

INTRODUCTION

In Fitness and in Health

A number of feminist scholars and therapists have argued that anorexia is an important “case study” for examining problems with the embodiment of feminine identity in the contemporary United States. Works such as “Anorexia Nervosa: Psychopathology as the Crystallization of Culture” (Bordo 1993a) and *Hunger Strike: The Anorectic’s Struggle as a Metaphor for Our Age* (Orbach 1986) emphasize that although anorexia is considered to be a psychiatric illness, it must be situated within new cultural expectations about ideal femininity. Anorexia’s incidence increased more than 50 percent in the 1970s and 1980s,¹ at the same time that there was an increasing focus within mainstream U.S. society on women achieving autonomy, self-control, and bodily fitness through dieting and exercise. Pressures for women and girls to diet and “keep fit” contain contradictions about females’ capacities for self-control: self-control (through control over the body) is thought to be both a necessary and a difficult achievement. The “battle of the bulge” is culturally coded as an unending struggle for women, and many scholars suggest that anorexia embodies this call to perpetual effort in a dramatic way. This struggle is linked to discourses of class, race, and ethnicity, as

well as gender. Most patients are middle-class and white, and the diet and fitness industries target this population and those who are “upwardly mobile” (note, however, that a number of scholars have recently raised important questions about this “typical” patient profile).² To the extent that fatness is associated with laziness, passivity, lack of productivity, and lower-class status—often conflated with nonwhite status—women and girls who live with anorexia can be seen to be engaged in a battle against “downward mobility.”³

Anorexia has been singled out as a significant case study within a very different body of literature as well: that of mainstream psychiatrists and other mental health professionals who are interested in a critical history of various theories and paradigms within their disciplines.⁴ Because anorexia has been quite difficult to treat, the history of approaches to it “recapitulates the megalithic history of psychiatry” in many ways (Sours 1980, 8). Anorexia has been assimilated to reigning psychiatric and medical theories and practices since it was first identified as a “disorder” in 1873.⁵ It was considered to be a type of hysteria in the late 1800s, when diagnoses were few and far between and at a time when a range of “female complaints” were corralled under the rubric of hysteria.⁶ Beginning in 1914, anorexia was widely considered a manifestation of pituitary dysfunction because of the identification of an endocrine disease (Simmonds’ disease) whose symptoms were superficially similar to those of anorexia. Anorexia was treated accordingly until the 1930s, when this theory of causation was thrown out and the concept of Simmonds’ disease itself came under question (see Sours 1980. These treatments persisted until the 1930s in spite of strong evidence before that time against their efficacy; see Selvini-Palazzoli 1974). From the 1930s through the 1950s, Freudian depth psychology enjoyed wide popularity, and psychoanalytic theories about anorexia took center stage. These theories circulated around fantasies and fears of oral impregnation, and the aim of therapy was to instantiate desires for a properly maternal form of femininity.⁷ But in the 1960s, a number of therapists began to mount challenges against Freudian ideas and to develop new forms of psychotherapy. In this context, and owing to efforts to find rapidly effective treatments that would curb anorexia’s chronicity, behaviorist approaches became the new focus for the treatment of anorexia.⁸ Here, simple (forced) “refeeding” protocols were translated into programs that included “positive reinforcement” for

weight gain (e.g., increased social contact) and “negative reinforcement” for weight loss (e.g., bed rest).

However, beginning in the 1970s, most therapists agreed that behaviorist approaches alone are not helpful in the long term. As a result, and at a time when the incidence of anorexia was rising dramatically, many treatment programs began following the multidimensional treatment paradigms that are still popular today. These paradigms combine strategies for weight gain, which usually involve some behaviorist principles, with individual therapy, family therapy, group therapies, and biomedical interventions (e.g., antidepressant medications) when they are deemed necessary.⁹ Most therapies no longer assume the strictly differentiated gender roles that were part of Freudian theory, and they emphasize patients’ (supposed) needs for individual autonomy.¹⁰ But even with this multipronged treatment approach, anorexia—widely understood since the 1960s to be a syndrome of complex (“multifactorial”) or unknown etiology—remains extremely difficult to treat. It has the highest mortality rate of any psychiatric illness (approximately 10 percent),¹¹ and according to a number of studies, most patients continue to struggle with significant anorexic symptoms many years after treatment. Follow-up studies conducted six years or more after treatment indicate that, of patients who live, about 10 percent meet full criteria for anorexia, and as many as 50 percent experience severe eating problems (Herzog, Schellberg, and Deter 1997; Sullivan et al. 1998).¹² For these reasons, anorexia has engendered almost as much critical reflection about psychiatric theory and practice during the past few decades as it has about contemporary ideals of female bodies and identities.

This book provides a bridge between psychiatric and “culturalist” accounts of anorexia as an important case study by investigating difficulties in treatment as themselves social and cultural problems. Patients diagnosed with anorexia are notorious for their often concerted resistance to therapeutic processes. Their noncompliance to treatment is usually explained as a consequence, or even a confirmation, of their illness.¹³ Although there is little question that patients often delay and resist treatment because of ideals of autonomy and self-sufficiency that are amplified and folded into many people’s experiences of anorexia, I will show that therapies directly re-create conflicts that patients and their families have been experiencing in their lives, conflicts that can-

not be reduced to epiphenomena of medicalized “disorder.”¹⁴ For example, I argue that power struggles in treatment participate in the cultural production of patients’ experience that they cannot control themselves (and that they should be able to). More generally, I will demonstrate that therapies for anorexia unwittingly engage cultural practices and ideologies that are constitutive of this syndrome.

By focusing on patients’ resistance to treatment—as well as disagreements among parents, doctors, therapists, and nursing staff—I show that participants in the program at Walsh actively struggle to negotiate agency and bodily control in the treatment process. My analysis brings together research in medical anthropology, feminist cultural studies, and critical studies of science. In addition to interrogating the disciplinary boundaries of psychiatry, I show how ethnographic analysis can extend social constructionist theories of science and the body, which can sometimes slip into totalizing, or monodiscursive, representations of corporeal experience and of human agency. Much of this book explores the multiple, and often contradictory, discourses that constitute the “anorexic body,” as well as the so-called anorexic psyche and family.

Throughout the book, I examine ways in which psychiatric treatments for anorexia participate in a core contradiction entailed in the making of “ideal” persons within contemporary capitalist culture, through the simultaneous construction of (1) a self-possessed individualism—in the shape of self-control, “boundaries” around the self, will-power, autonomy, and productivity—and (2) domains such as the body and the family that appear as “natural” constraints in people’s efforts to achieve autonomous individualism. I address the question of how dominant ideas about the fit body and about the consumption of food inform purportedly gender-equalizing notions of mental “fitness” today, as well as the question of how a focus on individual productivity articulates with powerful cultural and therapeutic representations of familial nurturance. I situate these questions historically by exploring changing ideals and practices surrounding femininity, women’s roles in the family, and women’s individual autonomy from the 1950s to the present. I also relate these changes to major shifts in psychiatric paradigms during this period—for example, the development of family systems approaches and new kinds of (individualizing) therapies. My aim is to locate popular and psychiatric discourses about the female body and psyche, and about the “naturalness” of the family, within a particular

sociocultural formation that enables anorexia—that nurtures its conditions of possibility.

I analyze these discourses as they are expressed and lived for many people in the United States. I should note that North America is not the only place where these discourses—or anorexia—can be found. Anorexia is most common in the United States, Canada, parts of Europe, Australia, New Zealand, and South Africa (American Psychiatric Association 2000). Although cases of anorexia have been reported elsewhere, the numbers are small, except in places where, apparently, a surge of capitalist development has accompanied a rapid increase in the incidence of eating disorders.¹⁵ There is a strong argument to be made that the phenomenon we diagnose today as “anorexia” is largely unique to contemporary industrialized and industrializing social contexts.¹⁶ However, there is some debate in the literature regarding anorexia’s historical (and contextual) specificity. For example, Rudolf Bell (1985) argues that fasting (female) medieval saints were “anorexic,” but Caroline Bynum (1987) offers convincing evidence that while these medieval saints and women diagnosed with anorexia may seem similar on the surface, the meanings of food and body shape in these two cases are quite different. Joan Brumberg (1989) notes that although the diagnosis “anorexia” was coined in the late 1800s, the experience of anorexia today—which includes calculated self-control and, often, exercise regimes—differs markedly from “the sentimental and doleful Victorian phenomenon of ‘wasting’ ” (99).¹⁷ This book foregrounds the particular social arrangements and cultural meanings that are salient for an experience of anorexia in the United States today, and that also inform certain psychiatric theories and practices at work in this same context.

In addition, by focusing on moments of conflict and struggle in the treatment process, I argue that while ideas expressed in therapy about the self and about feminine “nature” are culturally dominant, they are also unstable. Following Probyn (1987), I show that even as these ideas powerfully position people, their sometimes uneasy articulations also create spaces for negotiation. Power differentials in the treatment program reveal the different meanings and contradictions embedded in the discourses that constitute anorexia, which are inflected by gender, ethnicity, class, age, and professional status. This book explores how the normalizing experiences of psychiatric treatment both produce and

unsettle dominant constructions of gender, individualism, the body, and the family in late-twentieth-century U.S. society.

Research Site and Ethnographic Data

Walsh is a small, unlocked, psychosomatic inpatient unit located in an urban area in the western part of the United States. To protect the privacy of participants in the program, its exact location will remain confidential, and I provide only very general information here about my research site. Walsh accepts adolescents and children with combined medical and psychological diagnoses.¹⁸ At any given time, about one-half of the patients are adolescent girls diagnosed with anorexia; accordingly, there is a separate treatment program and set of protocols for so-called “anorexic patients,”¹⁹ including outpatient follow-up. I was a participant-observer in both the inpatient and outpatient contexts of this program during a fourteen-month period, from July 1993 to September 1994. I followed a total of fifty-two patients and participated in the program as much as I could. I attended therapeutic groups, doctors’ and therapists’ meetings about patients’ progress, individual therapy sessions, family therapy meetings, and staff meetings. I also ate meals with patients, took part in outings and recreational activities, and spent time at the nursing station and in the charting room (where clinicians and nursing/counseling staff record notes in patients’ medical charts and consult with one another informally). In addition, I conducted 146 interviews with patients, their parents, and the professionals and trainees who worked at Walsh.

One important feature of the program to note at the outset is a marked power differential between patients and caretakers. The average age of patients diagnosed with anorexia at Walsh is sixteen, so hospital admission and discharge for most require parental consent.²⁰ More often than not, patients say they do not want to be hospitalized, but parents usually insist. Parents are under considerable pressure to agree with medical recommendations. Their daughters are dangerously, perhaps fatally, ill. Also, if parents go against medical advice (a rarity), this decision is recorded in patients’ charts, creating the potential for adverse effects on insurance coverage (e.g., for future care). Patients are subordinate players in these negotiations.

The ratio of females to males diagnosed with anorexia is greater than ten to one (American Psychiatric Association 1987, 1994, 2000). Hos-

pital admissions during my fieldwork at Walsh reflected a ratio of approximately twenty to one. In this book, I discuss female patients only.²¹

Professionals and trainees at Walsh include psychiatrists, pediatricians, psychologists, nurses, “milieu counselors” (who manage the therapeutic milieu along with nurses), a nutritionist, recreation therapists, physical therapists, interns in psychology and psychiatry, and medical students. Nurses and milieu counselors perform almost all of the day-to-day work required to run the program at Walsh—I use the term “staff” to refer to this group. The term “clinicians” refers to all the other professionals and trainees listed. Note that the treatment environment includes more professional adults, and adults in training for similar positions, than patients: the staff/clinician-to-patient ratio in the program is about three to one. Clinicians consult among each other (and with staff) about patients and about their work almost as much as they interact with patients.²²

In addition, an intake coordinator manages patient admissions, a social worker helps to organize outpatient services and living arrangements on request, and one person from the hospital’s department of utilization management—a “case manager”—is assigned to Walsh to authorize and process insurance coverage and convey information about any pending or potential discontinuation of coverage. The unit also employs recreation therapists and physical therapists. The phrase “the treatment team” is a gloss for everyone who works at Walsh.

During the time I was conducting my fieldwork, clinicians and staff operated with a definition of anorexia provided by *The Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised* (American Psychiatric Association 1987, 67). The *DSM*, which is revised periodically to reflect new psychiatric judgments or findings, is an encyclopedic volume that lists every psychiatric illness along with the typical features and expected course of each. The diagnostic criteria for anorexia in the third edition revised are as follows:

- A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to a maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to a body weight 15% below that expected.
- B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration).

In addition to fulfilling these criteria, some of the patients I met also engaged in occasional food binges, and/or one or more forms of "purging," such as self-induced vomiting, the abuse of laxatives or diuretics, and vigorous "compensatory" exercise. Bingeing and purging are symptoms of bulimia nervosa.²³ Some patients' bulimic symptoms were so significant that they were diagnosed with both anorexia and bulimia. Note that for the fourth edition of the *DSM*, published in 1994 at the end of my fieldwork, the diagnostic criteria for both anorexia and bulimia were altered so that it is no longer possible to be diagnosed with both syndromes at once, although "restricting" versus "binge-eating/purging" "types" of anorexia are now specified. These changes reflect ongoing discussions and debates about the similarities, as well as the differences, between anorexia and bulimia.²⁴ Patients diagnosed with bulimia only were also admitted to Walsh, but most did not stay very long (these patients are usually not dangerously underweight and can therefore be removed from immediate medical danger very quickly). Bulimia was much more common in the outpatient clinic.

When patients diagnosed with anorexia are first admitted to the inpatient unit, they are extremely vulnerable: their physical health is acutely compromised. Criteria for admission are a body weight that is below 75 percent of a person's "ideal body weight," which is calculated by a nutritionist using a standard formula (taking into account a person's age, sex, and height), and/or medical instability, often referred to as "vital sign instability" (e.g., a low pulse, usually caused by low weight and malnutrition, and/or overexercise—and sometimes by vomiting or laxative abuse). From the beginning of any given patient's hospital stay, medical analyses and manipulations of the body take center stage. During hospitalization, which spans an average of about three weeks, patients' lives are heavily structured by eating—which involves a closely monitored, 100 percent liquid diet in the beginning, followed by calorie

counting, agonizing choices from menus, and sometimes the threat of tube feeding if daily calorie quotas are not met. Meanwhile, for each patient, weight limits and goals are defined and become pivot points for negotiating many aspects of their hospital experience, ranging from calorie requirements to a discharge date. Monitoring calorie intake and weight, and linking both to specific “consequences,” constitute the treatment program’s behavior modification component. A “discharge weight” is established and is often identical to a patient’s “exercise weight,” a weight at which exercise is considered medically safe (thus exercise is not allowed for most patients during a hospital stay). Also, an “admission weight” is determined, in the highly likely event that the patient begins to lose weight after she is discharged and will be readmitted to the hospital in the future. Patients are strongly advised to gain more weight after they are discharged from the hospital, and they are monitored for this goal on an outpatient basis.²⁵

In short, the major focus of the program is on food, calories, and body weights.²⁶ Many would argue that such a focus is inevitable, given the obstacles that treatment must overcome: “A person who is significantly underweight will have a hard time eating enough to gain weight without a great deal of structure around food intake. Because of metabolic abnormalities [due to starvation], such individuals usually require a huge number of calories to restore the metabolism to normal before they even begin to gain weight. For a person with a terror of food, this can be a seemingly impossible task” (Ellis-Ordway 1999, 189). However, as noted earlier, multidimensional treatment programs like the one at Walsh—which proliferated in the 1980s—aim to move beyond purely behaviorist solutions, and for good reason. Therapies that were prevalent in the 1970s focused entirely on weight gain and were not effective; in fact, many argued that they worsened patients’ symptoms by precipitating battles between patients and clinicians over bodily control (Bemis 1978; Bruch 1974, 1982; Lawrence 1979). Hilde Bruch (1974), a pioneering psychotherapist in her work with anorexic patients, writes that many patients experience strict behavior modification programs as “brutal coercion” and “unmitigated misery” (1421, 1422). Patients would often simply “eat their way out of the hospital” (1421) and then experience relapse or become suicidal or bulimic (see also Bruch 1978; Bemis 1978). Today’s programs are designed to circumvent these problems. For example, patients hospitalized at Walsh—both willingly and unwillingly—are captive audiences for therapies that are

designed to uncover the intra- and interpersonal meanings of weight loss. Caretakers consider the therapeutic milieu quite important for promoting a “holistic” approach to therapy and change. However, the medical justification for hospitalization, presented to patients and insurance companies alike, is the need for weight gain, and behavior modification techniques still loom large in most hospital programs.²⁷

There is little evidence that inpatient treatment programs have improved their success rates since the days when hospitalization was more of a last resort and forced feeding was commonplace. Arguably, behavior modification—regardless of a given program’s additional components—exacerbates patients’ problems by ensuring a constant surveillance and manipulation of the body on a very intimate scale. In addition to calorie counting at mealtimes, patients at Walsh are ritually weighed to one-tenth of a kilogram every morning, and their precise weights assume enormous significance in the program on a daily basis, affecting not only calorie requirements and length of stay in the hospital but also allowable physical activity and visitation. Ironically, when patients enter the hospital program, counting their calories and weighing and measuring their bodies often already intensely preoccupy them. Unfortunately, some learn how to engage in these activities with greater precision *during* a hospital stay.

In addition, feminist psychotherapist Robin Sesan (1994) notes that gendered hierarchies within professional treatment teams, and mystified notions of “expert knowledge” that often accompany these hierarchical power structures, are prominent features of most specialized and multidimensional programs, and Sesan argues that these features can also work to reinforce anorexia.²⁸ In fact, she suggests that the detrimental effects of hospitalization have become *more* widespread with the growth of specialized programs and the increased opportunity to hospitalize patients on a long-term basis. Multiple admissions to Walsh—often four or five for a given patient—are not unusual and can span the course of four years or more.

I should note here that since the mid-1990s, long-term inpatient hospitalization is slowly becoming more of a rarity once again. With the growth of managed care, a typical course of treatment now entails more outpatient and partial hospitalization services, and inpatient treatments are increasingly geared toward acute medical care only. Evidence of these changes was apparent during my fieldwork—a number of staff talked to me about shortened hospital stays at Walsh (compared to

longer stays during the 1980s). I discuss these topics in greater detail elsewhere in this book. But whereas Walsh in the mid-1990s resembles fewer programs today, my analysis here is directly relevant to the shape of the field today and to decision making about its future direction. Many practitioners today idealize programs like the one I studied and strive (or wish) to emulate its practices and principles as much as possible. Also, the centerpiece of most “pared-down” hospital programs remains, not surprisingly, weight gain through behavior modification. In fact, some hospital programs are now *narrowing* to this focus.

There is evidence that the “revolving-door” phenomenon in the treatment of anorexia—that is, multiple repeat admissions—has recently increased (Kaye, Kaplan, and Zucker 1996). Medical anthropologist Lorna Rhodes (1991) has documented this phenomenon on an emergency psychiatric unit, as well. In both cases, return visits are clearly linked to the shortsighted goal of limiting the length—and cost—of care in the first instance. However, unlike the emergency room practitioners who were part of Rhodes’s study, who (for complex reasons) accepted the imperative to (as Rhodes puts it) “empty beds” on their unit, most specialists who treat anorexia fight to keep patients hospitalized as long as possible and decry the economically motivated “revolving door” of late. It seems likely that the privileged social status of many patients diagnosed with anorexia leads to a higher level of visibility and advocacy when it comes to problems with illness chronicity. At the same time, however, when I was conducting research at Walsh in the early 1990s, multiple admissions to the unit and illness chronicity (like resistance to treatment) were cited as status quo and as unsurprising effects of anorexia itself. Again, for many, the program at Walsh at that time was, and is still today, considered ideal (although most staff members who had worked there ten years or more preferred the much longer admissions of the 1980s.²⁹ However, few considered a return to those days to be a realistic option). No one I spoke to believed that the system itself could play into illness chronicity.

Furthermore, clinicians and staff, while acknowledging the central role of behavior modification at Walsh, self-consciously guarded against a “top-down” (and chronicity-promoting) implementation of this form of medical power by merging it with therapist/patient/parent interactions that actively engaged patients in the therapeutic process on multiple fronts.³⁰ For most mental health practitioners, patients’ difficulties in such a well-designed multidimensional treatment program

can be attributed largely to patients' (and parents') "pathologies." For this reason, it is important to analyze conflict and chronicity at Walsh in ways that unpack not only the effects of behavior modification protocols but also assumptions and practices surrounding family relationships, practitioner/patient relations, patients' subjectivities, and the overall treatment milieu.

A Day on the Unit

To begin describing unit practices and the eating disorder treatment program at Walsh, let me walk readers through part of a "typical" day of fieldwork.³¹ For my purposes here, I will render a composite portrait from events and from conversations with various people that actually occurred on different days. I will save descriptions of individual and family therapy sessions, and patient rounds, for future chapters. As I present and analyze these various scenarios, I will pause to reflect on my own experiences and my position as an ethnographer on the unit, and to provide some background information about clinicians' and staff's roles.

One weekday morning, I arrived on the unit at about 7:00 A.M. As I opened the heavy double doors near the nursing station, I felt my usual stomachache coming on. The stomachache was partly an ethnographer's "performance anxiety," I knew; but it was unique to my experiences on the inpatient unit, and it lingered too long to be attributable only to that. I was about to witness elaborate, meticulous, and emotionally intense investments in eating, food, calories, and body weights. I was also about to witness, and participate in, a very high degree of surveillance over patients I had come to know well. As someone who grew up believing that dieting for several weeks was important preparation for special occasions, I always greeted my days on the unit with a bit of an upset stomach. That particular morning, the feeling was not too strong, because I was looking forward to accompanying Lorna, who had been a nurse on the unit for many years, through her shift.

As I walked onto the unit, the nursing station was buzzing with activity. I had arrived during a shift change, and while staff from the night shift were signing off on patients' medical charts, nurses and counselors on the day shift were waking patients up, preparing medications, and trying to listen to tape-recorded nursing reports on each patient from the previous evening's shift. Over time, I had learned to

slip in quietly and position myself unobtrusively. I would chat with people if they approached me, but usually I would keep busy myself by writing field notes, even when there was nothing of particular interest to write down. Waiting for Lorna, I thought about several ironies here. Patients are often said to avoid informal interpersonal interactions through “busywork” (e.g., calorie counting and perfectionistic approaches to homework). In addition, staff’s (crucial) acceptance of my daily presence on the unit had been, I was told, due to my respectful, “low-key,” and “unbiased” approach to my work—while anorexic patients on the unit were routinely characterized as overly quiet, deferential, and unopinionated. Finally, I reflected that my field notes were probably as detailed as patients’ medical charts (if not more so). In fact, I recalled that one day, when patients were complaining in group therapy about staff watching them and recording their behaviors and words in “the red books” (their medical charts), Sally, a psychologist, said to me privately: “It’s interesting that they don’t complain about *your* observations and note taking; you notice and record more details about the treatment program than any of us do.”

The difference, of course, was my lack of power over patients’ fates in the treatment program. Clinicians and staff could write something in patients’ charts that would prolong their stay in the hospital, or increase their calorie requirements (which were determined by a nutritionist and reassessed on a daily basis, depending on weight gain or loss). But Sally’s comment also spoke to some clinicians’ uneasiness about my role on the unit, especially near the beginning of my research. Generally speaking, the higher up in the power hierarchy a given person who worked on the unit, the more unsettled he or she was about my location within the treatment program’s complex layers of mutual watching.³²

When Lorna arrived for work that morning, we talked briefly at the nursing station. Lorna was excited about our arrangement for the day. She had let me know, as had several other female staff and clinicians, that she enjoyed the way I attended to her experiences and listened to her ideas,³³ especially given the pronounced gendered hierarchy within the unit’s treatment team. Pediatricians and psychiatrists are at the top of the hierarchy, and most are men. Psychologists and staff are next in the hierarchy, and almost all are women. One nurse told me that she often had trouble with her “voice” on the unit,³⁴ “and that’s what eating disorders are all about. We are all in it—the way women are treated.”

While Lorna stored her purse and jacket in the charting room, I

waited for her for a few minutes just outside the nursing station, reflecting on the unit's layout. The nursing station is centrally located in a wide, single hallway, with all of the patients' rooms, as well as a large community room, located on the opposite side.³⁵ Many patients' rooms are visible from the nursing station, and all rooms had internal glass panels and large windows to the outside to convey a sense of continuous visibility.³⁶ Foucault (1980b) discusses this arrangement of physical space as an important aspect of much of hospital medicine, modeled after Jeremy Bentham's panopticon, an eighteenth-century proposal for the architectural design of prisons (and also applicable to hospitals and schools; see Foucault 1979). Foucault writes that panoptical spatial arrangements ensure "a surveillance which [is] both global and individualising while at the same time carefully separating [of] the individuals under observation" (1980b, 146).

When Lorna was ready, we began to pick up urine "hats" (plastic containers) from anorexic patients' bathrooms, in order to measure patients' urine output from the night. We did not address any of the patients, many of whom were having their vital signs taken by another staff member. One patient's "orthostatic vitals"—a measure of the difference in pulse rate from lying down to standing—was found to be unsafe. She would be in a wheelchair all day, a conservative measure to guard against fainting, and to mark the seriousness of the patient's medical condition. Another patient was requesting that her vitals be taken *after* she was weighed. Usually patients' vitals are taken before their ritual weigh-in every morning (sometime between 7:30 and 8:30). This patient explained that she was so upset about the prospect of having gained a lot of weight, she was afraid her pulse would be artificially high.

Lorna measured and recorded patients' urine volume and density. She said that for the fourth morning in a row, Rebecca, who was on her second inpatient admission, had a urine density that was markedly low. This meant that Rebecca might be drinking extra water on the sly ("waterloading") to engineer the appearance of a higher body weight. Over the years, staff and clinicians had learned these patient "tricks" (which were then passed on from patient to patient). In fact, testing urine densities is a practice that was developed in response to patients' waterloading. It is meant as a deterrent but of course underlines waterloading as a possibility for patients by institutionalizing a response to it. Struggles around bodily surveillance and control can take on a life of

their own in the hospital. Lorna said that she would recommend a “random weight” for Rebecca, meaning that at some unspecified time during the day she would be weighed again, once any excess water weight had passed through her body. Random weights are also used if a patient is suspected of hiding weights—for example, batteries—in their hair or their underwear (patients are weighed in underwear and a medical gown only). Lorna said they avoid random weights as much as possible, because they are intrusive (staff are supposed to watch patients undress and put on their gowns for random weights).³⁷

Next, Lorna and I went to Carla’s room, and Lorna told her it was time for her to be weighed. Without a word, Carla walked with us to the scale, which was in a room a few doors down from the nursing station. Carla was eighteen years old and an “old-timer”: this was her fourth admission over a span of three years (not at all unusual). Carla stepped up on the scale. Lorna asked, “Do you want to do it?” Carla said no and watched nervously as Lorna determined her weight. “Up by .2,” Lorna said, writing it down. Two-tenths of a kilogram is just under one-quarter of a pound and is the least amount of weight a patient can gain to avoid having her calorie minimum raised for the day. At this point, Carla’s weight registered just under ninety pounds. Expressionless, Carla stepped off the scale and left the room. Lorna whispered,

Gaining is really hard for them. Even though it’s healthy, you never say “good job,” or anything like that. Carla’s happy that her calories won’t go up, but she’s upset about the gain. I had a patient once who insisted her gain was too much; she was worried her weight would go down the next day. About a half an hour after she was weighed, she came up to me, really flustered, and said she’d had a really big bowel movement, that’s what it was, and could we weigh her again? I explained that we could, and that we could even write the new weight in her chart, but that the *official* weight would be the one that was already recorded. We’ve learned over the years, just never compromise with these patients, they’ll start splitting hairs until it drives you crazy.

After weighing two more patients, it was time to get ready for breakfast, which began promptly at 8:30 in the community room. Patients picked up their trays from a cart in the hallway, which had been brought up by the hospital’s kitchen staff. Lorna and I sat with our own food at a table of patients who were “on observed,” meaning that a staff member was to record each item of food these patients ate and the number of

calories (and amount of liquid) they consumed. Patients who were “on unobserved” were nearing the end of their stay in the hospital and were responsible for monitoring their own caloric intake and keeping their own records. They sat at a table of their own that morning, along with a few non-eating-disordered patients. Susan, a milieu counselor, was also helping to observe that morning and was the only adult sitting at a third table of patients. (Milieu counselors do not have nursing degrees and cannot perform certain medical procedures but are otherwise identical to nurses in their roles on the unit. In general, milieu counselors are considered to be better skilled at group process than nursing staff.) A few minutes into the meal, Susan started up a casual conversation with Lorna about a recreational outing the previous afternoon (to a nearby mall), inviting patients to share their experiences, but not pressuring them to do so. Some patients chimed in with a few words, but most of them were concentrating on their food.

Patients are under considerable pressure to consume a specified number of calories each day, and several patients that morning were deciding what items to save for lunch or a snack as they slowly nibbled at their breakfasts. A few patients had brought calculators to breakfast to parcel out their required calories for the day’s three meals and two snacks in various permutations. Sylvia, a new patient, had no choice about what to eat: she was on a strict diet of 100 percent liquid nutrition, or Ensure, and was expected to drink one can that morning. Ensure is easier to digest than solid food, an important factor for some patients when they first arrive and are severely malnourished.³⁸ Lorna explained to her: “I need to see you open the can, just to make sure we’re starting with a whole can.” Meanwhile, Pam, a patient who was on her ninth admission in four years, was squeezing two small boxes of Shredded Wheat cereal and one box of Bran Flakes. After pouring the crushed cereal into a bowl, she added water while looking over at Susan, the milieu counselor sitting at her table: “Susan?” Susan said, “Six ounces?” and Pam nodded. While Susan recorded Pam’s liquid intake for the morning, Pam walked over to the microwave and “cooked” her cereal for a bit. Returning to the table, she added cottage cheese and began eating very slowly.³⁹

Valerie, a patient who was on her second admission, was still calculating different permutations of her menu for the day after fifteen minutes and had not started eating. It was not unusual for patients to spend a good deal of time at meals calculating and recalculating their

calories for the day, and therefore to delay eating (my analyses in chapter 1 suggest one way to understand this practice: it appropriates a mode of surveillance in the hospital—the requirement for precise calorie counting, with results that go on record—to “anorexic” ends). Looking over at Valerie, Lorna announced that it was 8:45, which meant that breakfast ended in twenty minutes. By this time, all the non-eating-disordered patients were finished with breakfast and had gone to their rooms. Valerie nervously wrapped up a bagel in cellophane, then got up to fetch a package of graham crackers from the kitchen’s communal food bins. Lorna gently reminded her that this was her second time up from the table, and that she would have to stay seated for the rest of the meal. Meanwhile, Susan spoke quietly with Lisa, a new patient who had just started on solid food the previous day. Susan was explaining that if Lisa did not finish her banana, she would have to count it at half its caloric value. Upset, Lisa asked, “But what if I eat three-fourths of it?” Susan told her that it was a rule, that they had to draw the line somewhere. Later that day, Susan, who was clearly flustered by Lisa’s challenge, told me that the eating disorder program has so many rules as it is, no one can remember them all.

The end of the meal was, as usual, a tense time. Valerie had begun eating only in the final five minutes, after Lorna reminded her that she had had a difficult time the day before at evening snack trying to make up for eating so little earlier in the day. Valerie had a doctor’s order for an “NG backup,” meaning that if she did not finish her calories for the day and was unable to complete them with Ensure after evening snack (within a designated period of time), staff were to force-feed her with a nasal/gastric (NG) tube. In practice, NG tubes were very rarely used: the threat of a tube was usually effective in convincing patients to finish their calories on their own. As the meal drew to a close and several patients struggled with the remaining food on their plates, one patient pointed to her calculator and to Lorna’s clipboard at the same time and said with a wry smile, “You’re five calories off!” Lorna added up her figures again and smiled, too, pulling out an eraser. “I’ve never been good at math,” she said, “but I can always rely on these folks to correct me.”

Pam and Sylvia finished their breakfasts on time, along with the unobserved patients, and they all returned to their rooms to fill out their menus for the next day (a rather time-consuming process for patients diagnosed with anorexia, who consider food choices extremely carefully). Valerie and Lisa had to be ushered out at 9:05, with plenty of food

still on their plates. On our way back to the nursing station, Lorna said, “We’re worried that Lisa might be hiding food in her shirtsleeves. I’ll make a note of it in her medical chart.”

At this point in the day, Walsh was bustling with activity. The head pediatrician and several medical students had completed their rounds (a meeting among themselves where they discuss patients’ medical progress and treatment protocols) and were trying to examine a few patients before school began at 9:30. The psychologists and psychiatrists who worked on the unit had also completed their morning rounds, and several were trying to arrange their schedules to see their patients that day for an hour’s worth of individual therapy each. Bob, the medical director, was writing a note in a patient’s chart. José in utilization management emerged from the charting room and came over to say hello. In his usual agitated state, he said, “I was just on the phone trying to authorize insurance coverage for Sylvia, the new eating-disordered patient.” José explained that Sylvia’s insurance company was planning to deny their claim (a common occurrence). José said that he would probably be successful in authorizing coverage, but in the meantime Sylvia’s parents would get the bill, “and at over \$1,500 a day, they’re gonna flip.”⁴⁰ Lorna interrupted to say that she and I should go pay Sylvia a visit.

Lorna had been assigned to Sylvia as her staff advocate, and because Sylvia was new, Lorna made the time to have a “one-to-one” with her. After introducing me, Lorna asked Sylvia if she had any questions. They talked for a while about Sylvia’s vital signs from that morning, how often vitals are taken, and so on. As Lorna spoke, Sylvia was so nervous and distracted that she was barely listening. After Lorna finished talking, Sylvia blurted, “Ann [the nutritionist] said I need five cans of Ensure today. Can I have them only at meals? One, two, and two? I don’t like snacks.” Lorna asked which snack she did not like, and Sylvia said, “Neither one.” Lorna replied, “You know, let’s check with Ann and your doctor. I’ll bet they’ll want you to spread them out until your vital signs are more stable. When they are, you’ll be more on your own with that. But now, I’ll bet they’ll want you to spread it out. But we can ask.” After talking for a few more minutes, Lorna and I left Sylvia’s room and talked briefly in the hallway. Lorna remarked (and I paraphrase):

Especially at this early stage, education is really important. She’s pretty overwhelmed, and I just explain what we do and why as clearly

as I can, and try to show how it's linked up with the state her body is in. And I try to empower patients, let them know they can ask for things, even if they won't get what they want all the time. After patients get a handle on the routine here, I'll talk with them about experiences other kids have had on the unit, and even share some of my own life experiences with them sometimes, in a way that's supportive of them. And sometimes I'll tell them girls are taught to keep things inside, so it's hard to say how you feel all the time, or express your anger.

Lorna said that in general, she saw her role with patients (particularly in one-to-ones) as supportive and educational—not “therapy” but “therapeutic.”

Let me skip ahead now to a brief description of “community meeting,” which takes place after lunchtime. Community meeting is one of the daily activities on the unit and counts as “milieu therapy.” It is considered more of a business meeting than “group therapy,” and a chance for all patients who are living at Walsh (including those who are not in the eating disorders program) to interact among themselves in a structured way. Normally, the meeting is held in the community room, but that week it was being held in Marlo's room, because Marlo was on “strict medical bed rest.” When a patient's anorexia is extreme, she may have a very low body temperature and chronic vital sign instability. Under these circumstances, patients are usually confined to their beds with a bed warmer and placed on a cardiac monitor. Marlo lay quietly, surrounded by machinery, as Lorna, several patients, and I brought chairs into her room. Once everyone had arrived, Lorna asked, “Who's the chairperson?” It was Pam that week. Pam was eligible for the role—that of (figurehead) facilitator of the meeting—because she had reached “level 2” of the behavioral level system on the unit, meaning she had attended groups regularly and was making progress toward her therapeutic goals. Before Pam could begin the meeting, Joey, a sixteen-year-old patient with asthma and “behavioral problems,” said he had an announcement. Pam said, “We have to do introductions first” (for Sylvia, the new patient). With tremendous sarcasm, Valerie said, “Oh, Joey, what a faux pas!” Valerie, her eyes heavy and narrow with depression and stress, was known for her bitter wit, and for delighting in critical remarks about unit procedure. Lisa, who was a poised and precise meeting secretary, included the crack in her notes.

After introductions and Joey's announcement that he was leaving

the hospital that afternoon, Pam asked if anyone had any issues to raise. Instead of the familiar complaints about the length of community meeting, the group was quiet. Lorna wondered out loud about the silence, and Marlo asked, “Do we always have to analyze everything?” Pam decided to move on to Joey’s “good-bye questions.” Someone asked what he had learned while he was here (how better to control his anxiety); another patient asked what he would do when he got home (watch tv whenever he wanted). Then Lisa asked Joey what he would tell his friends if they asked where he had been. Joey looked upset and confused. Lorna spoke up: “Sometimes we ask patients what they would say if someone asked them a question about their stay here that makes them uncomfortable.” Joey visibly relaxed and said, “I’ll tell them it’s none of their business.” After a few more questions, Pam noticed the time and wrapped up the meeting.

On my own for a short time at this point in the day, I reflected on the fact that interactive “social time” at Walsh is almost always carefully scripted. Some friendships are formed, often between roommates, but in general there is not much room for spontaneous socializing. Patients in the eating disorders program spend most of their free time by themselves—planning menus, counting calories, thinking about therapy sessions, perfecting homework assignments, and strategizing ways to prevent gaining weight and/or return home quickly. Also, according to some staff members and to several patients I got to know well, patients often compare themselves with one another in jealous ways. For example, they may ask themselves: Who here is thinner than I am? Are staff easier on her than they are on me? I wondered whether the (frequently reported) anorexic experiences of isolation and competitiveness are amplified in this treatment setting.

Shortly after community meeting, Lorna and I attended afternoon rounds, which included clinicians from both child psychiatry and adolescent medicine. (I will describe rounds in some detail later.) After rounds, Lorna was nearing the end of her shift. She picked up the medical charts of her assigned patients, and we went to the small charting room just next to the nursing station, where Lorna would write up her nursing reports. At this time of day, the charting room was crowded. Several interns and medical students were also “charting on their patients.” An intern in psychiatry was debriefing a therapy session with the medical director. Karen, a psychology intern, was on the phone with a patient’s parent, arranging a family therapy meeting, which,

ideally, took place once a week. At one point in the conversation, Karen said, “Yes, I know she’s a minor, but there’s certain information that should really come from her. We’ve found over the years that patients should be the ones to tell their parents about their weight and that sort of thing, if they choose to.” As I began thinking to myself about therapeutic accounts of healthy individualism in families,⁴¹ Lorna came over to tell me she was finished charting and was ready to go. I saw her out, and we said we’d see each other the following day. I left soon thereafter myself, to head home and write up my field notes for the day.

Interviews

The foregoing account is an example of my participant-observation at Walsh. I also conducted semistructured interviews with forty-five patients, thirty parents, seventeen staff, ten clinicians, and several other people affiliated with the unit (e.g., the intake coordinator). Many of these people were interviewed two or three times. Most interviews took place on site at the hospital, either in a private room (ordinarily used for therapy) or in the hospital cafeteria. In addition to these more formal interviews, I had many casual conversations with people over lunch, over coffee, in hallways, in patients’ rooms, in waiting rooms, and at social functions.

I began most interviews with an exploration of peoples’ personal and professional histories with the treatment program. I then asked a variety of open-ended questions related to everyday experiences on the unit or in the clinic; patients’ resistance to treatment; explanations of, and ideas about, anorexia and its relationship to gender, race, and class; notions of femininity and ideas about gender roles in the family; dynamics of gender and power within the treatment team; and parents’ roles in the treatment process. Here is a sample of the questions I asked: What are the strengths and limitations of the treatment program as you see it? What are the pros and cons of such “detail-oriented” treatment protocols for a detail-oriented problem like anorexia? Why do you think so many patients resist treatment? Why do you think that more than 90 percent of anorexic patients are girls and women? Do you think patients’ mothers and fathers are treated in a similar way, or differently, at Walsh? Many people have worked here for a long time—what do you think is compelling about this place? How could Walsh’s “team approach” to treatment be improved, in your opinion?

Data Collection and Confidentiality

During participant-observation, I hand-recorded details of events and others' descriptions of events "live," whenever possible. There were times when it was inappropriate or would have been disrespectful for me to take notes about events while they were occurring—for example, I decided not to put pen to paper during mealtimes with patients. In these situations, I would take a break from participant-observation as soon as was practicable and find a quiet place in the hospital (e.g., an available therapy room on the unit or a small table in the hospital cafeteria) to take notes from memory. At the end of each of my days or evenings at Walsh, I would review and flesh out my notes at home and record questions or lines of inquiry I might want to pursue as my research progressed. Interviews were tape-recorded whenever possible (some interviewees preferred that I take notes by hand), and transcribed along with several therapy sessions I was able to tape-record. Once I had collected all data, I read through my notes many times and began organizing them into broad themes, a process that initiated the organization of this book.

To protect patients' privacy, I have disguised certain identifying data about the treatment program. It has also been necessary to disguise certain personal data about patients so that, for example, a parent who took part in the treatment program will not have access to confidential information about another person's child. Also, I sometimes protect the identities of clinicians and staff within the unit's "community." To these ends, I occasionally create composite characters, slightly alter quotations, and attribute some people's words to others.

Critically Applied Medical Anthropology

My stance toward unit practices in this book is a critical one. I argue that Walsh's elaborate methods of surveillance; its meticulous accounting of patients' "progress" in terms of body weight, calories consumed, et cetera; its professional sexual politics of caretaking; and even its attention to patients' psychological "development," family lives, and interpersonal skills all participate in contemporary cultural discourses that help constitute what I am calling anorexia's conditions of possibility. At the same time, however, there is no doubt that in many important ways, the treatment program "works." Lives are certainly saved, and many

patients improve over time. Clinicians and staff at Walsh claim, and the unit has a reputation for, successful treatment—although “success” is open to a range of interpretations in this area of specialization (Lemberg and Cohn 1999).⁴² However, it is not my purpose to evaluate the effectiveness of this treatment program in psychiatric or biomedical terms, strictly defined. Rather, my focus is as follows: What do patients, parents, staff, and clinicians *mean* when they say that the treatment program works or does not work well? What are the politics of personhood that support these views? To borrow terms from cultural anthropologist Gananath Obeyesekere (1985), how can we characterize the “work of culture” that renders conceptualizations of health and illness on the unit powerful and persuasive?

In addressing these questions, I employ a critically applied medical anthropology. Critically applied work in this field can be distinguished from work that is clinically applied (Scheper-Hughes 1990). While these two approaches need not be mutually exclusive, the latter usually signals an allegiance to biomedical definitions and categories of illness, health, and personhood; often, the goal is to improve biomedical practice through a “cultural sensitivity” that helps assimilate or more effectively translate patients’ explanatory models of illness into physicians’ models (see Armstrong 1987; Scheper-Hughes 1990). In contrast, a critically applied medical anthropologist “works at the margins and sometimes (but not necessarily) from the outside, pulling at loose threads, deconstructing key concepts, looking at the world from a topsy-turvy position in order to reveal the contradictions, inconsistencies, and breaks in the fabric of the moral order without necessarily offering to ‘resolve’ them . . . [challenging the] economic and power relations that inform . . . every medical encounter” (Scheper-Hughes 1990, 191). My aim in this book is to situate psychiatric approaches to anorexia within certain powerful, problematic, and contradictory discourses that surround feminine identity and family life in the United States today. I want to emphasize that such a stance does not imply a disgruntled acceptance of the psychiatric status quo, or “mere criticism.” Critical work in the field can include an advocacy role (see M. Lock 1993). Such a role may be directed toward unmet patient/family demands, shifts in the practice or “culture” of medicine, and economic inequalities in the provision of medical services. It is my hope that this book could provide a groundwork for advocacy on a number of fronts.

Accordingly, when I write about patients’ resistance to treatment, I

do not depict mere “rituals of resistance” (see Gluckman 1963) that serve only to reinscribe, even to strengthen, (apparently) totalizing forms of cultural and medical power.⁴³ While I borrow from Obeyesekere, my stance differs from his in one crucial respect: the “work of culture” on the unit that “fuses into a conception” (Obeyesekere 1985, 136) called “anorexia”—and also a conception of fitness and health—is not uniform and all-determining; rather, it is fractured and contested. My analysis takes its cue from Good and Good’s work on the creation of medical knowledge (Good and Good 1993; Good 1994), and from Lorna Rhodes’s 1991 research on cultural contradictions within psychiatry, in challenging the assumption that biomedical discourse is seamless and therefore constitutes bodies and identities in a top-down fashion.⁴⁴ My goal is to make explicit the potentially transformative tensions and contradictions that already exist on the unit. Like cultural anthropologist Nancy Scheper-Hughes (1992, 29), but in a very different context (Scheper-Hughes writes about hunger and child malnutrition among shantytown dwellers in Northeast Brazil), I think of my role as an ethnographer at Walsh as, in part, that of a “clerk” or “keeper” of the records.” I have recorded and interpreted a version of events that are not told as such in official records at Walsh, and that indeed challenge these records in many ways—even as they crosscut and participate in the narratives and practices that constitute status quo medicine.⁴⁵

While recognizing contradictions at Walsh, I also recognize that many clinicians and staff lay claim to noncontradictory and authoritative accounts of illness and health, and that real forms of power accompany these claims. Throughout this book, I am clear about my political and intellectual stance against such claims, and against the hierarchies of gender, class, ethnicity, age, and professional status that support them. However, precisely because these authoritative accounts are produced within social fields of inequality, they sometimes falter on their own terms. These are the moments I seek to highlight. In other words, my critical analyses of unit practices emerge out of “practical” criticisms that are already unfolding. Believing that the potential effectiveness of “alternative” discourses lies in their potential to reconfigure dominant social forms persuasively, I focus on modes of resistance that patients, parents, staff, and clinicians express in situ (and that sometimes have conservative effects). Of course, when I ground my critique of unit practices in terms that are already available in the treatment

program, I am never “neutral” about the *particular* terms that I notice and then make explicit. Hence, my analysis does point in specific directions regarding treatment improvement (addressed in the epilogue).

This book is, of course, a partial account of cultural discourses at work in the treatment of anorexia. Much of my analysis circulates around the trope of “fitness” and unpacks a particular set of ideas and practices that intersect with it, focusing on hegemonic constructions of health, illness, and (hetero)normative family lives. There are a number of important debates in the field that I do not address—for instance, the role of childhood sexual abuse in the creation and experience of anorexia.⁴⁶ Also, I should note that with the exception of chapter 3, this book highlights experiences and clinical representations of patients and parents at Walsh. Although I include detailed ethnographic analyses of clinicians’ and staff members’ negotiations with patients and parents and with one another in the process of treatment, the primary subjects of this study are those who seek help at Walsh and (often) appear there as clinical “objects.” This choice on my part reflects my desire to challenge the pervasive privileging of powerful “expert” accounts of anorexia. The risk here is that clinicians and staff may at times appear merely to ventriloquize such accounts, when it is one of my central aims to show how these accounts are actively, if not fully consciously, produced.⁴⁷ I hope that I succeed in describing enough of the differences among, and uncertainties of, clinicians and staff to convey the complexities of their own positions as psychiatric professionals.⁴⁸

I anticipate that some people at Walsh will disagree with my interpretations. My analysis of the treatment program should be read in light of the fact that several patients and parents I interviewed supported the unit’s therapeutic practices (sometimes only in retrospect), in spite of their often bitter criticisms. In addition, most staff and clinicians found their jobs highly rewarding, especially compared to their previous experiences working in other psychiatric facilities. However, I do not believe that these points weaken my critical analyses. I am concerned not only with ruptures in, and resistances against, dominant ideas about feminine fitness and familial “health” but also with the creation of these ideas as normative, “natural,” and beneficial. Of course, the analyses presented here are my own. But they are informed by the mutual interests and ideas of many people I met during the course of my fieldwork.

Naturalizing Power: Thinking Through Intersections of Feminist Theory, Cultural Studies, and Medical Anthropology

Theorizing Anorexia as a Cultural and Psychiatric Phenomenon

Debate about the relative importance of “sociocultural factors” in anorexia’s etiology is ongoing. Few disagree that anorexia is culturally and historically situated, and that so-called sociocultural factors play a part in its development and maintenance, as well as its prevalence among young women and girls. Also, recent social changes have facilitated the emergence of many cases of anorexia—it is difficult to explain its increase in incidence in the 1970s and 1980s in any other terms (Bordo 1993d; R. Gordon 2000). Indeed, a number of cultural theorists and also some clinicians refer to anorexia as a “culture-bound syndrome.”⁴⁹ However, a vast body of clinical research on anorexia and much of the literature about its treatment include only passing mention of these issues, if they are mentioned at all. A majority of psychologists and psychiatrists follow a medical model in considering psychological, physiological, and familial “factors” to be entirely separable from cultural factors, and to be the only ones of real etiological significance.⁵⁰ In contrast, some feminist scholars assert that anorexia differs only (or primarily) in degree from “normal” dieting, which is chronic or problematic for many women and girls.⁵¹ In many of these latter accounts, biomedical and psychological categories fall by the wayside or are seen to misrepresent social problems as individual and familial “dysfunctions.” Sometimes, these categories sit uneasily beside a feminist cultural analysis.⁵²

Feminist historian Joan Brumberg (1989) claims to formulate a compromise between a medical model and what I will gloss as “the feminist cultural model” in her influential book on anorexia’s social history; but in fact, she too separates biology/psychology and culture in her analysis of anorexia’s etiology. Brumberg argues that psychological, biological, and cultural factors converge to cause anorexia, but that the psychological and biological variables involved are themselves culturally neutral, are not shared by “normal” dieters, and call for “objective” psychiatric treatment. Most clinicians who hold that sociocultural factors are significant in anorexia’s etiology share Brumberg’s view (including Dare and Eisler [1997] and Richard Gordon [2000], who count anorexia as a culture-bound syndrome). Gordon, for example, points to

“developmental vulnerabilities” to explain the difference between a person who lives with anorexia and “normal” dieters. Other (indeed, most) clinicians, using similar logic, have for some time now claimed to debunk or minimize the feminist cultural model through the argument that only a biomedical and/or psychological problem (or “vulnerability”) can account for the fact that only some, and relatively few, people develop anorexia (see Bordo 1993d; Way 1995). Proponents of the feminist cultural model reply that there are at least two different theories of illness causality at work in the debate between mental health professionals and cultural theorists on this subject: whereas clinicians are dedicated to identifying and repairing “internal” causes (internal to individuals and families), cultural theorists often conceptualize anorexia as an *internalization* of sociocultural norms that expresses an extreme form of “normal” behavior (Polivy and Herman 1987), or a “crystallization” of various gendered cultural streams revolving around bodily control (Bordo 1993c). Not everyone, of course, inhabits or lives with these discourses in the same way (which is another way to explain why only some people develop anorexia).

This debate often invokes reified concepts of psyche, soma, and culture. Psychiatric “nature” and cultural “context” remain conceptually distinct for many scholars and practitioners on both sides. For example, clinicians’ familiar charge that the feminist cultural model ignores the real suffering of those diagnosed with anorexia relies on the notion that suffering is, in this case, a psychiatric problem by definition. It also calls up the stereotype of vanity and privilege (as opposed to “true suffering”) that is sometimes associated with simplified, “cultural” explanations of eating disorders in the popular press.⁵³ Meanwhile, claims since the 1980s that an “epidemic” of eating disorders is upon us rely on a generic notion of cultural influence and simultaneously medicalize and pathologize all chronic dieting. A number of researchers imply that a majority of American girls are “at risk” of developing an eating disorder, and inflated statistics about the prevalence of anorexia and bulimia circulate in some quarters.⁵⁴ The latter can be understood as an overzealous application of the feminist cultural model, whose proponents are fighting an uphill battle on an institutionally uneven playing field in their efforts to challenge a medical model that draws a clean line between normal and abnormal, a line that encourages apathy about the cultural production of anorexia and also of chronic dieting. However, as cultural theorists Julie Hepworth and Christine Griffin point out (Hep-

worth 1999; Hepworth and Griffin 1995), many versions of the feminist cultural model tend to leave intact a reified concept of “anorexia” and to search for its “causes” (in an extrapsychiatric domain). When the illness category itself is not questioned and a familiar narrative of “finding causes” remains on the table, the door is open for understanding this model in terms of “culture” writ large producing “pathology” and its precursors. Lester (1997) and Malson and Ussher (1996) note a corollary of this problem: a poorly theorized account of internalization within many socioculturally oriented analyses of anorexia. These analyses often do not question the liberal humanist assumption that pre-given “individuals” absorb or react to cultural “overlays” and to processes of socialization (see MacSween 1993), and they often emphasize “dieting and the idealization of thinness to the exclusion of other aspects of anorexia or female subjectivity, without theorizing the sociocultural aspects of (gendered) embodiment and without exploring the wider cultural and political significances of female slenderness” (Malson and Ussher 1996, 268).

In this book, I follow suggestions from Bordo (1993c), Malson and Ussher (1996), and Probyn (1987) to locate anorexia within a complex sociocultural field, and at the intersection of multiple, and sometimes contradictory, discourses of feminine identity.⁵⁵ My aim is to avoid a reified concept of “culture” and thus also allow for a more nuanced account of subjectivity (a topic I address later in this introduction). I also take up the call from Hepworth (1999), Hepworth and Griffin (1995), and Malson (1991) to question anorexia’s status as a “pre-given medico-psychological entity” (Malson 1991, 31). In these ways, this book challenges the persistent drawing of contrasts between “nature” and “culture” in debates about “sociocultural factors” in anorexia’s etiology.

Embodied Forms of Power and Resistance

My ethnographic analysis of cultural discourses operating in the treatment of anorexia—a context that privileges biomedical and psychological explanations of bodily states—allows me to move beyond the argument that psychiatric accounts of anorexia *misrepresent* social problems as individual (and familial) dysfunctions. This dichotomy of individual/social is somewhat useful as a description of psychiatric ideology, but it is not useful for understanding the production or the power of beliefs in the clinic. Accounting for the day-to-day creation of identities and

bodies at Walsh requires an analytic shift that can contextualize this dichotomy. In this section, I focus on scholarship informing my analysis that unpacks presumed splits between individual bodies and “culture,” as well as attending dichotomies that cordon off biology and psychiatry from culture. Central to my discussion are theories that problematize any clear-cut distinction between medical power and individual agency/resistance.

In her review of “epistemologies of bodily practice and knowledge” within anthropology, Margaret Lock (1993) writes that research since the early 1980s “decentering the physical body of the basic sciences and questioning the epistemological assumptions entailed in the production of natural facts has radicalized and relativized our perspective on several recalcitrant dichotomies, in particular nature/culture, self/other, mind/body” (134). My own approach draws on such research in medical anthropology.⁵⁶ There are two particularly compelling reasons to question the commonsense notion that “the body” (or “the psyche”) is separable from “culture” in the case of anorexia: first, a struggle with anorexia *actively crafts* a certain kind of body; and second, no clinical study to date has been able to determine an etiology for anorexia that can be framed in terms of an “objective” psychological or biological cause (every physiological disturbance associated with anorexia can be shown to be secondary to extreme weight loss). I suggest that one of the challenges anorexia presents to the discipline of psychiatry is a living “cultural critique” of the assumption that the body is an acultural entity. At the same time, then, I take issue with some feminist arguments about anorexia’s etiology that appear to bracket out “the body” as less important than “culture.”

Increasingly, scholars in a range of disciplines are analyzing the body as a socially and culturally constituted entity. Much of this research is concerned with the naturalization of power through the body and draws on the work of Foucault (1975, 1978, 1979, 1980a)—and, for some, Bourdieu (1977, 1984, 1990)—who argue that normative perceptions of the body, both lay and “official” (e.g., psychiatric), are rooted in everyday cultural practices that work to socialize the body. Individuals literally shape their bodies in expected ways, and in this process, social expectations are made to seem “natural.” Foucault’s work along these lines is particularly relevant for my discussion here, and is well known in critical accounts of medicine and psychiatry: he shows how medicalized ideas about bodily health and fitness are culturally produced, so that

seemingly “objective” (acultural) psychiatric mandates to control the body actually encode powerful social norms (see especially Foucault 1975). This insight is important for understanding why anorexia is difficult to treat. Because the discipline of psychiatry helps to naturalize and even to create dominant Euro-American symbolic formulations and practices of bodily ordering, and because anorexia embodies contemporary ideals of femininity, it is no surprise that therapies often recreate anorexic symptomatology. For example, as I show in my previous work (Gremillion 1992), psychoanalytic therapies coupled with behaviorist treatments represent health as an “objective” control over an internal weakness or deficit; but ironically, patients themselves work to control a perceived “internal weakness” as part of their illness experience.

However, while Bourdieu’s and Foucault’s theories help to explain how therapies for anorexia participate in the problem, they can go only so far in helping us to understand patients’ resistance to treatment. Both authors tend to unify operations of power in their writings, even though they analyze the sociocultural constitution of different forms of subjectivity. Although Foucault (1978) has famously claimed that “where there is power, there is resistance” (95), he tends to write about both power and resistance in generalized ways.⁵⁷ To adequately explore the phenomenon of anorexic patients’ resistance, it is important to consider the specific and disruptive effects of gender. Here I draw on the work of a number of feminist scholars who have developed Foucault’s work by examining contradictory or contested constructions of gendered bodies, particularizing his overly abstract remarks about subjects’ resistance to power.⁵⁸

In her influential work *The Woman in the Body: A Cultural Analysis of Reproduction*, anthropologist Emily Martin (1987) shows that in a clinical setting, female patients are likely to be cast as “victims” of their own bodies, even when, as in the case of anorexia, they conform to values that are culturally sanctioned. She analyzes the cultural construction of childbirth in this light and shows that many women are compelled to resist medical practices surrounding labor and delivery. Martin argues that the dramatic increase in the number of cesarean sections performed in the decades before the publication of her book was due primarily not to medical emergencies but to a cultural notion that women are passive during childbirth. Several of Martin’s informants who had received C-sections in the past, and were advised against future vaginal deliveries, asserted their own wishes to deliver a child vaginally by

refusing to appear at the hospital to deliver their next child until it was too late to perform a C-section. Martin's work shows how medical constructions of feminine "nature" can highlight *social* relationships and cultural ideals that inhibit women and often engender struggle and resistance.

My own analysis draws on Martin's work and related scholarship about gender and the body, and it also emphasizes the complexities of resistance and its relationship to the status quo. A number of cultural anthropologists and cultural studies scholars have challenged the notion that resistance to sociocultural ideals and relations of power necessarily implies a fully *oppositional* stance. For example, in an early account of this kind addressing youth subcultures in postwar Britain, Dick Hebdige (1988) shows how rockers, skinheads, and punks often express rebellion through the appropriation and reconfiguration of dominant symbols and values. This theoretical approach allows for an analysis of cultural struggle and change as it occurs gradually, in practice, at a level that is not always self-consciously "activist."⁵⁹ There have been few applications of this approach to ethnographic studies of illness and medicine in American or European contexts, even though the medical anthropological literature widely recognizes that illness can often express a subtle and ambiguous form of social "protest" (Comaroff 1981; Good 1977; I. Lewis 1971; Scheper-Hughes and Lock 1991). One notable exception is feminist anthropologist Rayna Rapp's 1999 study of a range of women's responses to amniocentesis. Rapp shows that refusing amniocentesis, or interpreting its meanings in ways that clinicians might not predict or support, is not the same as refusing the medicalization of pregnancy. The two can coexist, and Rapp's research also suggests that ethnographic attention to difference and dissent in this area could reconfigure received understandings of motherhood and, to some extent, conceptualizations of viable personhood. Another exception is medical anthropologist Mark Nichter's 1998 essay "The Mission within the Madness," which describes a hospital patient's so-called "borderline personality disorder, hypochondriasis, and chronic pain of psychogenic origin" as "self-initiated medicalization," which afforded this patient agency and control in a system that could not control or "manage" her to clinicians' satisfaction (330). Nichter analyzes self-initiated medicalization as a complex form of resistance against medical authority on its own terms.

Anorexia provides an ideal case study for this type of analysis. Unlike

the women Martin interviewed—who *rejected* the imposed idea that they should play a passive role during childbirth—patients diagnosed with anorexia challenge medical and social power by *exaggerating* medicalized norms of self-control and bodily “fitness.” Patients’ resistance to treatment points to culturally constituted instabilities and fractures within medical discourse itself. In fact, chapter 1 shows that clinicians and staff at Walsh are compelled to accommodate, and even encourage, patients’ resistances, in part because of changing cultural definitions of anorexia. These resistances have been constitutive of the rapidly shifting set of clinical practices designed to treat anorexia.

Note that hospital settings are not the only sites where the embodied forms of power I analyze in this book are both naturalized and contested. But it is particularly important to examine critically the cultural production of medical discourse about anorexia. Following Taussig, I argue that when clinicians and patients objectify patients’ problems, they “*invigorate* cultural axioms” (Taussig 1980, 3; italics mine). Psychiatric treatments for anorexia invigorate contradictory cultural axioms about, for example, feminine fitness and individualism, not only recreating but also intensifying patients’ historically particular sociocultural conflicts. Because of this intensification, a clinical setting is ripe for exploring anorexia’s cultural constitution. In other words, claims to psychiatric “objectivity”—claims that sometimes incite the charge of medical “alienation” from cultural meaning⁶⁰—in fact do more than paper over the cultural conditions of their production. Hospital settings are important sites of struggle because these claims to objectivity render explicit what are normally implicit, everyday assumptions about the “nature” of bodies and subjectivities (for related arguments, see Comaroff 1982; Comaroff and Maguire 1981). I will show that in the treatment of anorexia, when psychiatric discourse mystifies the social shaping of bodies and persons through medical objectification, it also crystallizes certain ideas and practices that are designed to create fit and healthy bodies (and that, ironically, patients can use to support their anorexia).

My analysis is indebted to recent feminist readings of technoscientific discourse and practice.⁶¹ Charis Cussins’s (1998a) account of medical objectification in an infertility clinic is a good example. Unlike many feminist critics of science, Cussins shows that objectification does not necessarily lead to a loss of agency for women patients, and that, in fact, some important forms of agency in the clinic require it.

What is more, medical discourse allows patients “new access” to bodily processes and parts related to pregnancy: “it renders the parts visible and manipulable” (180).⁶² Of course, infertility patients are different from most patients at Walsh, in that they actively seek treatment and are therefore self-consciously motivated to achieve embodied agency in medicalized terms. Nevertheless, Cussins’s ideas are helpful for my own analysis because at Walsh, as in the infertility clinic, moments of overt rebellion are by no means the only moments that afford opportunities for critical analysis and for the renegotiation of medical meanings: “there is every reason to believe that [the clinics’] *normal* workings can yield clues as to its construction” (171; italics mine). For this reason, it is important to “work with a reconceptualization of agency that decouples any unproblematic linking between agency and the good”—as in, good for “escaping” medical objectification (193).⁶³ At Walsh, patients’ resistance to treatment sometimes takes the form of deploying “objective” psychiatric discourse in surprising ways, underlining the power of “objectivity,” but also disrupting psychiatric claims to seamless and authoritative accounts of illness and health.

Theorizing the Body

Because a person who struggles with anorexia alters and shapes her body in conjunction with historically and culturally specific discourses, one might say that anorexic bodies are “constructed”: they are thoroughly embedded in culturally normalized, gendered ideals surrounding dieting, fitness, the micromanagement of food and of body shape, and efforts to subordinate the flesh to willpower. But a difficult question arises when analyzing anorexia and its treatment in this way, and it is a question that can be posed about constructionist analyses of the body more generally: What is the status of the real material stakes involved? How can one speak about the “construction” of anorexia—and the “anorexic body” in particular—and also communicate serious concern about the physical dangers of the problem, and the real suffering involved? Does a constructionist approach risk ignoring actual anorexic bodies? These questions echo clinicians’ criticisms of the feminist cultural model cited earlier but are more focused on theorizing the body than they are with defining disciplinary “turf.”

Constructionism does not preclude attention to bodily “reality.” I take seriously the lived, material realities of both anorexia and biomedical practice, and I argue that these realities cannot be explained ade-

quately in biomedical terms (as they are currently conceived). At the same time, I suggest that certain of these biomedical terms remain unproblematized by, and can even be reproduced within, constructionist theory.

Some constructionist scholarship does appear to ignore the “reality” of the body. As cultural theorist R. W. Connell (1995) remarks about these constructionists, “with so much emphasis on the signifier, the signified tends to vanish”; their discussions seem oddly disembodied (50–51). In their analysis of “postmodern bodies,” Arthur Kroker and Marilouise Kroker (1987) assert explicitly that the body is no more, claiming that a general obsession with the body in the United States today gives the matter away: “Why the concern over the body today if not to emphasize the fact that the (natural) body in the postmodern condition has *already* disappeared, and what we experience as the body is only a fantastic simulacra of body rhetorics?” (21–22).⁶⁴

However, in spite of claims to remove the body from the realm of “nature,” much of this research actually (implicitly) posits a prediscursive corporeality in an effort to articulate social and cultural determinations of the body. This prediscursive body appears to be, necessarily, devoid of meaningful content (in this sense, it differs from the “natural body” posited in biomedicine, a body that is subject to “natural law”). But the assumed body in these constructionist theories does, in fact, carry a specific meaning: it is imagined as a kind of blank slate for imprinting dominant social scripts and is therefore—like the biomedical body—a relatively passive object available for human intervention (Grosz 1994; Haraway 1991b, 1991d; Price and Shildrick 1999). So I suggest that when constructionist accounts do not adequately theorize the lived materiality of bodily experience, the problem is not so much that they ignore the body; rather, they define constructionism as a (rather totalizing) process that operates on and through a material plane that is taken for granted. For example, in her analysis of anorexia as a “crystallization” of “cultural pathology,” Susan Bordo (1993a) asserts that gendered forms of social control are “etched” on the anorexic body (164), even as she argues that “there is no ‘natural’ body,” because the body “is constantly ‘in the grip,’ as Foucault puts it, of cultural practices” (142). As Elizabeth Grosz (1994) points out about Bordo’s position on this topic, the “very status of the body as [cultural] product . . . remains at stake here” (143).⁶⁵

The status of the body as a cultural product is very much at stake

within biomedicine, as well. The cultural production of bodies remains almost entirely untheorized within biomedicine, but as I have stressed throughout this introduction, it is important not to assume an absence of cultural discourses in the medical treatment of bodies. This book shows how medical and psychiatric practitioners actively craft the particular kinds of bodies that they claim merely to describe, diagnose, and normalize (according to seemingly “universal” standards)—producing very real, and socially located, embodied effects by acting as if these bodies preexist both socialization and medicalization. Further, I show that the female body is not simply given as raw material for the cultural and medical work that goes on in the clinic; rather, it is created in and through this work. More specifically, and more to the point regarding a critical analysis of social constructionist theory, I argue that treatments for anorexia invoke and produce an understanding and a lived experience of the body as stubbornly “natural”—an understanding and experience that is culturally and historically specific (although it is *represented* as objective, biomedical truth). I suggest that these are the ethnographic and analytic terrains to explore in order to adequately understand the undeniable corporeality of anorexic bodies. My approach follows Judith Butler (1993) and Donna Haraway (1991c, 1997b) in their understanding of normalized bodies as the *material effects*, the corporeal instantiations (over time), of particular sociocultural practices and discourses. I bring this kind of analysis to bear on certain institutional practices and lived experiences of “health” in the making. My analysis is mindful of Haraway’s claim that many arguments “against ‘biological determinism’ and for ‘social constructionism’ . . . have [not been] powerful in deconstructing how bodies . . . appear as objects of knowledge and sites of intervention in ‘biology’ ” (1991b, 134).

While I agree with the intent of “radical” constructionist approaches to deontologize representations of the body as natural, I believe that they overlook a crucial question: namely, how is it that people *experience* their bodies as natural? In other words, “deconstructing” the body does not allow for a consideration of the social and cultural practices that render the body a seemingly natural object. In failing to consider this question, some constructionists fall short on their own terms by reinscribing the body as an acultural “thing.”⁶⁶ In these accounts, the body tends to be cordoned off as a mere resource for the activity of social construction itself.⁶⁷

But the metaphor of corporeality as “resource” can be unpacked—

this kind of body is an imagined natural object of a particular kind. I will show that to understand anorexia and its treatment, it is imperative that we not reproduce this metaphor uncritically, because it is the very subject at hand: patients and clinicians alike view the body and biomedical criteria of health as resources for the construction of identities. In addition, I show that the female body is read and experienced as *both* a resource *and* a “natural limit”—that is, as an uncooperative resource—in this task. If the crafting of feminine identity is experienced in these ways, and not merely as abstract social forces but in and through lived, embodied practices and through struggles over bodies “on the ground,” we can consider the problematic status of “material stakes” and “physical limits” in social constructionist theories to be part and parcel of the (gendered) cultural field in question.

One could argue that an anthropologically informed phenomenological account of anorexic embodiment would offer an alternative to a radical constructionist approach without falling into biological determinism. While some of my descriptions in this book might be characterized as phenomenological, I am less concerned with the kind of questions that usually inform such an analysis (for example, questions about the relationship between the body and consciousness) than I am with unraveling lived articulations of historically specific North American discourses of identity that are manifest in anorexic bodies.⁶⁸ For example, I ask: What particular cultural practices lead anorexic patients, and the clinicians who work with them, to construe the female body as an uncooperative resource? More generally, why is the body such a productive effect of power in the United States today, such an important site for identity construction (and such a popular topic of analysis in the social sciences)?

Hegemonic Constructions of Identity

Throughout this book, I situate the body as one discourse among many within a particular social formation—postindustrial U.S. society—in which “fitness” is figured as a cultural dominant. I borrow this approach from cultural theorist Stuart Hall (1986, 1988), who maintains that hegemony is achieved when a *multiplicity* of ideas, practices, and institutions are aligned in a system of rule, which therefore always contains “a plurality of discourses—[e.g.,] about the family, the economy, national identity, morality, crime, law, women, human nature” (Hall 1988, 53). Furthermore, these discourses do not at every moment

converge into a neatly unified construct. By unpacking the naturalization of fit bodies and subjectivities within psychiatric categories, I show that these categories are continually created and negotiated through contested social processes. If patients and clinicians struggle over the terms of fitness even when they are explicitly naturalized (as part of an “objective” discourse), then the fit body must be seen as an unstable entity within a wider cultural nexus of identity formation.

In two different chapters, I focus on hegemonic constructions of family life. A vast body of clinical literature on “anorexic families” and family therapy normalizes and authorizes particular ideals of personhood that warrant scrutiny. Mother blaming is widespread and arguably contributes to anorexia’s conditions of possibility. Attending to representations of maternal caretaking in both family therapy discourse and clinical practice, I suggest that mothers, like female bodies, are figured as problematic “resources” for the creation of their daughters’ identities. A critical analysis of these representations within psychiatry and psychology is important not only for pointing up their unstable and contested character but also as an intervention against their naturalization. The prominent sociologist of the body Bryan Turner cites “facts” in the psychological literature on anorexia to support the claim that a “principal dynamic in the social aetiology of this disease is the conflict between the daughter and the over-protective mother” (1992, 224), who is “overpowering,” “dominant,” preoccupied with her own career, and known to “raise [her] children to satisfy [her] own interests” (1984, 192). When a sociologist can cite as truth such deeply problematic sociocultural constructions of identity because they have been naturalized in psychological discourse—especially when we consider that much of Turner’s work challenges psychiatric discourse—these representations require careful unpacking.⁶⁹

I also explore articulations of race, class, and gender in psychiatric accounts of “human nature” by considering how psychiatric practices help to create a higher number of (recognized) cases of eating disorders among relatively privileged young women. Patients who are perceived as ideal candidates for treatment tend to be middle-class and white, and clinicians often argue that certain patients, patients who are both non-white and working-class, cannot participate fully in the treatment program because of a “personality disorder” or a “chaotic family.” I show that disagreements among hospital staff about how to care for these “difficult” patients can highlight, disturb, and sometimes begin to

transform culturally dominant ideas about “good” patients and families in the clinic.

My analysis of identity construction as a hegemonic process extends a perspective that is often adopted in cross-cultural research within the fields of medical and psychological anthropology. In their efforts to show how the notion of bounded, rational, autonomous individualism—assumed in Western medical constructions of illness and health—is a “cultural” rather than (or in addition to) a “natural” phenomenon, some scholars in these fields write about a singular “Western self,” as a way to provide a foil for examining selfhood in (a) “non-Western” context(s) (see especially Kleinman 1986; Schepher-Hughes and Lock 1987; Schweder 1991). For example, Anne Becker (1995) argues that attention to feeding and nurturing bodies in Fiji is not about cultivating the individual body but about congealing specific kinds of social relationships and collective concerns within bodily practices. The key to her analysis is a contrast between American and Fijian ideas about personhood. Becker argues that in Fiji, one is focused on the bodily experiences of *others* because of a relational understanding of personhood, while in the United States, autonomous individualism leads to a focus on one’s own bodily experiences. But I would argue that collective concerns and multiple narratives are at work in the United States in the production and naturalization of *individual* bodies and selves, as well. Certain of these discourses—those that predominate in the treatment of anorexia—are the subject of this book. I now provide an overview of these topics by chapter.

Chapter Summaries

In chapter 1, I argue that the fit body is an icon for contemporary American imperatives to achieve individual productivity and self-control by successfully managing new incitements to consume, incitements to indulge the body with food and other forms of leisure. Fitness practices are both predicated on, and productive of, bodies that are imagined as personal resources for work on the “self,” work that signals an ability to consume in a productive and efficient way. But because fitness as a cultural dominant contains multiple meanings, it also contains contradictions, and anorexia reveals that feminine fitness in particular is a contradictory construct. I show that in the second half of the twentieth

century, uneven changes in dominant discourses about women's "consumption work" have rendered the female body a more problematic resource for fitness than the male body. Many women and girls today experience repeated temptations to eat and serve food, even as they are enjoined to diet and exercise, so that crafting a fit female body seems to require heroic efforts. Anorexia, and chronic dieting more generally, are dramatic enactments of the contradictions entailed in feminine fitness: the harder one works to create a fit body and identity, the more the body's desires and appetites seem to be obstacles in this task, until finally the body itself is at risk of being consumed.

Psychiatric treatments for anorexia participate in the contradictions of feminine fitness. While treatment practices are meant to create fit and healthy bodies, young women struggling with anorexia take them up for their own purposes. Patients are consistently able to deploy seemingly "objective" and gender-neutral psychiatric assessments of the body and psyche in the service of anorexia, pointing to the gendered contradictions implicit in these assessments.

Chapter 2 provides a concrete ethnographic example of gradual change in American ideals of the family. Most patients are engaged in family therapy as part of their treatment, and in keeping with the perceived need for "flexible" family structures in an advanced capitalist system, which Judith Stacey (1990) describes in her work, therapists attempt to loosen family ties—mother-daughter "enmeshment," in particular—in order to support "individuation" in the family. But patients' mothers are still expected to assume nurturing familial roles, putting others' needs before their own as a matter of choice. This chapter shows that rhetorics of individual freedom and choice reconfigure, but do not revolutionize, "traditional" ideas about maternal caretaking. For instance, patients' mothers are encouraged to give up the role of caretaking to the treatment program, but a "minimal" degree of natural mothering is still required. Further, assumptions about what I call "minimal motherhood" help to justify keeping from mothers information about their daughters' progress in treatment, an exclusion that, paradoxically, produces a level of maternal investment in the treatment process that is seen as a central part of patients' problems.

Chapter 3 continues the analysis begun in chapter 2 by exploring the hierarchical production of sexual difference, and the naturalization of "minimal" motherhood, within the so-called "therapeutic family." Cli-

nicians and staff think of the treatment team as a substitute family that models gender equality, but when a female clinician voices a controversial opinion, her assertion of difference is often seen as a sign that the supposed unity of the therapeutic family—ordinarily expressed as such by a powerful male figure on the treatment team—needs to be re-established. So even as contemporary psychiatric discourse actively challenges prescribed gender roles in the family, ideas about familial health continue to create and conceal familiar gendered inequalities. At the same time, the imagined effects of personal family histories on the professional work of female staff highlight contradictions in the cultural and therapeutic construction of minimal motherhood. As a result, the gendered logic of therapeutic family “unity” is sometimes disrupted.

Chapter 4 analyzes the race and class politics of “healthy” families and subjectivities at Walsh. White, middle-class patients are the only patients imagined to be always already “fit” for effective treatment, and certain nonwhite, working-class patients are excluded from full participation in the treatment program. At the same time, these “difficult” patients seem to embody, to an excessive degree, important qualities of personhood that relatively privileged patients and their families appear to lack. In this way, notions of health on the unit are written in and through the exclusion of identities that seem to deviate from white, middle-class ideals of personhood. This chapter also traces a history of these ideals in the development of structural family therapy, an influential model for conceptualizing therapeutic “family” relations at Walsh (relations among clinicians, staff, and patients).

In the epilogue, I discuss “narrative therapy” both as an alternative approach to the treatment of anorexia and as a clinical application of many of the theories of identity formation, medical power, and resistance that are explored in this book. Drawing on a Foucauldian critique of scientific epistemology and practice to reformulate concepts and experiences of identity that dominate the mental-health professions, narrative therapists treat illness as a “problem story” that is supported by powerful cultural specifications for identity, and they create alternative stories with clients by focusing on life experiences that these norms fail to capture. As a result, the active, collaborative, and ongoing work involved in both the construction of, and resistance against, “problem identities” is rendered more visible. In many ways, a narrative approach to anorexia is a radical departure from current practice at

Walsh, but I suggest that its conditions of possibility are present there (in fact, as I discuss in chapter 2, there is at least one clinician at Walsh who engages in narrative work with patients one-on-one). The full incorporation of such an approach would render more explicit, and would begin to transform, important tensions and contradictions that already exist in the treatment program.