Bodily becomings: Personal reflections on the constitution of an 'anorexic self'

Abigail Higgisson

This article is a modified version of a paper originally submitted by the author for a course on gender, health and biomedicine undertaken as part of a combined undergraduate Bachelor of Arts/Bachelor of Social Work degree jointly hosted by the Australian National University and the Australian Catholic University. Although successfully completing one year of her degree, Abigail Higgisson has been on medical leave since 2004 due to a significant deterioration of her condition with anorexia nervosa. Despite this, she remains an aspiring social worker and intends to resume her studies as soon as her health permits.

Abstract

While there is a considerable body of literature devoted to post-structural theoretical analyses of cultural discourses, and an extensive array of personal memoirs cataloguing individual lived experiences, there is a paucity of work that combine the two approaches. Responding to this dearth in the literature, I adopted an auto-ethnographic approach and deployed a post-structural framework in an exploration of specific aspects of my experiences as someone who has struggled with anorexia nervosa for 15 years. In doing so, I elucidate some of the processes by which cultural discourses engage in a reciprocal interchange with the phenomenology of lived experience to constitute particular conceptions and configurations of self. In particular, I focus on the ways in which biomedical discourses, along with those of Cartesian dualism, intersected with my own lived experiences as a child to create the conditions of possibility for the emergence of an 'anorexic self'. By highlighting the processes of such 'bodily becomings', I aim to render visible the operations of modern constitutive power. I contend that an awareness of this power is vital for, and even ethically incumbent upon, social workers who are inextricably engaged in the co-creation of particular types of 'selves' in their daily practice. Without such an awareness social workers risk becoming unwitting participants in the formation and solidification of the very same problematic categories of self they seek to assist; perpetuating suffering and inadvertently doing incalculable harm in their earnest attempts to 'do good'.

The assemblage of selves: Introduction

> [W]e are assembled selves, in which all the 'private' effects of psychological interiority are constituted by our linkage into 'public' languages, practices, techniques and artefacts (Rose 1997, p. 226).

I have always wondered how someone such as myself, who ostensibly cares so little about outward appearances, has spent the past 15 years engaged in a struggle ultimately indexed by bodily appearance. Why have I been prepared to lose so much – my freedom, schooling,

relationships and sanity – and, most upsettingly, hurt those who I care about the most, all in the name of something so 'shallow' and trivial as thinness? How is it that as a 10-year-old, inadvertent weight loss due to a viral infection led to the formation of an 'anorexic self'? Employing an auto-ethnographic approach – 'a turning of the ethnographic gaze inward on the self (auto), while maintaining the outward gaze of ethnography, looking at the larger context wherein self-experiences occur' (Denzin, 1997: 227) – the following paper engages with such questions. I draw upon post-structural theory which posits that discourses are not merely descriptive but rather 'systematically constitute the objects, the individuals, the bodies, the experiences of which they speak' (Foucault, 1979: 100, cited in Malson 1998:6), to elucidate the formation of a specific subjectivity – that of 'the anorexic' – as an exemplar of how 'public' cultural discourses combine with 'private' phenomenological lived experience to 'assemble selves'. More specifically, I explore how biomedical discourses which construed my body as a biochemical object knowable through a narrow empirical gaze provided me with the 'linguistic tools' and 'self-disciplining practices' to engage in a set of new relations with my body at age 10. My active embracement of these self-disciplining practices can be understood in light of another cultural discourse upon which biomedicine is founded – that of Cartesian dualism. Thus the second half of this paper briefly examines how my lived experiences have been profoundly informed by Cartesian dualist discourse in which the female body is rendered problematic and the slender body is invested with particular symbolic significance as the 'controlled body'; as proof of self-integrity and signifier of 'absolute will and total control over one's life' (Malson, 1998: 124). Finally, I conclude with some cursory musings on the implications of the issues raised throughout the paper for social work practice.

Enacting bodies: Embodying selves

> 'Bodies' are not interpreted, not pre-existing, not merely the concrete instantiation of 'larger' historical developments, but performed, in concrete practices and in highly specific ways (Berg and Akrich, 2004: 4).

While there is a fairly substantive body of literature devoted to cultural analyses of anorexia nervosa, particularly from a feminist perspective, much of it unwittingly reproduces problematic binaries of mind/body and culture/nature characteristic of biomedicine (Bray and Colebrook, 1998: 35-37; Gremillion, 2002: 382-383; Lester, 1997: 479-481; Malson and Ussher, 1996: 269). In doing so, the bodies of those struggling with anorexia are rendered passive entities – texts upon which cultural discourses are inscribed. In Lester's words, many feminist cultural critiques have substituted the 'medical model's *individual body* with feminism's *cultural body*, the medical model's *disembodied self* with feminism's *de-selfed body'* (1997: 481). Hence we are left with questions of how the 'outside' (read: culture) gets 'inside' (read: the individual body-self). Through the adoption of an auto-ethnographic approach, I attempt to respond to such a dilemma, illustrating, in a manner beyond the capacity of either theory or personal memoir taken in isolation, how the 'outside' gets 'in'. In so doing, I render visible the operations of Foucault's (1979) 'modern power' (see White, 2002 for an accessable overview): a form of power that operates within discourses and which 'grasp[s] the individual at the very level of its...very identity and the norms that govern its practices of self-constitution' (Sawicki, 1998, cited in O'Grady, 2004: 94). Such an exposition facilitates a movement away from simplistic understandings of 'cultural influences' on the development of anorexia nervosa as external oppressive 'forces' exerting their influence

on self-contained individuals, or of culture as being directly inscribed upon the passive body of the anorexic. Instead, it invites more nuanced conceptions of how the anorexic self emerges in the interstices between cultural discourses and lived experience; in a play of modern constitutive power.

When seeing is believing: The biomedical body

In the practice of medicine, diagnosis and classification are founded on the clinical sign, a construct that presupposes that any underlying pathology can be linked to a physical sign, an indicator that can be observed and measured. Clinicians and scientists are granted the authoritative gaze, the power to define what constitutes a clinical sign and its linkage to health or pathology (Austin, 1999: 247).

I am 10-years-old and I am sick. Well, at least I was sick with a virus and couldn't eat much but now I don't know what is wrong with me. I don't have a virus anymore but I still don't feel like eating. This doesn't bother me but everyone is getting worried; my parents are pressuring me to eat and keep taking me to the doctor who doesn't know what is wrong with me either. The doctor weighs me and is concerned as the number on the scale continues to decline. I like it as my bones become more apparent – it makes me feel better but I'm not sure why. Everyone is asking me - 'why won't you eat'? I don't know what to say because I don't know myself. I have been having lots of stomach-aches and think that that must be the reason why. After all, why else would I find myself unable to eat? I am so confused – nothing makes sense anymore. All I know for sure is that my stomach hurts and I cannot eat.

At age 10, I have my first intimate, all-encompassing encounter with biomedical constructions of the body; an encounter which, in retrospect, marked the rapid transformation of my body from a lived corporeal whole to an estranged disembodied 'object'. Upon admission to hospital due to weight-loss, malnutrition and dehydration, I undergo test after test in the quest to uncover the cause of my stomach-aches and associated food refusal. Ultra-sound, endoscopy and colonoscopy; no physical 'underlying pathology' is found. In a final attempt to find a 'legitimate' cause for my food refusal a CAT-scan is done to see if I have a brain tumour that is suppressing my appetite.

I am lying flat on a hard examination table – sheets stiff, pinning my body to the table. I feel like I can't breathe; suffocated by the tight pressure of the spotless white sheets meticulously tucked and folded around my motionless body. My body feels exposed; no longer my own but that of the doctor's, to be poked and prodded, injected and tubed. As I lie here, watching as dye is injected into my arm before I am to be enveloped by the scanning machine, I secretly hope that they find something…anything…even a tumour. Nothing could be worse than the stigma that comes with the words – 'it's all in your head'.

Nothing is found but much is discovered. Having failed to uncover any 'legitimate' (read: physiological) cause of my stomach-aches they are pronounced 'not real'. Suddenly paediatricians step back to make way for a new set of health professionals; psychiatrists, psychologists and social workers. A few weeks later I sit watching a nurse refill the bag of nutritional supplement that, via a tube down my nose, has been my sole source of sustenance since entering hospital. Engaged in the task at hand, a slip of paper falls unnoticed from the nurse's pocket. My eyes wander to it and are instantly attracted by

the sight of my name. Curious I focus in, trying to see what is written next to my name, and then I see it…'Anorexia Nervosa'. That was my first discovery of my 'diagnosis' and I knew from that moment my fate was sealed; the words had been spoken…'it was all in my head'.

As Kirmayer (1988: 61) notes, in biomedicine the knowledge of medical experts 'eclipses the bodily-felt reality of the patient'. By constructing my body as a biochemical machine – an object knowable only through objective, 'expert' examination – my lived experiences and 'insider' knowledges of my body were rendered suspect and disqualified. Having had my pain dismissed as 'not real', I was left with no way of articulating or understanding my inability to eat other than as that of an 'anorexic'. Thus not only were all my actions and intentions henceforth interpreted by those around me as those of an 'anorexic', but I too, slowly and subtlety, came to know and understand myself as such. In this way, biomedicine and its allied professions '...act as definers of truth around the self-starving body', and, in doing so, come to have a profound 'influence on the way people 'can be'' (Eckermann, 1997: 162-3).

To be known and controlled by numbers: The biomedical body

> [W]here persons themselves and their bodies are turned into 'objects', self-surveillance emerges as a practice of control…When people are treated as objects they see themselves as objects and tend to torture their bodies and desires to fit instructions and specifications. They evaluate their behaviour and tend to become either docile subjects or rebellious subjects (Eckermann, 1997: 157).

During my first hospitalisation, which was to become the first of over 15, my body is not only rendered an object of medical professionals, I am also actively recruited into monitoring my body. In an attempt to 'engage me' in the well-being of my body, I am ordered to participate in a surveillance of its health. I must measure my urine and test its chemical contents, the results of which are to be plotted on a chart, made bright by the coloured penmanship of my social worker, stuck on the wall beside my bed. This chart sits alongside two further charts – one documenting my blood sugar levels, which I also have to take daily by pricking my finger and squeezing out the blood to be analysed. The other is the most crucial chart of all – that of my weight, also taken daily. Whereas I once thought I knew my body from my subjective experiences of it, I discovered that this knowledge counted for nothing; my body was 'knowable' in ways that I had previously been unaware of. Everywhere I went I was reduced to numbers: blood sugar levels, ketone levels, blood pressure levels, pulse rates, millilitres of supplement per day, and of course, weight.

I step onto the scales, looking furtively around me to make sure that nobody sees me. I am weighed every morning by the nurses and I'm not supposed to weigh myself any more than that but once a day isn't enough anymore. The doctors want me to put on more weight but I think I have gained more than enough already. I hate the way my bones are disappearing, replaced by repulsive squishy fat. I have to sneak, several times a day, to weigh myself to ensure I haven't gained any more weight. When I do, I turn off the tube feeding pump. The nurses get cross with me and turn it back on again but then I just clamp off my tube soaking myself and my bed-sheets in sticky nutritional supplement. I know exactly how many millilitres of supplement it takes to maintain my weight and won't allow a drop more.

In an ethnographic study of a leading North American eating disorders treatment facility, Gremillion (2003) powerfully demonstrates how modern treatments of anorexia nervosa, through their constant surveillance and intimate bodily manipulation, inadvertently recreate and augment forms of bodily control that are already defining features of the 'illness'. In a similar vein, Segal (2002) documents the experiences of women who have undergone inpatient treatment in various Australian eating disorder facilities, highlighting the ways in which an anorexic self-identify can be unwittingly reinforced and perpetuated during treatment; a process she refers to as 'anorexification'. Having entered hospital without any detailed understanding of the calorific value of specific foods, the relationship between weight and exercise, or how weight can be controlled on a gram-by-gram basis, I emerge upon discharge replete with all the necessary knowledges and techniques of self-surveillance to refine my bodily manipulations and solidify the formation of an anorexic self; my anorexification had begun in earnest. Thus, as I came under the 'medical gaze' I learnt how to perfect it and turn it against myself: A gaze whose piercing, unforgiving stare I have yet to escape.

Embodied deviance: The biomedical body

> Palpable and visible, the body's contours, anatomical features, processes, movements and expressions are taken to be straightforward, accurate indications of an individual's essence and character (Terry and Urla, 1995, cited in Austin, 1999: 247).

It is not only my body that comes under the purview of the medical gaze. For, although biomedicine is based upon a separation of mind and body, the two are not completely severed – the state of body, as the 'house' of the mind-self is taken to be a reflection of an individual's psyche; a phenomenon Terry and Urla (1995, cited in Austin, 1999: 247) refer to as 'embodied deviance'. Having determined that there was no physiological explanation for my starved state, my bodily condition is taken to be a indication of my 'sick' mind. Thus every aspect of my 'self' is scrutinised in a search for the source of my psychopathology. Ruthlessly measured against 'developmental norms' and ideals of personhood, I am inevitably found to be sorely lacking.

I know there is something wrong with me...I mean seriously and fundamentally wrong with me as a person – with who I am. No one has told me that in as many words but I am not stupid. I may be only 10 but I can tell what they are thinking. They think I am too shy, not assertive enough, too dependent on my parents, lacking in self-esteem and socially inept. I just know it. Why else is it that I have to see a steady stream of psychiatrists, psychologists and social workers when none of the other children on the ward do? Why else am I asked never-ending questions about myself, all of which subtly yet unambiguously imply there is something wrong with me? Why else am I the only child on the ward whose parents are prohibited from visiting me as much as they wish? Why else am I reproved when I shrug my shoulders, shake or nod my head instead of answering verbally? I always suspected that I was 'different', 'weird', 'bad', 'lacking'. What more proof do I need?

As O'Grady (2004: 96) notes, when people perceive themselves as failing to meet accepted norms they often experience it as a transgression of the self. Such transgressions typically elicit a profound sense of shame: 'the distressed apprehension of the self as inadequate or diminished...the recognition that I am, in some important sense, as I am seen to be' (Bartky 1990: 86, cited in O'Grady, 2004: 96). Although done with the best of intentions in the name

of my wellbeing, the increasing involvement of the 'psy' (Rose, 1997) professions in my care, with all their attendant norms and judgments supplied an authoritative confirmation of my perceived deficiencies. Such norms and judgments were all too frequently applied devoid of any contextual contingencies, so that, for example, what was deemed pathological shyness and dependency could easily be explained by the fact I was in a strange and hostile environment, which, for an already sensitive and quiet child was extremely stressful and difficult. Likewise, my parents' 'over-involvement' when taken in context was understandable given their child was wasting away – both figuratively and literally – before their eyes. Indeed, had they shown less care and concern, they would have inevitably been labeled as overly detached and even negligent. Whatever the case, by inadvertently reinforcing pre-existing self-doubts, self-loathing and shame, my 'treatment' paradoxically provided the perfect soil for the seeds of anorexia to take root and flourish.

According to Lester, anorexia can be seen as an attempt to bring about a transformation of the self, a transformation she contends 'can best be achieved at this point in history through a certain set of bodily practices' (1997: 485). Finding my inchoate doubts about my worth as a person reinforced by the lexicon of the 'expertocracy', my will to bring about my self-transformation was heightened, and I turned to the means most readily available to me at the time – anorexia. Such a turn was, however, a double-edged sword; my 'self' was further damned by virtue of the fact I was struggling with anorexia, a 'disorder' seen in the eyes of those around me, as indicative of a certain type of character – selfish, immature and attention-seeking.

Whenever one of the other children on the ward or their parents ask me the dreaded question 'what is wrong with you?', I always answer, 'I don't know'. I never utter the words: 'anorexia nervosa'. What shame is embodied in those words. Who ever knew that a couple of words could say so much about me as a person. I am not like the other sick kids – they are worthy of compassion and pity. Their suffering real, mine brought upon myself. Just the other day one of the nurses told me that I should 'pull myself together' and think how selfish and stupid I am being when all around me there are children who are 'really sick' – cancer, cystic fibrosis, diabetes, asthma, broken bones. And what was it that my psychiatrist said about how much it was costing tax-payers to keep me in hospital for all this time? I am such a bad, unworthy person.

The threatening fleshy other: The Cartesian dualist body

> Cartesian dualist discourse produces the body as alien to the mind/self. As eruptive Other, the body threatens to overwhelm the self and to disrupt self-integrity. This discourse thereby discursively produces the need for control over the body and at the same time constructs 'control' as a form of war against the body. The body is produced as the prime target of control, and body management acquires immense significance because self-integrity requires control over the body (Malson, 1998: 124).

It is a testimony to the power of cultural discourses that, what began as unintentional weight loss and failure to regain appetite after a virus at age 10, became so infused with cultural meanings surrounding the slender body and need for bodily control. Although biomedical constructions of my body provided me with the discursive resources and practices crucial in the assemblage of an anorexic self, they did not operate in isolation. Indeed, I am shocked to find upon reflection that, long before my intense hatred of my body and fear of fat was borne, I already understood the moral significance of bodily management in a culture in

which the mind is equated with the self and signifies rationality and purity while the body represents all that is impure, alien and limiting; 'the locus of *all that threatens our attempts at control*' (Bordo, 1995: 145, emphasis in original).

I am eight years old and I'm standing in the school playground. I am freezing cold but I will never admit that to you. It is the middle of winter and I'm a wearing a skirt with my bare legs protruding. My whole body is so cold it aches and my lips have turned blue. If I were to be honest, I would admit that I hate being cold – it is miserable. However, I refuse to wear trousers in winter. I'm not sure why but I like the fact that I can resist the temptation to wear trousers. It would be so easy just to submit to my bodily desire for warmth, however I refuse to 'give in'. I can resist the cold – I am strong.

When located within Cartesian discourse, in which control of the body is emblematic of the integrity and ascendance of the mind/self (Malson, 1998: 124), experiences that I have always dismissed as mere idiosyncrasies such as that described above, emerge as highly cultural performances. Even armed with this knowledge, my lived experiences of my body remain that of threatening 'Other'. Just recently I experienced the sheer terror of having my bodily needs encroach upon my equanimity – threatening insurrection and transgressing the integrity of my 'self'.

I am horrified. I have only gone a day without food or fluid – a formerly regular occurrence – yet I am already engulfed by nausea and light-headedness. How can this be? I only ever used to feel this bad after numerous consecutive days without sustenance. I am outraged at myself – at my body. How dare my body begin to demand food after only one day of abstinence? See what happens, I think, see what happens when you concede to your body's needs for too long. By consistently feeding my body I have allowed it to 'take over' – to become greedy. My body has come to expect too much; spoilt by soft treatment it has become needy. I am furious – how have I allowed my body to become so undisciplined, so unruly? Instead of being grateful for the food it has been receiving, my body has become demanding. I am no longer supreme master of my body, managing to transcend my body's needs for food or fluid. What if I continue on this path…will I become slave to my body, subject to its every whim?

Clearly my struggles cannot be understood outside of the cultural context in which I am located. My seemingly incomprehensible quest has not been for the thin body in and of itself but rather for what it represents in the society in which I live. It has been, as Bordo (1995: 67) suggests, 'an attempt to embody certain values, to create a body that will speak for the self in a meaningful and powerful way.' Upon finding '[t]he tools of this labor…supplied: the vocabulary and syntax of the body…culturally given' (Bordo 1995: 67), I have actively constituted myself in a dialogical exchange between lived experience and cultural discourses.

Breaking through the crust: What anorexia as 'exception' reveals

> The exception confirms not only the rule but also its existence, which derives only from the exception. In the exception the power of real life breaks through the crust of a mechanism that has become torpid by repetition (Schmidt, cited in Wolin, 1990: 399).

Although a very personal account, this paper has sought, not to illustrate the peculiarities of my own life, or even to provide particular insights into anorexia, but rather to more generally explicate, albeit partially, the processes by which we all come to know and understand ourselves as certain kinds of people. We are all 'assembled selves'; constituted within and

by a matrix of cultural discourses which give meaning to, and are productive of, our lived experiences and very 'selves'. It is this productive power of discourses – their profound embodied effects – that renders their examination so crucial. However, as Davies notes, 'just as we disattend the pane of glass in order to look at the view out of the window, we generally disattend discourse (it is not until the glass fractures or breaks, for example, that we focus differently)' (1993: 153, cited in Viljoen, 2003: 59). Throughout this paper I have taken my struggles with anorexia – my personal 'glass shattering' event – in order to render visible certain discourses and reveal their constitutive power: a productive force that remains hidden when power is thought of in exclusively traditional terms; as a repressive force possessed and wielded by individuals, or solidified in social structures (see White, 2002 or O'Grady, 2004 for discussions of the implications of holding such a conception of power on therapeutic practice). More specifically, I have demonstrated how biomedical discourse imposed its own framework of intelligibility over my lived experiences and provided me with new knowledges and practices with which to understand, and engage with, my body. This, when combined with an increasing entanglement in a language of psychological deficit and broader cultural discourses such as that of Cartesian dualism, proved to be a lethal cocktail; ultimately leading to the formation, and solidification, of an anorexic self.

On knowing what what you do does: Implications for social workers

> People know what they do; they frequently know why they do what they do; but what they don't know is what what they do does (Foucault, cited in Drefus and Rabinow, 1983: 187).

Whilst not initially written for a social work audience, and primarily focused on biomedical discourses, this paper nevertheless has particular relevance for social workers who, by the very nature of their work and professional status, actively participate in regimes of expert knowledge through which people come to understand and know themselves (see Rose, 1997 for a general theoretical discussion of the role of 'experts' in the formation of particular configurations of selfhood. Alternatively see Maisel, Epston and Borden, 2004 or Gremillion, 2003 for more specific descriptions of how clinicians may inadvertently contribute to the formation and solidification of 'eating disordered selves' in practice). As such, they are necessarily intmately engaged in the co-creation and constitution of particular types of 'selves' in their daily interactions with clients. For social workers, whose primary tools of trade are discursive, it is critical – and indeed, an ethical obligation to clients – that they have sound insight into the effects of the discourses they are engaged in. And if, as Mol asserts, '[r]eality does not *precede* practices, but is *part of them'*, then a key question becomes 'what is being *done*, and what, in doing so, is *reality in practice made to be'* (2002, cited in Williams, 2006: 20-21). Unfortunately however, many people, including those in the 'helping professions', remain unaware of 'what what they do does'. That is to say, they are not aware of the constitutive consequences of their actions – of the 'reality' they are actively bringing into being. Lacking such knowledge they run the risk of inadvertently doing incalculable harm in their attempts to 'do good'. While social work espouses critical, reflective practice, in the face of the immense demands and pressures of everyday work, and lacking an adequate analytical framework, many social workers may find themselves losing touch with a knowledge of 'what what they do does'. This paper has offered social workers an insight into just that, inviting them to reflect on the constitutive effects of the cultural discourses they are participants in as 'helping professionals'. Finally, it is important to note that it is not sufficient for social workers to simply replace reductionist biomedical accounts of illness

and other forms of human suffering with cultural analyses if such analyses are not 'experience near' – that is to say, if they do not privilege the voices, experiences, and knowledges of those whose lives are at stake. As Kleinman and Kleinman assert:

> …just as biomedicine delegitimates the suffering in somatization by entifying it as a disease, so too do the other professions and institutions of post-modern society...[when they] transform somatization into something other than human experience' (1991: 292).

Thus they proclaim an urgent need for approaches to human suffering which evoke and honour 'experience-near' accounts; accounts which are allowed to stand for themselves rather than be seen as 'representation[s] of some other reality (one that we as experts possess special power over)' (1991: 293). It is my contention that such approaches are crucial if more efficacious and respectful ways of assisting those struggling with anorexia, and all other forms of human suffering, are to be developed and instigated (see Maisel, Epston and Borden 2004 for an excellent example of such an approach).

References

Austin, B. S. (1999). Fat, loathing and public health: The complicity of science in a culture of disordered eating. *Culture, Medicine and Psychiatry, 23*(2), 245-268.

Berg, M. & Akrich, M. (2004). Introduction – bodies on trial: Performances and politics in medicine and biology. *Body and Society, 10*(2-3), 1-12.

Bordo, S. (1995). *Unbearable weight: feminism, western culture, and the body*. Berkley: University of California Press.

Bray, A. & Colebrook, C. (1998). The haunted flesh: Corporeal feminism and the politics of (dis)embodiment. *Signs, 24*(1), 35-67.

Denzin, N. K. (1997). *Interpretive ethnography: Ethnographic practices for the 21st century*. Thousand Oaks: Sage Publications.

Dreyfus, H. L. & Rabinow, P. (1983). *Michel Foucault: Beyond structuralism and hermeneutics* (2nd Ed.) Chicago: University of Chicago Press.

Eckermann, L. (1997). Foucault, embodiment and gendered subjectivities. In A. Peterson and R. Bunton (Eds.) *Foucault, Health and Medicine*. New York: Routledge.

Foucault, M. (1979). *History of sexuality: An introduction*, Vol.1. London: Penguin Books.

Gremillion, H. (2002). In fitness and in health: Crafting bodies in the treatment of anorexia nervosa. *Signs, 27*(2),381-414.

Gremillion, H. (2003). *Feeding anorexia: Gender and power at a treatment center*. London: Duke University Press.

Kirmayer, L. J. (1988). Mind and body as metaphors: Hidden values in biomedicine. In M. Lock and D. R. Gordon (Eds.) *Biomedicine Examined*. Dordrecht: Kluwer.

Kleinman, A. and Kleinman, J. (1991). Suffering and its professional transformation: Towards an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry, 15*, 275-301.

Lester, R. (1997). The (dis)embodied self in anorexia nervosa. *Social Science and Medicine, 44*(4), 479-489.

Maisel, R., Epston, D. & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: W.W. Norton.

Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. London: Routledge.

Malson, H. & Ussher, J. M. (1996). Body poly-texts: Discourses of the anorexic body. *Journal of Community and Applied Social Psychology, 6*, 267-280.

O'Grady, H. (2004). An ethics of the self. In D. Taylor and K. Vintges (Eds.) *Feminism and the final Foucault*. Urbana: University of Illinois Press.

Rose, N. (1997). Assembling the modern self. In R. Porter (Ed.) *Rewriting the self: Histories from renaissance to the present*. London: Routledge.

Segal, J. (2002). *Listen to our stories: Young women with anorexia nervosa speak out about hospital experiences*. Honours thesis, Sydney: University of New South Wales.

Viljoen, H. J. I. (2003). Rekindling hope: Deconstructing religious power discourses in the lives of Afrikaans women. PhD thesis, Pretoria: University of South Africa.

White, M. (2002). Addressing personal failure. *International Journal of Narrative Therapy and Community Work*. Adelaide: Dulwich Centre Publications.

Williams, S.J. (2006). Medical sociology and the biological body: Where are we now and where do we go from here? *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 10*(1), 5-30.

Wolin, R. (1990). Carl Schmitt, political existentialism, and the total state. *Theory and Society,* 19(4),0 386-416.