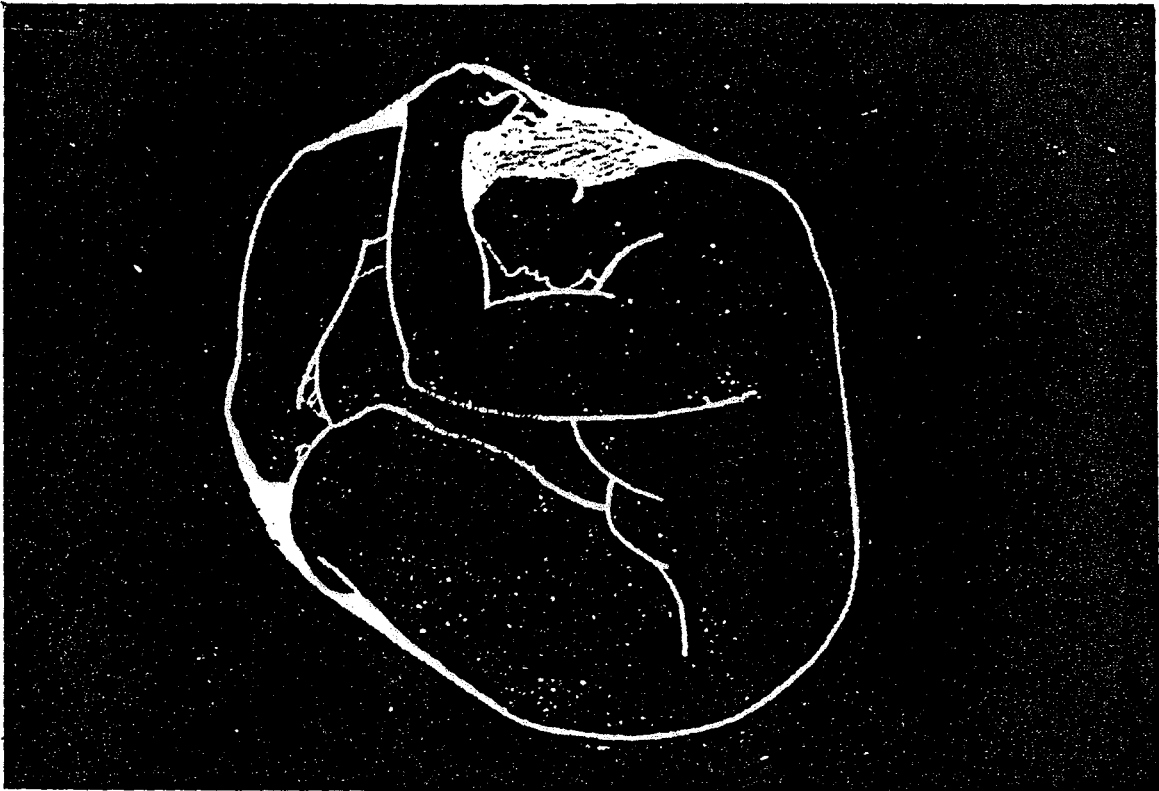
By way of conclusion, an apt quote from Nietzsche (1960):

“There is more reason in your body than in your best wisdom.
And who knows for what purpose your body requires precisely
your best wisdom?”
(p.62).

As is argued, it is in the often overlooked works of Merleau-Ponty that the answer to this question can be sought.

APPENDIX

Figure 1



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