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Eating Lolly – The exegesis

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Abstract

There is an overwhelming archive of literature written on so-called 'eating disorders' and the social and cultural contexts that shape these 'conditions'. Theories framed by psychiatry, feminism, psychoanalysis and sociology have each presented insights and specific understandings of the causes of the 'disorders' anorexia and bulimia nervosa and the 'type' of people they affect. Although such theories are often presented as objective 'truths', their meanings are constructed in a cultural context. They are often contradictory, frequently ambiguous and regularly paradoxical. Despite the wealth of research being done on 'eating disorders', we are still most likely to read particular and specific explanations that are mostly informed by the psycho-medical discourses, that are preoccupied with anorexia over other forms of eating distress and that neglect the thoughts, theories, language and voices of women with lived experience.

My research explores the opposing cultural constructions of anorexia and bulimia against women's personal narratives of life with bulimia. My specific interest in bulimia contests the focus on anorexia in the medical, academic and popular spheres. I address this imbalance, and speculate on why there is such a preoccupation with anorexia over other eating issues in our culture. I believe that this is not a coincidence, for there are deep seated, cultural and historical reasons why our culture demonstrates a fascination with, even admiration for, anorexia.

Research into the socio-cultural construction of 'eating disorders' provided a rich and complex resource for developing my novel: *Eating Lolly*. *Eating Lolly* follows the developing relationship between Mumma and her daughter, Lolly. It explores the mother-daughter bond, love, family and food. It deals with the experience of pregnancy and motherhood, representing developmental stages, through childhood, adolescence and the forging of identity as a woman in a western cultural context. I explore women's hunger, metaphors of cooking, eating, feeding and being fed. I examine our culture's perceived separation between mind and body. I consider the power of medical discourses in shaping how we think and feel about our health and well-being and our experience with illness. *Eating Lolly* is about female identity, the right to self-determination and the power of reclaiming story. It is a celebration of difference, of family, community and landscape and the impact of these factors on identity formation.

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

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

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And lastly, thank you always to my parents for making me and making this possible.

Keep a diary, said her supervisor. *Plot the evolution of your thought.*

Have a system.

Keep on top of your references.

Be organised.

Take care of yourself.

Don't get pregnant.

I can't stress it enough. A diary is really important. You'll never know what you want to go back to, what will end up being significant.

A diary. The student stood on a chair and reached for the boxes up the top of her wardrobe. She sorted through years of school work, cards, paintings, letters and photographs and she got pins and needles in her legs from sitting in the same position for so long. Eventually she found her old diaries sealed with masking tape. She tore through the plastic bag and carefully stacked them in sequence. The first one was written in plump print—all round and neat and ordered in the opening months. She had written it when she was twelve. Reading it now, as an adult, made her embarrassed. And sad.

The student found it interesting that throughout her life she had made various attempts at writing herself. She was not a dedicated diary-writer, but the times when she had chosen to keep a journal were those of change, of depression, of searching. At thirteen she wrote of all her desperate loves and yearnings, of movies and music and trips to the city with her best friend. These were the things that thirteen year-old girls wrote about. These were the things she had learned to write about and the way she had learned to shape herself. When a close friend died in a terrible accident she could only write, *Lee died. Fucked...* and scribble until her biro ran dry. She didn't know how to write about that, then. She wouldn't think about that death until years later.

At fourteen she had gone back over her writings from the previous year and crossed things out, exclaiming in the margins in red, *No way! I don't think so! Wrong!* She was rewriting herself, bringing in the new, over-riding the old, cancelling out, shedding skin—simultaneously growing out of herself and into herself. Recently the student had heard someone speaking about childhood,

that as children we look back on our former selves with scorn, that we are encouraged to grow up. She had noticed this in marketing directed at children. In her day it was Playschool and finger paints and teddies. Now it was pop music, midriff tops and mobile phones, logos and labels, girls of four in bikinis, girls of six with handbags and nail polish, girls of eight dressed as women.

After an hour or so, the student came to the other diaries. The secret ones. The tracking of her adolescence. She hadn't looked at them for well over ten years. She hadn't wanted to think about them. After all, she was over it now. She was better—recovered. It shouldn't matter. And yet recently something had been troubling her about those years. Something had been drawing her back.

She sat on the floor surrounded by hand written versions of herself. The phone rang out. The sun finished its arc. She wiggled her toes and thought, *Who am I?* She traced the scar over the bridge of her foot. *And why is this stuff important?*

What is your PhD project about? quizzed the student's supervisor, her index finger above her lip.

The student flushed blood red and fumbled with her papers. *Well...* she stuttered. *I will just refer to my notes, here.* Shuffle, shuffle, shuffle.

The supervisor raised her eyebrows and sat back in her chair, waiting.

My project... her eyes madly scrolled her scrawlings and fixed on a phrase. *My project is on the social construction of bulimia nervosa.* She exhaled, dabbed the sweat that had collected in her right eyebrow and looked up at her supervisor. She was surprised how like a child she felt—all unstitched hems and stains and scabs and insecurities, wriggling her toes in her shoes, kicking her legs, twirling a length of hair around her finger. *Nanna's lamingtons*, she thought. *Sweet, square, neatly finished—perfectly dressed.* She was hungry for Nanna's lamingtons, but Nanna had long since stopped cooking. She wore herself out after too many years and now relied on Sara Lee frozen desserts.

The supervisor touched the tip of her tongue to her top lip and asked, *Can you elaborate?*

The student looked down at her notes and said, *Perhaps it would be easiest if I just read you this.* She could feel the blood burning up her throat, over her cheeks and across her scalp. She knew the supervisor would see straight through her, see the fraud that she was, see that she never should have gained entry to a PhD, that she was a waste of valuable university resources and that she took up too much space on the worn carpets of the English department. The student wheezed on air, willed her pulse to calm and read:

> *There is an overwhelming amount of literature written on so-called 'eating disorders' and the social and cultural contexts in which these 'conditions' occur. Theories framed by psychiatry, feminism, psychoanalysis and sociology have each presented insights and specific understandings of the causes of the 'disorders' anorexia and bulimia nervosa and the 'type' of people they affect.*

I'm interested in... The student flipped pages, glanced up quickly, felt the heat of her supervisor's attention and looked back to her notes. *I'm interested in considering... Considering... Sorry. I've lost it.* She traced a finger, found her spot and continued reading.

> *I am interested in considering the impact of classifying certain eating behaviours within the Diagnostic and Statistical Manual of Mental Disorders as psychiatric illness. I am interested in how the contemporary preoccupation with therapy shapes how we think about 'problems' and the influence of 'self-help' manuals, 'self-improvement' workshops, support groups and alternative therapies. I am also interested in considering the overwhelming saturation of the mass media with images of femininity, the influence of the health, fitness and cosmetics industries on how we think about women and their bodies. These are just a handful of examples which contribute to our understanding of 'eating disorders'. These understandings are often contradictory, frequently ambiguous and regularly paradoxical.*

The student took a breath, cleared her throat and tried to read on with authority.

Despite the wealth of research being done on 'eating disorders', we are still most likely to read particular and specific explanations of disordered eating that are greatly informed by the psycho-medical discourses, that are preoccupied with anorexia nervosa over other forms of eating distress and that neglect the thoughts, theories, language and voices of women with lived experience.

The student looked up from her notes and said, *I imagine this is also true of other studied experience. You know—research on birth, mothering, grief ...* She found her place with an index finger.

My research begins by exploring the opposing cultural constructions of anorexia and bulimia against women's personal narratives of life with bulimia. My interest specifically in what we call bulimia nervosa, is due to the large amount of attention focused on anorexia in the medical, academic and popular spheres. I hope to address this imbalance and to speculate why there is such a preoccupation with anorexia over other eating issues in our culture. I believe that this is not a coincidence, that there are deep seated, cultural and historical reasons that our culture has a fascination, even an admiration for anorexia.

In speaking with women about their experience I have noted how frequently anorexic and bulimic 'symptoms' overlap. I am not interested in debating the importance or seriousness of the conditions over one another, rather in considering how the opposing constructions of anorexia and bulimia impact on how women identifying with bulimia experience themselves and the 'illness'.

The student exhaled, glanced at her supervisor and hoped, desperately, that she would not be questioned further. She felt herself leave her body and hover above the scene, looking down on her dishevelled form perched on the edge of a chair. It was a familiar experience when she wanted to escape. *Leave your body behind ... Take to the air ...*

The supervisor twirled a ring on her finger and exploded into talk. *What have you been reading? Surely you would have started with Bordo. It will be important to know her work well. Everyone associates her with anorexia.*

The student bit her lip and thought, *But my project's on bulimia.*

Days later, the student sat at her desk and stared over the top of her computer out the window. She was still thinking about the meeting with her supervisor. It was ruffling her: the blushing, the sweat, the erratic hammering of her pulse, the way her hands gestured madly, as if they were trying to divert attention. She wondered if her body was trying to sabotage her, to reveal her. She wondered if she could get away with future meetings via email. Then she wouldn't have to lug herself along and be humiliated by the results. She looked at the blank screen. Her supervisor had encouraged her to, *Write! Just start writing. Even if it's just in a diary. Get your thoughts down.* The student's fingers hovered above the keyboard. She typed tentatively.

> *My intention is to examine the discourses which inform our understanding of so-called eating disorders and set this against women's accounts of life with bulimia.*

She looked at the words. Did that sound all right? Did it come close to academic style? Did she come close to writing critically with authority? Could she prove herself? She felt like a kid faking a letter to the teacher. She felt like a piece of date cake—with walnuts.

The student sat in the library walled in by books. There was no shortage of texts on disordered eating, on women's health, women's psychology and the female body. The student was interested to read the scrawlings of strangers in the margins, to see what other women had underlined, what they had found interesting and what they had objected to.

Get real! someone had written.

Not true for me, declared another.

Bullshit …

Go back to medical school ...

The student wondered if those women were on a similar search, if they were trying to make sense of some complex experience, work themselves out.

Hi there. It was another student from her department. *Working hard?*

Trying to.

What're you doing this year?

A PhD.

Really? Shit. I didn't even know you'd finished your Masters. You did that new one, didn't you?

In Creative Writing.

Yeah. That sounds fun—writing stories all day.

She obviously didn't think it was real university work. There was an awkward pause. The student swallowed. She knew what question came next.

So, what's your PhD on?

A breath. *Eating disorders.*

Oh yeah... She cocked her head, screwed up her nose. *I went to school with a girl who was anorexic. She was pretty sick with it. You should have seen her wrists. Shit ... I can't remember her name now ...*

Actually, my project's specifically on bulimia.

Oh. You still get to have your cake with that, hey? In fact... Fuck it! Have the whole thing! So why the interest in bulimia?

The student looked down at her notes and wondered what was the appropriate way to answer. *There's a gap in the literature.*

Really? I suppose bulimia's not the sexy one, is it? Did you hear about that girl that died recently? Apparently her guts exploded or something.

The student nodded. *She was mis-diagnosed in emergency. Her stomach ruptured.*

How revolting... So what's your methodology?

Methodology. The student closed the library books, started collecting her things and stood up. *I'm not sure yet ... Sorry but I've got to get going.*

Oh. Okay. Well good luck with your project.

The student sharpened a pencil and wrote:

> **methodology** (*say* metha-**doll**a-jee)
> *noun*
> the study of the methods used in a particular subject

Methods. What were her methods? She let her head fall into her hands. She had a memory of agonising over a school project on insects. She had been so proud of herself but the teacher had asked where she'd copied the information from. The teacher said it was bad to copy someone else's work. You had to work out ways of finding things out for yourself and if you did use other people's work, you had to learn how to use references. The student didn't feel like she had come far. She didn't know how she had ended up doing post-graduate research when she didn't even know what 'methodology' meant.

> *Research=*
> *Objective.*
> *Statistical proof.*
> *Clinical.*
> *Disembodied.*

Her stomach ached. It was all such a mess. She wished she could chuck it all in and just write stories all day. She emailed her supervisor and the reply said that these feelings were all part of the process, that she'd find her feet in time and that she should just stick with it, stick at it and if she was really that worried about her research design, why didn't she set herself a task of writing a paper—it might help her get her thoughts straight about the direction she wanted to go.

Right, thought the student. *I'll write a proper paper on my research design. A proper paper—just like a proper student would.* She created a new document in her folder and titled it in capital letters: RESEARCH DESIGN.

Identifying the problem area—*Eating disorders*

Disordered eating has been identified as a major burden in young women and girls and as having a significant impact on young women's health.[1]

In 1997 it was estimated that eating disorders affect around 2.2 percent of women, comparable with statistics that represent those living with epilepsy, kidney cancer and rheumatoid arthritis.[2]

It is considered that such disorders have both economic and social implications and impact on health policy in the National Health Priority Areas of mental health, cancer control, diabetes, cardiovascular disease and stroke, injury prevention and control and arthritis and musculoskeletal conditions.[3]

In Australia the cost for treating eating disorders in 1993–94 was $22million—a figure which does not include ongoing treatment costs for chronic conditions sufferers may develop in later life, such as osteoporosis and heart problems.[4] Such statistics indicate that this problem is of on-going concern to the community and a relevant area to pursue further study—one of Rothery's four criteria for research problems.[5]

Narrowing the focus—*Bulimia nervosa*

Specifically, my interest is in what we have come to know as *bulimia nervosa* (refer to Appendix for diagnostic criteria).

This is good, thought the student. *Authoritative and assertive and objective—just like a real researcher.* She said this to herself over and over when the quotations from her secret diaries played in her head, when the curiosity about what the psychiatrist had written in her medical records niggled and gnawed.

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1 Australian Institute of Health and Welfare, www.osw.dpmc.gov.au/pdfs/health_wellbeing/Looking_Risky_paperApril2003.doc Accessed March 2004.

2 Australian Institute of Health and Welfare, www.osw.dpmc.gov.au/pdfs/health_wellbeing/Looking_Risky_paperApril2003.doc Accessed March 2004.

3 Australian Institute of Health and Welfare, www.osw.dpmc.gov.au/pdfs/health_wellbeing/Looking_Risky_paperApril2003.doc Accessed March 2004.

4 Australian Institute of Health and Welfare, www.osw.dpmc.gov.au/pdfs/health_wellbeing/Looking_Risky_paperApril2003.doc Accessed March 2004.

5 Michael Rothery, 'Problems, Questions and Hypotheses', *Social Work Research and Evaluation*, ed. R.M. Grinnell, 4th ed. (Chicago: Peacock, 1993) 20–1.

In exploring bulimia, I hope to address this imbalance and to speculate why there is such a preoccupation with anorexia over other eating issues in our culture. It appears a comprehensive exploration of bulimia has been eclipsed by the medical, academic and popular fascination with anorexia. I do not believe this is due to the 'researchability' of bulimia as a phenomenon in its own right, rather I speculate that there are complex cultural and historical reasons that our culture is allured by anorexia.

The magazine covers still caught her eye. *My Anorexia Hell—Sufferers tell their stories.* If she was on her own, the student would still feel compelled to pull one from the shelf, flip through the glossy pages.

Through research in the area, through conversations with women about their experience and through my past involvement with EDASA (Eating Disorders Association of SA (Inc), it worries me greatly that bulimia is belittled as a failed attempt at anorexia and that so many women living with bulimia speak of the shame of not 'being anorexic'.

She remembered that the psychiatrist spoke to himself as he wrote. *Formerly anorexic—now bulimic.* She remembered the shame was dark and twisted and knotted like scar tissue.

It worries me that an unspoken hierarchy of eating disorders exists (i.e.: anorexia at the top, bulimia in the middle, compulsive eating at the bottom and all shades of grey in between), that the body has to advertise the presence of a 'disorder' (i.e.: by being dangerously thin) before a woman's distress can be taken seriously.

She had started quiet conversations. She knew she was not alone. She had heard stories about women's secrets.

It was once suggested to me that the cultural focus on anorexia may be due to the gravity of the condition, the extreme weight loss, the element of dicing with death. I do not want to underestimate the potential severity of anorexia. The mortality

rate for anorexia ranges from 5–10% and is between 5–40% for those also engaging in bulimic behaviour—the highest mortality rate for a psychiatric condition.[6] But in those who have bulimia without drastic weight loss there are also serious consequences, including the strain on mental health, dental problems, ruptured esophagus, digestive disorders, irregular menstruation, poor nutrition, iron deficiency, ulcers, skin, nail and hair problems, to disturbances in the electrolyte balance and lethal heart rhythms (Waldrop). It is also reported that there has been a dramatic increase in the incidence of bulimia in the last 20 years and that women with bulimia are more likely to commit suicide.[7]

Last year South Australian doctors emphasised the severity of bulimia when a young woman died in emergency from a ruptured stomach.

Background research—*The opposing cultural constructions of anorexia and bulimia*

As Julie Hepworth finds, prior to the medical 'discovery' of anorexia in 1874, dominant interpretations drew on Western Christianity, providing very different explanations of the relationships between women and food.[8] But unlike anorexia, historical evidence of bulimia is hard to trace. It is only relatively recently that bulimia has been defined by the medical establishment. In 1979 Gerald Russell first formulated and introduced a definition in his paper 'Bulimia nervosa: an ominous variant of anorexia nervosa'. Russell found that:

> [t]he constancy and significance of overeating [in the thirty selected patients] invite a new terminology for the description of this symptom—bulimia nervosa—even though it would be premature to think of the disorder described in this article as constituting a distinct syndrome. *It will seem still to be related to anorexia nervosa.*[9]

The language used by Russell in medicine's first attempt to define bulimia and its associated symptoms is revealing. This paper displays a particular understanding of

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6 Ron Waldrop, 2001. www.emedicine.com/emerg/topic34.htm Accessed March 2004.
7 http://www.womhealth.org.au/studentfactsheets/eatingdisorders.htm Accessed April 2004.
8 Julie Hepworth, *The Social Construction of Anorexia Nervosa* (London: Sage, 1999) 13.
9 Gerald Russell, 'Bulimia nervosa: an ominous variant of anorexia nervosa', *Psychological Medicine* 9 (1979): 429, my emphasis.

anorexia and a particular understanding of bulimia. Bulimia is considered only in relation to 'true anorexia' and presumed merely another method of weight control in response to overeating.

> The curious phenomenon of self-induced vomiting often elicits the term 'hysterical' to qualify the patient's behaviour, her attitudes, or the disorder itself ... In any case, the self induced vomiting is merely the method used by the patient to protect herself against the effects of overeating.[10]

The problematic nature of defining eating disorders in this way is compounded by the fact that these conditions occur in a climate where women express great dissatisfaction with their bodies. *The Australian Longitudinal Study on Women's Health* found that between 40 percent and 82 percent of young women were dissatisfied with their weight and/or shape.[11]

Research finds that factors affecting women's body image include the cultural disempowerment of women and the pressure to attain unrealistic culturally imposed beauty ideals.[12] Statements such as Russell's obscure the cultural context, over-writing women's experience of bulimia leaving little room for them to explore their own meanings attributed to their behaviour. No mention is made of the complex interaction of culture, society, family and psyche. Rather, this definition is based on women's weakness and dysfunction and simply explained as a 'psychopathology characterised by a dread of losing control of eating and becoming fat'.[13]

From the first medical definition, bulimia has been belittled as a failed attempt at anorexia.

> Whereas anorexic patients are capable of starving themselves, bulimic patients can only resist eating for so long before succumbing to a bout of overeating. *Bulimic patients may be said to exemplify the worst fears of the anorexic patients come true.*[14]

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10 Russell 1979: 441.
11 www.osw.dpmc.gov.au/pdfs/health_wellbeing/ Looking_Risky_paperApril2003.doc Accessed March 2004.
12 www.osw.dpmc.gov.au/pdfs/health_wellbeing/ Looking_Risky_paperApril2003.doc Accessed March 2004.
13 Russell 1979: 432.
14 Russell 1979: 444, my emphasis.

The student sighed and rubbed her head. There were things she wanted to say, claims she could make, but they were in the wrong voice and came from the wrong place. It was such an effort to silence herself that she wondered if she should create another file, spill some stories into a secret folder titled: RESEARCH FINDINGS (an innocuous enough name to protect her privacy). Last week her supervisor had stressed, *I think you have to be more clear about your position on all of this. Think about your perspective.*

My perspective. She wondered if her supervisor could see right through her. *My perspective ...*

The woman struggling with bulimia reads herself denigrated in medical literature, catching the expert's description of her 'rapid and grotesque eating orgies', the opinion of her as a 'victim of powerful and irresistible urges to overeat' and as an embodiment of the anorexic's 'worst fears'.[15] Even Hilde Bruch—respected researcher, renowned in the field of eating disorders—claims of women with bulimia:

> [t]hey make an exhibitionistic display of their lack of control or discipline, in contrast to the adherence to discipline of the true anorexics, even those with eating binges ... The modern bulimic is impressive by what looks like a deficit in the sense of responsibility ... Though relatively uninvolved, they expect to share in the prestige of anorexia nervosa.[16]

Bruch's quotation was so outrageous it almost made the student laugh. *An exhibitionistic display of their lack of control or discipline ...* The student had never known anyone struggling with bulimia who made their eating public and she had certainly never met anyone who *expected to share in the prestige of anorexia nervosa*. Most of the women she had spoken to were so paralysed with shame and fear and self-loathing that even considering seeking help was terrifying.

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[15] Russell 1979: 443–4.
[16] Russell 1979: 443–4.

In the 1970s feminists initiated a significant rethinking of women's dilemmas with food, eating and the body. Links were made between women's psychological distress and the social, cultural and political positions of women. Links were made between anorexia and women's position within patriarchal society. But despite such important work, feminist theorists did not explore the nature of bulimia nervosa with enthusiasm. Troy Cooper is worried by the lack of feminist interest in bulimia.

> The problem lies in the fact that feminists of any persuasion live within culture and cannot avoid absorbing at least some of its strongest values. At a gut level, feminists share with other women a sneaking and unwilling admiration for anorexia which mixes with and reinforces a basic ideological viewpoint. There is a strong inclination within feminist theory to regard women as spiritually superior to men because of the injustice and ill-use we have suffered at the hands of a patriarchal society. Because of a tradition of stoic, silent suffering in response to this position, and of self-sacrifice (especially for our children), the stance of the anorexic woman appeals strongly to a sense of what it is to be traditionally feminine, of women's greater morality. Unfortunately, bulimia is not so easily translated into a sympathetic symbol of women's oppression. Its only cultural standing is in an opposite role: as an affirmation of all that is degrading and uncontrollable in women's physicality and their appetites.[17]

Despite the overwhelming interest in anorexia, some feminist therapists have identified bulimia as a phenomenon in its own right, engaging in a reassessment of bulimic behaviour. They suggest that it is

> only when [women affected by bulimia] begin to unlock the symbolic meanings of the symptom that they begin to understand why they have chosen their particular way of expressing distress and what this 'choice' says about their internal world.[18]

Considering a line of inquiry—A tentative research question

In conversation with Cina Mastrantone, director of EDASA (Eating Disorders Association of SA (Inc), I discovered that numbers of women struggling with bulimic behaviour are probably much higher than estimated due to the shame, secrecy and stigma surrounding the condition. Obviously this has grave implications for women

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[17] Troy Cooper, 'Anorexia and Bulimia: the Political and the Personal', *Fed Up and Hungry: Women, Oppression and Food* ed. Marilyn Lawrence (London: The Women's Press, 1992) 185–6.

[18] Mira Dana and Marilyn Lawrence, ''Poison is the nourishment that makes one ill': the metaphor of Bulimia', *Fed Up and Hungry: Women, Oppression and Food* ed. Marilyn Lawrence (London: The Women's Press, 1992) 197.

seeking assistance—a motivating factor in pursuing such research. After speaking with women about their experience I believe it is important to question the cultural preoccupation with anorexia and consider how the opposing constructions of anorexia and bulimia impact on how women identifying with bulimia experience themselves and the condition and how this affects them seeking help.

The student sat back in her chair. Her memories were intruding—intrusive. They flashed and startled at inconvenient times, while she was thinking over a turn of phrase, piecing together a paragraph. She diverted them by making a cup of tea, doing a lap of the garden or considering what she would make for dinner. When she felt more settled, she went back to her books and tapped her fingernails on the keyboard.

In examining the frictions between the contemporary cultural context and women's personal stories of life with bulimia it is crucial to connect with affected women. In conversations through EDASA, it appears many women who have sought medical treatment for bulimia were automatically approached to contribute to research into disordered eating. It seems that this research is quantitative in approach, as women speak of surveys with sliding scales to measure their experience and 'yes / no' answers. I am concerned that the experiential component of bulimia is being overlooked and believe that the voices of these women can contribute greatly to our understanding of this ever-increasing problem. Therapists Mira Dana and Marilyn Lawrence assert that to be any use therapeutically:

> our understanding must be based on more than mere hypothesis or theory. In fact, it is derived from work over a number of years with women who suffer from these difficulties and who have discussed the connections with us.[19]

Embarking on this form of research in an area which has been dominated by the psycho-medical model and the quantitative approach is a challenge.

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[19] Dana and Lawrence 1992: 194.

The psychiatrist did not maintain eye contact with her as he referred her to the research team. She remembered the way he smoothed his gold pen and how he spoke over her head. *Research is important.* Thinking about him made her upset. And angry.

As Immy Holloway finds, in medicine 'qualitative approaches are slowly becoming respectable but have not yet been wholly accepted as an alternative form of research'.[20] I do not want to dismiss the importance of medical science, the value of its expertise in assisting women to live healthy lives and its place in treating the physical symptoms of disordered eating. But I believe that a socio-cultural perspective has much to offer in exploring food, the female body and weight as imbued with meanings about gender, identity, control and personal agency. I consider these to be significant issues in our understanding of eating disorders. Although my interest in the socio-cultural perspective appears most compatible with qualitative research design, there is an important place for statistical information in such a study. My research is supported by a wealth of studies indicating the prevalence of women's dissatisfaction with their bodies, the incidence of risk-taking behaviour and disordered eating and the literal and metaphorical cost to our community.[21]

Such statistical data alert us as a community to the severity of the problem and the proportion of the population affected by such issues. It is this form of information that motivates initiatives in policy change and development, encouraging social change on the large scale. An understanding of how the research findings will be used obviously impacts on the research design. I do not aim to construct a definitive account of life with bulimia. Instead, I hope to provide rich and complex information about the experiential aspects of this condition.

A qualitative approach

Although I believe both quantitative and qualitative research methods have something to offer this problem area, my interest in the socio-cultural perspective on bulimia

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20 Immy Holloway, *Basic Concepts in Qualitative Research* (Oxford: Blackwell Science, 1997) 4.

21 For example, see www.osw.dpmc.gov.au/pdfs/health_wellbeing/Looking_Risky_paperApril2003.doc Accessed March 2004.

appears most compatible with qualitative research design which focuses on meanings over behaviour, identifies cultural patterns over scientific laws and is inductive over deductive in approach.[22] A qualitative approach has me considering:

- the understandings women attribute to a diagnosis of bulimia nervosa
- the interpretation of symptoms / behaviours / actions
- making sense of rituals, behaviours and thought processes
- associations with being healthy and being ill
- significant moments, markers and milestones
- the meanings assigned to thinness and to femininity
- thoughts and feelings about the body
- hopes, dreams, beliefs and intentions
- the experience of reality
- the use of language and symbolism
- ideas of transformation
- rites of passage
- identity
- spirituality
- community
- the meanings of recovery.

I understand that my exploration of the opposing social constructions of anorexia and bulimia may not necessarily be of interest to research participants and that concepts such as the social construction of reality may be unfamiliar and alienating. As Foddy argues, when formulating research questions 'the overriding principles should be brevity, simplicity and concreteness'.[23]

Considering this, the questions I have formulated are as follows:

1. What does the label 'bulimia nervosa' mean to you?

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22 See Martyn Hammersley, *What's Wrong with Ethnography?* (London: Routledge, 1992) 160.
23 W. Foddy, *Constructing Questions for Interviews and Questionnaires* (Cambridge: Cambridge University Press, 1993) 50.

2. How / why did you first identify yourself as bulimic?

3. How would you tell the story of your experience with bulimia?

4. Some people have said bulimia involves many private rituals. (For example: doing things in a set way, the eating of particular foods, associations with particular foods, hand washing, teeth brushing.) Have you observed any rituals in your bulimia?

5. Have you ever sought help for bulimia? If so what kind? (For example: counsellor, therapist, psychologist, doctor, psychiatrist, in/out-patient at hospital.)

6. How did the help affect you?

7. What was the most and least helpful thing about seeking treatment?

8. Perhaps you have seen someone very thin and thought they might be anorexic. In this way anorexia is said to be public; it is seen. How would you respond to such statements about the visibility of anorexia?

9. Do you feel that bulimia is 'seen' in the same public way?

10. Some theorists have described bulimia as hidden behind a mask of normality and as being different to anorexia because the bulimic's body remains a 'normal' size. How do you feel about this comment?

11. It has been suggested that the bulimic woman does not want to make a public statement like the anorexic woman. She maintains a 'normal' sized body telling the world that she can cope with anything. How do you respond to these ideas?

12. Have you ever tried to interpret what bulimia is all about for you? If so, can you explain?

13. Have you done any reading on 'eating disorders'? What have you read and how did you respond?

14. Have you ever read anything specifically on bulimia that you felt described your own experience?

It took the student a long time to think up the questions in negotiation with The University of Adelaide Human Ethics Committee and she still wasn't sure if they were all right. She worried that they were too long and too repetitious. Someone had said they were 'pretty political' and the student worried what that meant. It didn't sound good. It sounded as though she was being too prescriptive or suggestive—as if she was forcing her own agenda.

Her supervisor said not to worry, that the questions had ~~being~~ been cleared by the committee and that they should elicit some interesting responses. She said, *Anyway, there's nothing wrong with being political. In fact, I think you should be more assertive.*

More assertive. The student had blushed, then tried to hide her embarrassment with too much leg kicking and too much hair flicking. She was most definitely a fraud and her body was letting everyone know.

Using this approach, I would be interested in women exploring, expressing and contextualising their own concerns regarding their relationship with food, eating and their bodies and how this fitted with their understanding of the process of medical diagnosis and of the public debate surrounding eating disorders.

The realisation had been creeping up on the student. Now it seemed so obvious. There was a message in this project. A message to herself. She shut down RESEARCH DESIGN, opened her secret file and began to write. After some time, she pulled back from the screen and considered what she had written. Her story was entangled in the voice of the psychiatrist. Strangled. She could still hear his pen scratching across the page, filling her medical record.

Her records... Maybe they held the explanation.

Straight-backed with confidence she reached for the phonebook, found the number of the hospital and dialled. Eventually she was put through to someone who could help her with her inquiry. *I need a copy of my medical records.*

The receptionist said that the Freedom of Information Act now permitted records to be available to patients.

I never would have assumed otherwise.

Oh no. You haven't always been able to access them for personal use. Records remain the property of the hospital.

But it's my story. How can it be owned by the hospital? She could tell the receptionist had better things to do than to discuss this.

You'll have to make the request in writing. I'll give you the details. Have you got a pen?

It was well after midnight and the air breathing through the window was heavy with dew. The student was lost in her secret diaries, straining to read by the light of the computer. The more she read, the more she was able to attempt stepping back from the embarrassment, the shame and the hurt and appreciate the story of a girl struggling to grow up female in a particular culture, in a particular time and place. Of course she knew that only a relatively small proportion of girls battled so vehemently with eating, but she suspected that much of her adolescent conflict, her confused desire, the unfurling of her sexuality, her anger, fear and pain was common to many.

Sitting there, into the early morning, with everyone else asleep, the house sighing, the student was able to think quietly to herself. In the dark, she was able to admit that seeking medical treatment for her troubles all those years ago did not facilitate recovery. In fact, it probably reinforced the anorexia, supported the development of bulimia. The student looked into the night. Believing the logic of the psychiatrist was probably the worst thing she could have done. If she was really going to close that chapter of her life she would have to re-visit his writings, pull apart his language and re-work the story until it was her own. Overhead, a possum tumbled over the roof. It sounded like thunder. The student was starting to think this project was bigger than a PhD.

The student didn't want to go in to uni and risk running into another post grad who would inevitably have a pile of books, a copy of their first draft, a cappuccino in a disposable cup and an authoritative cough. She had left her pigeonhole for such a long time that one of the office staff rang her to say it was so full that it was spilling on to the floor. Did she want them to post everything out to her? The student felt bad for being so much trouble when

the office staff had more pressing jobs than clean up after her, so she apologised and said she'd come in and tidy things up.

There was nothing too important in her pigeonhole—scholarship pay slips, notices of guest lectures, newsletters, articles from her supervisor. She dropped most of it into the recycling bin and was about to leave when another post grad tripped through the doorway.

That's the third time I've done that today.

The student smiled and thought, *Please don't ask me ... Please don't ask me...*

How's your work going?

Good.

Really? Lucky you. I feel like chucking the whole fucking thing in.

The student exhaled through her nose and nodded.

Shall we have a coffee?

Of course it's real fucking research? Why would you think otherwise?

The student shrugged. *I don't know. It just seems so hard.*

Well you're up against a lot of history, aren't you? What constitutes a legitimate field of study... All that shit.

It's paralysing.

But if you remain stuck then nothing ever changes—no one ever does anything different. There's nothing wrong with examining personal experience if that's what you want to do. I mean 'the personal is political' and all that. The feminists have been saying it for forty years.

I don't know... It seems self indulgent.

It depends how you do it.

I worry it'd be compared to American talk show revelations or the confessional or something.

But you don't have to do it like that. It could be as simple as stating that your own experience informs your research.

There's something about it that doesn't feel right—like I'm exposing myself, admitting to being unstable and not being able to cope with the rigors of academic work. It's embarrassing.

Maybe you need to deconstruct all that shit—take a position on it. Because it seems pretty messy to take a stand for women who've gone through this stuff—like the respondents to your questionnaire—to align yourself with them, only to be ashamed—to be silent—about your own experience.

The student closed her eyes and finished her coffee. She knew she would re-run this conversation at some point in her sleepless night.

Anyway... Maybe the PhD in Creative Writing will be approved and then you can let it all go, write a book about it.

The student sat forward. *Is that likely to happen?*

Apparently. It's under negotiation now.

On the bus, on the way home, the student was unsettled, agitated. She was starting to panic about wasting time. She would find herself at the computer dreaming up ideas for a novel, catch herself slumped over her books cooking up characters. The news that the Creative Writing PhD was under negotiation would only exacerbate her wanderings into fiction. She rubbed her eyes, pulled her notebook from her bag, told herself to focus. *Focus*. A bump in the road knocked her writing off course. She tried again. *My Worries*, she wrote.

1. *The grey area between public and private, between professional and personal.*
2. *'Inappropriate' subject for research—too difficult, too confronting, too messy.*
3. *Inclusion of personal experience possibly seen as self-indulgent, as if I must continue to re-live and re-tell my own story.*

What is important:

1. *Locating myself in relation to the subject matter.*

2. *Fitting my own experience alongside that of other women (without assuming authority).*
3. *Encouraging dialogue with critical theory.*
4. *Dismantling traditional barriers between public and private life. (Jane Tompkins asserts that the 'public-private dichotomy, which is to say, the public-private hierarchy ... is a founding condition ... of female oppression'.*[24] *What do I reckon about that? I'm certainly stuck somewhere... with something...)*

Go home and get writing. Work some of this stuff out. Write it out.

*

Personal experience and research

Feminists have passionately defended the inclusion of subjectivity in research, as they perceive that all knowledge is already influenced by the writer/researcher's standpoint.[25] Personal experience can reveal the effects of society and culture on our lives. As Catherine Garrett believes,

> it is the combination of personal experience, attention to the experience of others, consideration of social theory and a critical appraisal of them all in the light of each other which give readers the broadest information from which to make up their own minds. Subjectivity is a valuable aspect of research when its own part in the story is analysed like any other part.[26]

Although writing is increasingly viewed as part of composing culture and identity, there is a continuing anxiety about women's writing on what are perceived as personal, difficult and painful subjects.[27] In *Bodily Violence—When Students Write*

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[24] Jane Tompkins, in Nancy Miller, *Getting Personal: Feminist Occasions and Other Autobiographical Acts* (New York: Routledge, 1991) 5.

[25] Catherine Garrett, *Beyond Anorexia: Narrative, Spirituality and Recovery* (Cambridge: Cambridge University Press, 1998) 32.

[26] Garrett 1998: 33.

[27] Michelle Payne, *Bodily Violence: When Students Write about Abuse and Eating Disorders* (London: Heinemann, 2000) xvi.

about Abuse and Eating Disorders, writing teacher Michelle Payne observes that writing on 'personal' and 'painful' subjects often results in concern about the student and assumptions that the writer must be 'fragile', 'unstable'.[28]

Once the student had walked behind two tutors on North Terrace.

And their therapist—you also have to be their therapist, one was saying.

Oh yes, the other one nodded. *And I'm just not comfortable with that role. I'm not qualified to be a therapist.*

I wish they could just stick to the texts, but inevitably something comes up. I had a girl crying in class the other day.

What did you do?

The student didn't want to hear any more. She skipped past them, her bag bouncing against her legs.

In this expression of unease, in discouraging women from exploring difficult / confronting / personal subjects within the university context, it is implied that this sort of experience is inappropriate subject matter for academic consideration, that it should be kept secret, kept private.[29] Such students / writers are often constructed as 'damaged', not 'normal', their experience pathologised, furthering and confirming the sense of shame.[30] This also serves to imply that 'problems' women may experience today are solely the concern of the individual and the psycho-medical profession, that they occur in isolation from society, culture and historical forces. As Payne finds, the preoccupation with what is appropriate subject matter for academic consideration serves to maintain taboos on certain subjects, obscuring the fact that abuses happen as well as the cultural and historical contexts that make such violence possible.[31]

In her life away from the university, the student had studied a course in narrative therapy and taken tentative steps as a counsellor. It had become

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[28] Payne 2000: xvi.
[29] Payne 2000: xvii.
[30] Payne 2000: xvii.
[31] Payne 2000: 10.

particularly important to resist conspiring with the silence around issues of abuse and so-called eating disorders. *But,* the student jotted in her notebook, *the dilemma is how to write and talk about such experiences publicly without furthering exploitation and without buying into the current confessional culture of talk-shows and the scandalous revelations and tell-alls of women's magazines.* The student worried about this a lot and wondered how it could be done. At times she opened a drawer in her mind and filed some ideas for a story. She was growing a character called Lolly.

Payne suggests that the university can be seen by student / women writers as offering a space for composing and controlling identities that have been constructed as 'unacceptable'.[32]

Maybe that's it, thought the student. *Maybe I am preoccupied with this idea because I want to make things right.* The student was reminded of a quotation from the work of narrative therapist, Michael White. She flipped back through her notebook:

> To know that we know what we know, and to consciously embrace this knowledge as we live our lives, it is necessary for us to experience a degree of authenticity in our knowledge claims, whatever those claims might be. This sense of authenticity is not something that is achieved by referring to 'factual grounds' or 'objective data', but is instead something that is the outcome of processes of authentication. These processes of authentication require social arenas or forums in which persons might express or perform their knowledge claims before an audience that witnesses this performance, an audience that responds in ways that are acknowledging of such claims. It is through such processes of authentication that persons experience being at one with such knowledge claims.[33]

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[32] Payne 2000: 14.
[33] Michael White, *Re-Authoring Lives* (Adelaide: Dulwich Centre Publications, 1995) 13.

Maybe the university is my 'social arena' where I can express my 'knowledge claims'? Maybe the university makes talking about, thinking about, re-visiting those dark years all right? Maybe it is a way to raise it? And yet...

The student paused, frowned to herself. *Maybe it is also a way to continue to avoid it, because talking about it in a university context is different to talking about it with those who really matter? Talking about it in a university context keeps it disembodied, keeps it separate from me, from my skin, my body. Talking about it in a university context keeps it clinical.*

As Payne suggests, the writing genres which are customarily privileged within the university—for example, the researched essay—provide opportunities for the management and re-thinking of unacceptable identities within discourses that normalize traumatic experiences, making them acceptable for an academic audience.[34] She goes on to argue that

> students are not confessing sins, but are participating in one avenue offered them for normalizing their sense of identity—writing in a classroom of strangers about a stigmatising event, illustrating their normalcy and protecting their intimates from the threat of their emotions.[35]

But what if this 'normalising function' of writing the personal within the academy is not further explored. The student stared down at her handwriting and felt the weight of these dilemmas.

I worry that the type of writing a woman might be encouraged to engage in—objective, void of emotion, disembodied—the type of discourses she may utilise—the medical, the psychotherapeutic, formal academic style—may shut down possibilities for women's expression outside of conventional gender prescriptions, outside of strict medical diagnosis, further pathologising, further constricting the writing of self.

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[34] Payne 2000: 13.
[35] Payne 2000: xxiv.

As Payne suggests,

> this [normalising] function seems even more problematic when young women who have been abused or who have eating disorders appropriate (or make explicit) this mechanism for inscribing middle-class ideology. The situation seems more complicated by the role confession seems to play: According to Foucault (1978), the act of confession serves to maintain the separations between the normal and the deviant, requiring the deviant to confess her sins and promise to realign herself with normals, all before a silent judge who confirms the truth about the confessor's deviance (59-63). Panoptican power—power which is internalised through constant self-surveillance (1979, 228)—turns self-analysis into an instrument of maintaining power, with someone like the teacher in a dominant position to verify truth through shaming.[36]

Importantly, Payne believes the term 'confession' to be inappropriate when describing those who choose to write about violence, abuse, eating disorders. She points out that judging such writing as confession 'contributes to maintaining those discourses that blame the victim and construct women as sexually deviant and threatening'.[37]

If this 'normalising function' of writing the personal within the academy is not further explored I worry that cultural 'norms' are thus further obscured and simultaneously become more deeply entrenched.

What is 'normal' anyway? The student blinked at the scraps of her lunch. *It's 'normal' for women to grow up disconnected, alienated from their bodies, to hate their physique, to feel dissatisfied and depressed, to want to look different, to diet, to fight their natural body shape. It's normal for women to 'feel fat', to 'feel ugly', to 'feel disgusting'. It's 'normal' to participate in such dialogue with yourself, but it's not 'normal' to do it too much or all the time because then it's an illness and illness is 'abnormal' and illness—particularly mental illness—is not something you talk about publicly because it is indicative of weakness and instability and weakness and instability are shameful and embarrassing.*

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[36] Payne 2000: 19.
[37] Payne 2000: 19.

The student thought about this. She certainly didn't want to reinforce such norms, to conspire with silence.

Payne believes that women writing about their experience of traumatic life-events have a right to be angry, the right to speak, should be encouraged to reassess blame, guilt and shame and critique cultural systems of gender, power and truth.[38] Such writing can explore the 'barriers constructed between deviant and normal identities, dramatizing the arbitrariness of such distinctions'.[39] From this perspective, women writing the personal can be seen to be resisting dominant ideologies.[40]

We are uncomfortable when the private erupts into the public. We are taught to be anxious about feminine exposure, about the revelation of female desires, appetites and bodies. Growing up female, many women accept culture's invitation to restrain their appetites, to curb their desires, to discipline, restrict and regulate their bodies.

I know.

This is an all-consuming, painful and self-defeating exercise, that preoccupies many women.

I know.

In deconstructing personal experience through the academy women can scrutinize such cultural prescriptions.

The student took a breath. And typed.

I have personal experience with anorexia / bulimia, and although making a conscious choice not to make my experience the focus of my work, I chose to acknowledge the extent to which it influences my thinking. In acknowledging my involvement with my

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38 Payne 2000: 20.
39 Payne 2000: 20.
40 Payne 2000: 20.

subject matter, I am not only recognising the personal sources of my preoccupations, my interests and my writing but I am also recognising the ways in which I am a social / cultural being, a being who seeks to make life matter, to make meaning from experience. I, the researcher, am a socially-constructed person, a product of my culture. I speak through my experience of gender, sexuality, race, class. I have had particular life experiences, particular privileges and challenges, a specific education, opportunities to travel. I speak through all this and more. My life is my filter. My experience is important because it offers insight into the cultural construction of self and, in the case of my work, into the cultural construction of bulimia nervosa. My own relationship with bulimia highlights my engagement, conformity, resistance and struggle with the rules and regulations of gender. This self-scrutiny invites readers to explore ways in which their own experience shapes, filters and informs their work. My self narrative is interwoven in my critical argument in ways of which I am aware and ways of which I am not aware.

The student read over her work. Deleted it. Rewrote it. Deleted. And rewrote it. She decided to leave it. At least to see what her supervisor thought.

The student re-read the email with disappointment. *It certainly puts a different spin on things. Now I read your work thinking, 'Oh poor girl. How horrible she had to go through that'.*

Shit. That wasn't the response she had wanted. She didn't want pity. She *really* didn't want pity, but she suspected that with her shyness, with her blushing and retiring and avoidances, pity was probably the response she could expect. She would be better off taking the piss out of herself, making it all a big joke, calling her thesis 'Yum Yum... Waa Waa...' like a friend had teased.

A day later her medical records arrived in an official envelope, with a typed cover and spiral bound. The student carried them around the house, looking for the right place to read what the psychiatrist had written about her and what she was going through all those years ago. She sat down under the trees, rested the folder on her lap and read quickly with her mouth open. Then she

went inside, lay it on her desk and followed his words with the nib of a pen. She read it again, late at night, by the blue glow of her computer screen. At 2:34am she lifted a pile of papers and hid it in the bottom drawer of the filing cabinet.

Some days later, the student went back to her medical record. *Once I was a patient*, she thought. They gave her a number. UR NO. 4488613. Now she sees the irony. UR NO. You Are Number.

UR NO. 4488613
The patient described an episode of abstaining anorexia nervosa beginning about two years ago when she weighed 56 kilograms and realised that she could vomit to lose weight. At that time she dieted, vomited and over-exercised to reduce 10 kilograms in a two-month period whilst her parents were in India. The precipitant to this event was her rejection by her boyfriend.

On their return from India her parents took control of the situation and successfully demand that the patient eat, and she quickly regained her weight and is now 58 kilograms. However, she is secretly binging and then vomiting every day. She is vegetarian, avoids breakfast and lunch and overeats late in the evening, after which time, she vomits.

She over-exercises, riding her bicycle to and from the university, including one and a half hours through the hills on the way home. She attends aerobics two to three times per week and jogs once or twice a week. She has previously used laxatives and does not use diuretics.

She is constantly preoccupied with the thought of being fat. Menstruation began at the age of 12, ceased when she lost so much weight, and has more recently been irregular...

She has agreed to embark on a treatment program in which she is to eat a weight maintaining diet, abstaining from binging and vomiting, reduce her exercise and to be weighed once weekly by me when she attends for the first ten weeks of the program. I will keep you informed of her progress.

The psychiatrist had written a story about the student. He called her a patient and he knew the story so well he didn't need to consult her. He got all the important details. *Number: 448861.3. Anorexia. Now with bulimia. Height: 154cm. Weight: 57.2kg. Clothed; no shoes, no jumper. A healthy weight for someone of her height is 50 kilograms.* He had decided she was

overweight—unhealthy. That was his informed medical opinion and he wrote it in her permanent record.

The student thought about this, about how he had the power to assume authority over her body, to measure her against his standards, to weigh, assess and label her experience in such a way—without question. She chased up a reference and made a note.

Medicine stipulates the correct weight range for healthy people, deeming some bodies 'normal' and others objects of its scrutiny. As Robertson suggests, 'normal' eating behaviour has been established by lay and medical discourse and in the production of 'truth' about correct diet and eating habits, medicine exercises power by categorising and labelling the ordinary person's private activity of eating.[41]

The psychiatrist's story consisted of numbers and labels and headings and behaviour. *Dieting ... Over-exercising ... Binging ... Vomiting ...* The student could not remember ever making sense of it all like that. She remembered the 'rejection by her boyfriend', but she did not remember it as so significant to her struggles with eating. It would have been easy for the groomed psychiatrist to make sense of her like that. *Girls love their boyfriends. Girls love pretty clothes and dream about weddings and feel fat and devastated when their boyfriend loses interest.*

She remembered they had sat in a room with no windows, with vinyl furniture, white walls and a buzzing fluorescent light.

Over his laminated desk, he told her that at this institution, they use the term 'weight disorder' as 'eating disorders are more about weight, than eating'. She remembered wondering about this, but he was the one with years of medical training so she accepted his truth.

He asked her to tell him about herself, about her 'weight disorder'. He scribbled and she talked. He raised his eyebrows at certain things.

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[41] Matra Robertson, *Starving in the Silences: an Examination of Anorexia Nervosa* (Sydney: Allen & Unwin, 1992) 1–2.

She noticed. He pressed harder with his pen and underlined particular words. She could not read what he wrote about her, but she noticed.

She remembered that it was hard telling him a story about what she was up against. It was hard for many reasons. He was young—maybe thirty. He had glossy hair and a nice suit and a silk tie. He wasn't her type, but she knew women who would exclaim, 'Oh my God' and call him 'gorgeous' and ask if he was married. He walked the hospital corridors with a hand in his pocket and pushed open doors with authority. He smelled clean and cold. He kept his eyes down, focused on his notes and she soon learned they were a more important account than the bits of sentence she struggle to piece together.

Patient feels bad about herself—ugly, depressed. She feels dirty—'really full'. After vomiting, she feels 'cleaned out.'

She remembers him raising his eyebrows. Again.

Height: 154cm. Weight: 57.2kg. The psychiatrist tapped his pen and considered her height to weight ratio. He asked what weight she wanted to be, what her 'magic number' was, resolving that weight was central to her 'disordered eating'. He checked his charts and decided that she was now overweight. He pointed at the lists of numbers with the nib of his pen. She remembers a deep, dark shame, a shame that she wasn't considered 'anorexic' anymore, that in regaining weight, in becoming 'bulimic', she had failed.

She went home and wrote in her diary that she was more depressed than ever. *I must lose weight. I must ... I want to be delicate and brittle and so fragile that people are afraid to touch me for fear of breaking me ... It is five weeks until my next appointment. I must lose at least five kilograms by my next appointment.*

The difference in being labelled bulimic over anorexic was not explored and the resulting distress was not examined, not contextualised. Her experience was never located in a broader social context. The aspects of dominant culture which sustained and supported the bulimia and her body-loathing were

made invisible. The power relations of gender and of therapy were never addressed. The psychiatrist never invited her to read his notes. He rarely made eye contact with her. He never acknowledged her jokes, her tears or how dishonouring his assumptions were to her family. These dominant psycho-medical narratives were for her paralysing, all-consuming and overwhelming.

The story scrawled in her medical records had been written before. It was assumed that she would have difficulty expressing anger, that her parents were over-protective and had pressured her to succeed, that she would be preoccupied with control, wholeheartedly believe that 'slim is beautiful', horrified by menstruation, disgusted by her sexuality and that her mother would be to blame for her condition. Through her psychiatric consultations, she became yet another young woman sucked into the trivialities of femininity, another young woman obsessed with 'dieting', with 'weight', with being 'attractive to men'. The implications of this story made her think about herself, anorexia and bulimia in particular ways. This story was disempowering as it was based on her failings, her deviance from normality. She was being measured against accepted norms for how a young woman *should* behave and how a young woman *should* look.
The student was reminded of an interesting quotation:

> Psychiatrists traditionally arrange data in terms of deviation from the norm, i.e. in terms of pathology. Diagnosis involves matching symptoms and signs with knowledge about established disease entities. A diagnosis of 'normal' occurs in the absence of pathology, rather than in the presence of some indicators of health.[42]

The psychiatrist had said that her behaviour was a serious threat to her health and possibly her life and that she should strongly consider coming into hospital. He said if she refused, things would be much more difficult, but they

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[42] Robertson 1992: 69.

would start challenging her 'fear of eating forbidden foods' during the sessions. He said he would bring along some hots chips, some icecream, a doughnut, a cream bun—whatever it was that made her the most distressed and she would sit, eat, measure her 'anxiety levels' on a chart and agree not to 'induce vomiting' after the consultation was over.

He waited for a response. She toed the blue carpet and was speechless.

When she spoke of her 'bulimic behaviour' she felt as though she hovered above her body. She wafted on thick, hospital air just below the ceiling. She looked down on that young woman stooped and folded in a plastic chair, picking at her fingernails, curling her toes in her shoes, smiling at the psychiatrist in beige, desperate for him to like her. Sometimes it was too much for her to participate in those sessions. She was not present when the psychiatrist took her measurements, took her blood, took her voice.

> *I am writing to give you some follow-up information regarding the patient's progress with her bulimia. When last seen on the 6th January her weight was 57.2 kilograms. She described that she has always been overweight, apart from her period of anorexia. A healthy weight for someone of her height is 50 kilograms. Since her program began, she has tended to maintain some distance from me by attending on average, once monthly. She has however made considerable progress and in particular during her exams was able to minimise her bingeing to one evening per week. She has become aware that family issues contribute to her feelings about herself and hence to her bulimia... Issues of her inability to express anger appropriately and separation from her parents have been highlighted. The aim of her program continues to be to have three meals per day.*

The psychiatrist had books on the shelves of his office on which he could rely. The student sought out those books, reading them with her head bowed, sucking on warm, musty air in the university library. She wanted to understand herself better. She wanted to know what was wrong with her so that she could become right.

> *There is an increased frequency of depressive symptoms (e.g. low self-esteem) or Mood Disorders (particularly Dysthymic Disorder and Major Depressive Disorder) in individuals with Bulimia Nervosa. In many or most individuals, the mood disturbance begins at the same time as or following*

the development of Bulimia Nervosa ... There may also be an increased frequency of anxiety symptoms (e.g. fear of social situations) or Anxiety Disorders ... Substance Abuse or Dependence, particularly involving alcohol and stimulants, occurs in about one-third of individuals with Bulimia Nervosa ... Probably between one-third and one-half of individuals with Bulimia Nervosa also have personality features that meet criteria for one or more Personality Disorders (most frequently Borderline Personality Disorder).[43]

She had worried that she had a 'personality disorder'? Did she have *one or more* 'personality disorders'? She certainly had an *inability to express anger appropriately.* That was committed to her medical record in ballpoint pen.

Inability to express anger appropriately ...

What was the appropriate expression of anger for an eighteen-year-old woman? The psychiatrist never asked what she was angry about.

She learned facts from books. In her diary she wrote with authority that *bulimic patients lack a sense of identity and self esteem. Depression is a common link.* Her handwriting in black ink bled into the pulp of her notebook. On 11 May, some thirteen years ago, she tried to write a story about herself.

The Five Organisations of the Self. FROM BOOK: *Diagnostic Issues in Anorexia Nervosa & Bulimia Nervosa.* Edited by David M. Garner PhD & Paul E. Garfinkel, MD.

Mode III. Bulimia Nervosa.
Individual experiences others as 'self objects' ...
'Mirroring' self objects affirm the individual's sense of personal vigour, greatness and worthiness ...
Individual internalises the vital functions supplied by self objects, advancing self-regulation and independence ...
Basic cohesion of self structure ...
Vulnerable in self esteem and tension regulation ...
Unconscious illusions about self not consonant with reality ...
Perfectionism, shame and failure. No achievement is good enough ...
Optimal disillusionment ...

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[43] *Diagnostic and Statistical Manual of Mental Disorders* IV (Washington: The American Psychiatric Association, 1994) 547.

Individual seeks physical sensation as a means of bolstering depleted, discordant, devitalised self ...

These stories filled her diaries, wrote the way she thought about herself. *11 May. The 'false self' is elaborated at the expense of the 'true self', which remains dormant and underdeveloped.*

The student had written, *My story* and paused.

What should she write about the experience of suffering / surviving bulimia nervosa? *Diagnostic criteria for 307.51 Bulimia Nervosa ...* Would she document her behaviour? List her statistics, her height, her weight? Her anxiety ratings? *0—No anxiety. 2—Slight anxiety. 4—Definite anxiety. 6—Marked anxiety. 8—Panic.* Should she re-visit those desperate scrawlings on scraps of paper, tucked in her old diaries. *Food is bad ... Food is bad ... Food is bad ... Fat is bad ... fat is bad ... fat is bad ... I am fat ... I am fat ... I am fat ... I am bad ... I must lose weight or I don't deserve life ... Only 200 calories a day ...* Would she list what she ate, when and why? *Wednesday, June 6th: Breakfast: None. Anxiety rating: 0-2. Lunch: Lots of bread and butter and icecream and chocolate bar (Mars). Aprox 2000 calories. Got rid of everything. Tea: 9 oranges. 6 laxatives ... Thursday: I felt very depressed—no idea why ... Walking for one hour. Aerobics for half an hour ...* 'My Bulimia Hell—Sufferer tells all'. Who was she? What did she know? She was number 448861.3. She was bulimia.

At some point the student had stopped writing that story. Different voices were beginning to resonate; those of artists, writers, film-makers, of anthropologists, sociologists, feminists, cultural theorists.

Years later, while studying narrative therapy, the student went back to the story—the self—she had left hanging, mid-sentence, un-resolved, un-finished. *Disruption of self-cohesion, intrapsychic conflict, primary repression, lack of*

boundaries and absence of tension regulations... She began to realize that the story was not just about *Number: 448861.3. Anorexia. Now with Bulimia.* The story was much bigger. Much bigger—even than her.

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Citrus morning. The student created a new file, titled it tentatively: *Another Chapter ??* and felt refreshed—relieved to be moving on. She sat forward in her chair and typed*: Discourses which shape our understanding of anorexia and bulimia: Popular Culture.* She sipped her tea and glanced across the desk at her medical record. It was closed and she was glad. She rested her cup on it and typed on.

The influence of popular culture

We make sense of our eating habits by referring to medically prescribed norms for diet, eating and weight, but we are also influenced by pleasure, tradition, culture, religion and ceremony, by trends in cookery and the ever-increasing interest in the food and wine industry.

The student sat back from the screen and thought about her partner—a viticulturist—employed in the wine industry. She remembered when wine was something that came in a cask, something she had syphoned into drink bottles to scull, wincing, under the railway bridge. Wine still made the student wince, but now it was also about earth and rain, about the changing seasons and about the intersection of art and science.

Since her sister began studying to be a chef, the student's consideration of food had shifted again. Once, her sister had supervised five litres of stock as it reduced throughout the night to one litre of rich sauce. The student's family had eaten the perfectly presented meal in minutes. They sat back and shook their heads. The student remembered her mother saying, 'We don't deserve this.'

As Robertson finds, the 'normal' eater has a tangle of complex and contradictory messages regarding food consumption, self-control and the ideal body to decipher.[44]

Yes, the student thought. You don't have to be preoccupied with popular culture to be entangled.

She remembered from her own childhood how food soothed and comforted and confused. She and her sister practiced their creativity in the kitchen, icing cakes, shaping biscuits, sneaking peeks at bread dough as it swelled under a tea towel in the sun. They learnt about the science of cooking, about how meat cooked, cakes rose and about how yeast fed on sugar. Food was about togetherness, about family, love and loving. Food marked occasions—Nanna's sponges for birthdays, plum pudding at Christmas, 'Lolly Day' on Fridays to mark the end of the school week, the beginning of the weekend. But food was also confusing. Her Uncle pushed his glasses up his nose and said, 'Woah up, there! Save some cake for us! You'll get fat if you eat all of that.' Sometimes eating was good, but she learned it could easily make girls bad. She learned to cut delicate slivers from a cake and eat behind her hands. She learned eating was secret. By twelve, the student was very much immersed in the food / eating / body culture. She learned that her body was not within her control. It was something to fear; something to hate. By twelve she was fluent in the language of food. By twelve she had learned to be female. She had learned to diet.

You need only to pick up a women's magazine and you find an overwhelming amount of 'talk' surrounding cooking, eating, dieting, body image and 'eating disorders'. There is much speculation over celebrities' weight loss or gain to the extent of quoting height to weight ratios. *New Weekly* magazine encouraged readers to visit their on-line discussion board to comment on model Elizabeth Hurley's body after the birth of her first child.[45] The following week, readers were queried ' Do you

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[44] Robertson 1992: 17.
[45] *New Weekly,* 19 August 2002.

think the new look curvy Hollywood is hot or do you prefer the skinny stars of old? Share your thoughts at our discussion board' (www.ninemsn.com.au/nw) *New Weekly*.[46] In these women's magazines, before / after photographs highlight the apparently changeable nature of the body. Specific images of women advertise products, playing on this notion—that if we buy their product, we too could look like that.

The student remembered watching chat shows while her parents were out. The host introduced a row of starving girls and there were shots of the audience gasping, shaking their heads. In the commercial break the student continued to watch, wide-eyed. There were jingles for weight loss centres, beautiful women hanging out the family's washing with perfect smiles, ads for exercise machines, indulgent chocolates.

Anyone who has flicked on the TV, flipped through a magazine knows what a confusion of messages women are subjected to.

The student had told her grandma to keep any of her magazines which contained articles on eating disorders. Her grandma had given her a stack, collected over a few months and the student read through them sprawled on the floor, indulgent. *It's for my research*, she laughed to her partner. And he laughed and made himself a sandwich.

The student typed: *Leafing through 'Woman's Day', June 12, 2000. The following quotations are all from the one, the* same *magazine!* She didn't know how she would use them, but they were interesting, revealing.

Page 8:

Heather confesses: *I'll have plastic surgery for Richie.*

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[46] *New Weekly,* 26 August 2002.

Heather has thought of another gift she can give her beloved husband—having cosmetic surgery. As her 40th birthday looms next year, Heather admits that, given a choice, she'd rather cheat time and stay sexy. 'It seems that 40 is when things really start to change, when you get to the age where you start looking not real good. Then it's time to do something,' Heather says firmly ... 'Let's put it this way –I hope there's more depth to me by the time I'm older, but if I have to choose between Richie waking up one morning and saying to me, 'Gee you're a fascinating woman,' or 'Gee, you look sexy and fantastic,' I'll go for hearing him tell me I look sexy and fantastic!

Page 16:

Woman's Day Exclusive. Bulimia teen: *Savage Garden saved my life*

Pretty 17-year-old Melbourne student Jody Kooijman was still floating on air after a fairytale meeting with her hero Darren Hayes—lead singer in Savage Garden, who she says saved her life ... Fighting back tears of joy, Jody, who is in year 12, revealed to the lead singer how his band's inspirational music had helped her overcome a life-threatening eating disorder which had driven her to the brink of suicide.

Page 34:

The Wedding Dress DIET!

showered with kilojoules
As if you don't have enough on your plate right now: getting the right addresses on the invitations, choosing presents for your bridesmaids, deciding on the food for your reception and trying to lose weight, when your family and friends will heap on more. You want to look perfect on your big day, and the last thing you want is to walk down the aisle feeling everyone's eyes fixed on your straining seams. Don't worry, thanks to dietician Robyn Flipse and author Jaqueline Shannon, you'll be looking and feeling fantastic.

Page 54:

Lose weight. Gain Life.

Being overweight can overshadow everything you do, every day. It can affect your blood pressure. It may raise your cholesterol. It increases the risk of diabetes. It can affect how much you enjoy being with family and friends.

Sometimes, diet and exercise just aren't enough. But, happily, your GP can make a difference.

If you're ready to lose weight and gain life, it's time to talk to your doctor or pharmacist.

Page 56:

good health: Eating Disorders—is your child at risk?

Every mother must dread her child becoming anorexic or bulimic. Watching your child waste away or knowing they are sneaking to the bathroom to throw up is a nightmare no parent wants to face ... Experts are unsure why some people develop eating disorders and others don't, but they have a number of theories. First, it could be due to genetics, as disorders are more likely to develop in families of sufferers. Stress is also a trigger. Bereavement. Being bullied or abused, a divorce in the family or worries about being gay can all contribute to the development of anorexia or bulimia ... 'Eating disorders are serious psychiatric conditions and are usually linked with chronic low self-esteem. They should not be confused with diets,' [consultant dietician Lyndel Costain] explains.

Page 71:
Fast Fabulous Food ...
Page 72-3:
Shepherd's Delight. Everyone loves Shepherd's Pie, so make a double quantity of the mince filling and freeze it for later. Then, simply thaw, reheat and serve it in jaffles, over hot pasta, or make one of the following recipes ...
Page 74-5:
That Fruity Feeling. These desserts can all be made in less than 30 minutes ...
Page 76-77:
25 ways to make chicken sing ...
Page 78:
The ultimate choc chip cookie...[47]

The history of women's socio-cultural position informs our contemporary understanding of so-called 'eating disorders' and contributes to the belittling and trivialising of these conditions as just 'women's problems'. In recent times, popular

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[47] *Women's Day*, 12 June 2000.

culture's fascination for 'eating disorders' has connected with its representations of femininity. Contemporary media are saturated with images of the ideal female body characterised by extreme thinness. It is ironic that today, in the West, when food is easily accessible for the fortunate majority, popular standards of female beauty restrict their ideal to the alarmingly thin, toned, tall and eternally young. The multi-million dollar diet and exercise industries encourage practices of self regulation—self deprivation. Women scrub and buff, comb and brush, pick, pinch and squeeze, they cover up, conceal, support, lift and reveal. They watch what they eat, count calories, opt for low fat, low carbohydrate, low GI, high protein snacks. They go without or they give in to temptation, they choose to be *good* or to be *bad*. They weight-train, resistance train, take classes in body attack, lite 'n' low, body combat, pump ... They do this because it is *what women do*.

The student paused. She remembered the way she sat in that vinyl chair as the psychiatrist's language shaped her. She had sat perched on the edge of a chair, her knees together, her legs crossed. She had tried to make herself smaller. To relax into her body and assume space felt unnatural, wrong. She pictured all the times she had lowered her gaze, crossed her arms across her breasts, touched at her hair, pulled in her stomach. She pictured how she responded to her reflection, looking over her shoulder, smoothing the skirt at her hips, how embarrassed she was if anyone caught her staring at the mirror. She thought of blisters bursting on her heels, bras cutting into her ribs, elastic biting the flesh at her hips. She thought of her clothes. Women's clothes—revealing and concealing body-parts.

Our culture is inscribed on our bodies. It is not a 'natural', biological response that women should sink into depression when scrutinising themselves in a mirror or flinch if their flesh is felt by another. This is a result of living within a culture which insists that some female flesh is to be desired, is sexy—beautiful, but some female flesh is to be feared, is shameful, disgusting and repulsive. In this way, women's bodies have been made obedient, manageable, submissive to our culture. Such examples of self-production, self-observation, restraint and control are entwined in systems of power. As Payne and many other feminist writers have pointed out, Foucault's panopticon

can be used to describe how the patriarchal gaze has taught women the proper and submissive attitudes, gestures and understandings of herself as female.[48]

> An anorexic woman is in many ways the embodiment of this panoptical power, a woman who has internalised this violence and identity so that physical and sexual abuse are no longer necessary to accomplish the same goals ... [E]ating disorders are on a continuum with sexual and physical violence, all three creating a similar sense of identity for women that maintains a focus on the body as a site for control.[49]

Payne finds the female body is subject to such disciplinary power differently to a man's because the female body is understood to be more docile, subject to ritualised practices in constructing an image of femininity, implying the body is deficient and in constant need of self surveillance.[50] Thus women's identity can be understood as structured around the struggle to control and manage the body. In such a climate it is not surprising that so many women turn against themselves, spending many years of their lives in a perpetual violent assault against their bodies. Women (and an increasing number of men) are encouraged to impose control over their bodies, dominating and subduing physical needs in an attempt to conform by changing the physical self. In today's world, triumph of the mind over the body is rewarded. It is not surprising that anorexia nervosa has been perceived as 'the logical culmination of cultural beliefs about, and attitudes towards, the female body'.[51]

Anorexia has come to be a preoccupation and cultural symbol in the West. It is represented in popular culture as enigmatic and fascinating. It is celebrated in cultural mythology as mysterious, exotic, desirable. *A nightmarish four years saw a sporty Sydney teen become a walking skeleton close to death.*[52] Its representation commands attention—*she was a deathly 31kg, but in her mind believed she was chubby*—declares power over others—*I'd rather be dead than fat.*[53] It is seen and reacted to. It is public. It is political. Anorexia gives an impression of self-denial, of silent suffering and self-control in pursuit of conquering the flesh. *Lauren was*

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48 Payne 2000: 51–2.
49 Payne 2000: 52.
50 Payne 2000: 55–6.
51 Cooper 1992: 185.
52 *Who Weekly*, 10 Dec 2001, 69.
53 *Who Weekly*, 10 Dec 2001, 69.

exercising obsessively, running 10km a day and doing calisthenics at night. That December she dropped to 38.5kg.[54] It is read as a woman's endeavour to improve herself. These are qualities and goals which our culture considers feminine and which the mass media reflects and reinforces.

> Her own battle began when she was 12. Determined to succeed at her exclusive Sydney girl's school, Hutchings threw herself into school work and experimented with diets. During a gruelling Sunday study session in her bedroom in 1986, she caught a glimpse of herself in the mirror and thought: 'Why can't I be better?' ... Desperate for control, the slender student decided: 'I'm going to lose weight. I'm going on a diet. I'm going to cut out food'.[55]

> *Anorexic Olympian: I was a 48kg skeleton.*
> ... Against all the odds, the stunning blue-eyed swimmer had staged an incredible comeback to win a place on Australia's Olympic team, putting behind her the desperate battles with crippling depression and a deadly eating disorder. Sarah-Jane unfolds her willowy 186cm frame from a poolside bench.[56]

Her willowy frame. Some words resonated. Some words reminded the student of past longings that now, as an adult, she worked to un-pick, considering carefully which were a result of cultural conditioning, which were connected to anorexia / bulimia and which were just her. It was confronting to re-visit the beliefs she had clung to as a teenager, to follow the loop of her adolescent script, to note how hard she had pressed with the pen. It was embarrassing. Humiliating. Unsettling and upsetting. If the quotes were written by anyone else they would be interesting, possibly useful for her thesis. But as they were the revelations of a shadow self she could never include them. Never.

The student shut down the computer, closed her diaries, her notebook, stacked the magazines, her texts and walked away. For two days she didn't step into the study. For two days she read recipe books, baked cakes to give away. While the sponges cooled, she picked grass seeds from her sneakers and challenged herself to a ten kilometre run.

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[54] *Who Weekly*, 10 Dec 2001, 70.
[55] *Who Weekly*, 10 Dec 2001, 66–7.
[56] *Woman's Day*, 19 June 2000, 14–15.

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The continuum perspective

> Diet and eating can be seen as a part of the self that people feel can be controlled by morals, healthy-diet information, cost, availability and medical mandates. Women in patriarchy are required to fill social roles that maintain their social inequality and their position as passive consumers, who buy and eat food in the correct, prescribed way. Part of their sense of self / identity may depend on their ability to demonstrate 'feminine' eating patterns.[57]

We live in a cultural context that promotes, values, celebrates and rewards thinness in women. Simultaneously, our culture pathologises those who fit the criteria for 'eating disorders'. This pathologising of experience separates and segregates. It undermines the experience of women, negates and normalises the struggle many experience in relation to their bodies and reminds us of the supposed fragile line between 'normality' and madness. 'It is as though these [anorexic] bodies are speaking to us of the pathology and violence that lurks just around the edge, waiting at the horizon of 'normal' femininity'.[58] As demonstrated by the postings of young women on the Something Fishy website, feeding oneself and living up to feminine expectations is fraught with a confusion of desires.

> *I am a pre-anorexic and bulimic (would love to be) and love it!!! I am crazy ... From the calories of an apple to the calories of a chocolate bar, a bag of chips, a McDonalds's hamburger ... I know all of them! Sometimes I hardly eat (a fruit in all day) and there are other times where I just can't stop eating ... Am I anorexic? But I am not really skinny like the bony, size 0 anorexics that I have seen. I do not seem to lose weight!!! Oh my god, I wish I was anorexic!!!!.*[59]

> *I don't know why, but I'm extremely envious of girls who are anorexic or bulimic ...*
> *I just wish I could be thin ... so thin I would finally be seen.*[60]

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[57] Robertson 1992: 15.
[58] Susan Bordo, *Gender/body/knowledge: Feminist Reconstructions of Being and Knowing* (Eds. Alison M. Jaggar & Susan R. Bordo (New Brunswick, N.J.: Rutgers University Press, 1989) 20.
[59] Something Fishy Website, posted 15/4/98. Accessed March 2000.
[60] Something Fishy Website, posted 24/4/98. Accessed March 2000.

'In Western society, food signifies success and failure; temptation and restraint; force and freedom'.[61] Feminist therapist Bonnie Burstow has us consider a continuum of experience women can encounter in relation to eating and their bodies.[62] A continuum of values and beliefs shape each woman's individual identity in the context of food: from the starving woman, to society's horror and ridicule of 'fat' women—which Robertson believes is 'out of proportion to their numbers in the population and their political or social influence'. She goes on:

> In the medical and lay discourse that equates femininity with restraint, those who restrain themselves too much (anorexics) and those who supposedly exhibit little restraint (fat people), become the objects of admiration or disgust; these reactions in turn enable the ['normal'] eater to form meaning and identity in relation to food.[63]

For women today in the Western world, it appears the boundaries between health and disease have blurred. The culturally desired—'ideal'—female body which saturates our mass media is one far from the reality of women's experience.

> A body that has been reshaped to signify a woman's desirabiliy as a sexual being has also come to signify disease and disorder, both physically and psychologically. While trying to mold herself into what she says is a media image of an attractive woman, she also molds herself into what the media, academia, and medicine have defined as the disordered body.[64]

The student wondered how today's girls and women negotiated such complexities. She remembered how confusing it had been to be labelled anorexic, to be encouraged to regain weight only to be informed that at 57kg she was considered over-weight. She wondered how the psychiatrist thought this preoccupation with her heaviness would help her find herself. At the Australian Narrative Therapy and Community Work Conference, 2002, she had listened to women from 'Living Large', women who stood for bodily respect, diversity, a non-diet approach to living—women who had come

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61 Robertson 1992: 72.
62 Bonnie Burstow, *Radical Feminist Therapy—Working in the Context of Violence* (London: Sage, 1992) 202-23.
63 Robertson 1992: 72.
64 Payne 2000: 70.

together to sustain physical activity in their lives. She had heard how affected these women had been by medically prescribed weight 'norms' and how after many miserable years battling their bodies they had united to challenge the 'expert knowledge' surrounding their size. The student could imagine the psychiatrist shaking his head, his arms folded across his chest. *Very unhealthy*, he would say. *Very unhealthy indeed. These women are quite obviously clinically obese.*

As Robertson explains, the so-called 'anorexic' (and the so-called 'bulimic') is not merely a person with dieting and eating problems:

> She is part of a culture that, socially and symbolically, has made eating a problematic transformation of nature by culture. The creation of 'eating disorders' as an illness category, and the commercialisation of food consumption, place the eater, whether self-starving or 'normal', in a maze of food patterns, taboos and meanings. Anorexia nervosa and dieting are among the eating choices and patterns of food consumption in both patient and non-patient populations. The dieter is expressing cultural meanings and beliefs about food consumption and the biopolitics of food production in society.[65]

The continuum perspective understands women's preoccupation with body shape and size within a cultural framework, respecting a diversity of experience. It does not set out to trivialise and normalise so-called 'disordered eating', to overlook the dangers to health and well-being, to imply that women with troubled eating and body-loathing do not need support and / or assistance. It is to suggest that such 'behaviours' are not necessarily limited to those labelled 'anorexic', 'bulimic', 'mentally ill'. Robertson asks how the label 'anorexia nervosa' makes the experience of self-starvation explicable and meaningful to the woman diagnosed. She asserts that

> as a category of illness, anorexia was created because it made meaningful to the medical profession—not the starver—a set of symptoms and patterns of behaviour which were unreasonable and inexplicable. Anorexia nervosa was rendered an abnormality by a discourse which was privileged to define what was normal. This

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[65] Robertson 1992: 20–1.

> discourse is patriarchal and also medical, and I believe the anorexic patient has little hope of finding herself inside it.[66]

Yes. The student stretched back into her chair. *I couldn't find myself in it.* Engaging with the medical discourse in the midst of her conflict probably confused her more, diverting her further from herself.

Like Robertson, I worry that

> [t]raditional treatment participates in silencing women at a time when they most need to discover for themselves a vocabulary of words and non-verbal ways in which to express thoughts and feelings about their lives.[67]

Helen Gremillion finds that in fairly recent history, women have been encouraged to 'resource' their own bodies:

> the dominant idea now is that you 'make yourself', you shape your own body, you use your body as a resource. Women and girls are now resourcing their own bodies in ways that draw the same traditions of thought that place nature as an object that exists outside of us.
>
> I saw this same logic playing out in standard treatment practices for anorexia. In these treatment practices, the body is thought of as an object that has to be manipulated and controlled for weight gain rather than weight loss. But that difference (gain rather than loss) is really a very minor difference compared to the amazing similarity between the ways of thinking that inform the treatment and the creation of anorexia. Both construct the body as an object and a thing that needs to be resourced to create a self of a particular kind. So there is an expectation in treatment that the body should be resourced to create a healthy self, rather than an ill self.[68]

Gremillion believes that one crucial reason that anorexia has been so complicated to treat is because traditional medical treatments 'participate in a cultural logic of self-management through management of the body, a cultural logic that has been particularly problematic for women and girls'.[69]

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[66] Robertson 1992: xiv.
[67] Robertson 1992: 76
[68] Helen Gremillion, 'Anorexia: a canary in the mine. An Anthropological perspective'. *Working with Stories of Women's Lives* (Adelaide: Dulwich Centre Publications, 2001) 142–3.
[69] Gremillion 2001: 143.

It was a thrill to find others who agreed, others who had a diversity of extensively experience in the field, others who could be bold with their assertions, who could find the right words, whom she could quote with authority. It made her feel more comfortable with the development of her own thinking, more powerful in her expression, more capable of dealing with the stories of other women.

Six questionnaires had been returned to her. Two interviews had been completed. Now, with some reading and research behind her, the student felt more prepared to explore other women's stories.

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Stories of bulimia—The qualitative research process

I believe much care must be taken in considering such personal stories of experience. I know through conversations at EDASA that many young women have struggled with the effects of labelling, measuring and 'quantifying' their experience. As narrative therapist, David Epston puts it:

> the objectifying practices of weighing, assessing, and measuring of women associated with the discourses of psychology and psychiatry could very well co-produce what is referred to as anorexia/bulimia in those very persons oppressed by anorexia/ bulimia.[70]

The findings of my research support these concerns.

So does my own experience. The student remembers the obligatory sessions with the research unit. There was no choice. If you wanted treatment at the hospital, you had to be involved with their research. *Research is important,*

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[70] David Epston, Fran Morris and Rick Maisel, 'A narrative approach to so-called anorexia/bulimia', *'Catching Up' with David Epston: A Collection of Narrative Practice-based Papers Published between 1991 & 1996* (Adelaide: Dulwich Centre Publications, 1988) 150.

said the psychiatrist. Of course the student realised that. But there was no choice in the way your experience was 'measured', you had no say in the methodology or no chance to comment on its design, you were not invited to comment on the process, or to view 'findings'. You were a subject on whom tests were performed. The tests were analysed, interpreted by 'experts' and kept from your knowledge. The most harrowing of these test were the colour charts. The student—the *subject*—remembered being given pages of words to read, but the trick was that each word was coloured differently. Instead of reading the words FAT BAD UGLY GROSS FAT DISGUSTING... the subject had to say the colours the words were written in and say them as quickly as possible. The researcher sat and timed how long it took for the subject to read out a page of colours, never intervening when the subject—pressured by the stop watch—spoke the word instead of stating the colour, when the subject became embarrassed, distressed, when the subject could barely speak with the distress or the humiliation or the anxiety or the rising anger... BUTTER CREAM CHOCOLATE CAKE SUGAR CALORIES... FAT BAD UGLY GROSS FAT DISGUSTING... never pausing to ask what sense the subject was making of the research process, what effect it was having on the anorexia / bulimia, never inquiring after her thoughts or feelings or fears or what she believed the anorexia / bulimia might be about. The subject was over-written in this research. *Number: 448861.3. Anorexia. Now with Bulimia.*

Commenting on the methods of medical treatment, 'Ruth' explained in interview,

> The thing is [the medical staff are] just feeding back into it [bulimia], because that's what you feel like anyway. You have no identity. When you take on an eating disorder you have no identity and then they just reinforce that when you walk in. And the looks! You could see on the nursing staff—the spoilt brat thing. Attention-seeking, little pansy-wansy. I hear it out in public. There's very little sympathy for eating disorders. Very little.[71]

For 'Ruth', her eventual recovery involved taking

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[71] Interview 2: 'Ruth', 2001.

> a more 'spiritual' path—massage, alternative healing and therapies … Some so-called 'help' was more detrimental than anything. The feeling of just being part of a system. Had more understanding outside of the eating disorder circle than in … Least helpful thing was being treated like a number, and addressing the illness. Most helpful was when I was treated like an individual, not an illness.[72]

Another woman contested the medical diagnosis, stressing

> I don't identify with the label ['bulimia nervosa'] and I actually resent it. I resent it being used to describe someone and that its meaning is not exclusively what is written in the DSM-IV. I hate labels because people are much more than labels and I try not to use them.[73]

It is important to me that the respondents' opinions are expressed in their own words. As Holloway asserts, '[q]ualitative research is based on the premise that individuals are best placed to describe situations and feelings in their own words'.[74] Qualitative research is considered trustworthy 'when it reflects the reality and the ideas of the participants'.[75] This is also a political stance—a choice to give authority back to those women whose experience has been appropriated. I made a conscious decision to involve participants in the process of the study, to let their concerns shape and drive how explorations progressed. However, I appreciate I am still a significant influence in the research process. In qualitative research '*the researcher is the instrument.* Validity … therefore hinges to a great extent on the skill, competence, and rigor of the person doing fieldwork'.[76] This includes my background research and life experience, the formulating of questions, the ways in which I requested contributions, any communication with potential participants, skills at interviewing, data analysis, critical thinking, engagement with theory and the use of findings. What I find so engaging about such an approach is that qualitative research 'is not static but developmental and dynamic in character; the focus is on *process* as well as outcomes'.[77]

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[72] Questionnaire 6, 2001.
[73] Questionnaire 1, 2000.
[74] Holloway 1997: 8.
[75] Holloway 1997: 160.
[76] 'Notes on Sampling', *Research Design: Sundry Notes and Handouts #3* ed. Peter Blanksby (Adelaide: School of Social Administration and Social Work, 2003) 26.
[77] Holloway 1997: 6.

> New concepts are developed throughout the process of data collection. They are continuously adapted and new questions formulated about the phenomenon as incoming data may challenge or modify findings.[78]

But most importantly,

> [t]his type of research is thought to empower the participants, because they do not merely react to the questions of the researchers but have a voice and guide the study.[79]

Early in the research process, I recruited women with an experience of bulimia to complete questionnaires (see Appendix). After gaining Human Ethics Approval through The University of Adelaide, my project was advertised through EDASA, *The Adelaidean* and was brought to the attention of The Weight Disorder Unit at Flinders Medical Centre and the Food Without Fear program at Blackwood Hospital. Although my project was encouraged and supported by these organizations, the response from women identifying with bulimia was not overwhelming. The ultimate aim of qualitative inquiry is to sample the 'full range of perspectives available ... trying to construct a 'conceptual map' of the research area'.[80] This is a challenging task due to the large numbers of women struggling with this condition, due to the stigma associated with bulimia, due to those not identifying with a clinical diagnosis and due to the fine line between what behaviours are currently pathologised and what are considered 'normal' weight control measures in a culture which increasingly prescribes unrealistic standards of physical beauty. But in qualitative research it is thought that 'sample size is based on conceptual, rather than statistical considerations'.[81] As Patton points out,

> *[t]here are no rules for sample size in qualitative inquiry.* Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources. (Patton in Blanskby).

Obviously the more responses to my call for research participants the more complex and substantial the data. But although my sample is only small and by no means

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78 Holloway 1997: 10.
79 Holloway 1997: 8.
80 Blanksby 2003.
81 Blanksby 2003.

representative of *all* women's experience, the data gathered offers an elaborate and layered source of insight into surviving bulimia. My aim in exploring these findings is not to propose a typical profile of a women with bulimia—rather, I hope to open up discussion surrounding this condition, exploring the meaning made by those with lived experience.

Although I appreciate the individuality of each woman's story, I am also keen to compare responses, noting similarities and emerging themes, issues and metaphors. I am interested to learn of the multiple meanings women attribute to bulimic behaviour, what they believe to be significant moments, markers and milestones. I note their use of language, their symbolism, their beliefs, concerns and interpretations of bulimia, their thoughts about transformation, the body, rites of passage, identity, femininity, spirituality, community and recovery. I am interested what it means to be prescribed or identify with the diagnosis of bulimia nervosa, how the symptoms of 'disease' are interpreted, how rituals, behaviours and thought processes are made sense of and what meanings are prescribed to the perceived appearance of the body. I am interested in women's exploring, expressing and contextualising their own concerns regarding their relationship with food, eating and their bodies and how this fits with their understanding of the process of medical diagnosis and of the public debate surrounding eating disorders. My inquiry occurs outside of the strict criteria of the current *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), illuminating experiences women feel have been obscured by medical definition. The responses I received are informed by an intricate weaving of discourses, including issues of gender, identity, health, relationship, class, dis/ability, education, sexual development, sexuality, tumultuous adolescence and parenting.

Alexander, Aroni, Minichiello and Timewell propose a basic set of principles—or 'interpretive bedrock'—to aid in the understanding of people.[82] These include *cultural commonality* (where the researcher assumes overlap between the person's beliefs and those of his / her culture), an appreciation of *social context* (where the person's behaviour is given meaning by his / her social context) and *ideals* (where similarity is maximised between the person's underlying aims or ideals and those of his / her

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[82] Loris Alexander, Rosalie Aroni, Eric Timewell, Victor Minichiello, *In-Depth Interviewing: Principles, Techniques, Analysis 2nd Edition*, Melbourne: Longman, 1995) 35–6.

culture).[83] These principles are of great relevance in exploring the data in my study, particularly considering my interest in the overlap between the cultural construction of both anorexia and bulimia and women's lived experience of bulimia.

Despite my small sample, the amount of data generated is extensive. After careful examination, information was organised under six broad headings: *Meaning associated with the label 'bulimia nervosa', Identifying with bulimia, The story of experience, Rituals, Seeking help* and *Different societal perceptions of anorexia and bulimia*. I will focus largely on *Different societal perceptions of anorexia and bulimia* and *Seeking help* as respondents consistently expressed concerns in these areas. I am well aware that my particular interests shaped and informed my line of questioning and that this impacted on the type of information I received back—an on-going concern in research design—but I find it significant to note how passionate responses were in these two areas. Little attention was paid to the question regarding *Rituals*. I find this meaningful, as so much of the literature on disordered eating focuses on the behavioural symptoms.

The stories women tell about their experience of anorexia and of bulimia traverse a variety of discourses.

The student paused, let herself think of her own story. It was fraught with inconsistencies, with contradictions, confusions, complexities. She remembered from her own experience how pleasure was so closely connected to pain, how she believed in one thing, yet acted out another, how passionately she felt women should stand against self-policing their bodies, yet how difficult it was to let go of oppressive self-imposed rules and rituals. She remembered being highly critical of the images of women depicted in *Woman's Day, New Idea, Cleo, Cosmopolitan*, yet she would frequently slink into newsagencies and flick through the glossy pages. She was particularly hungry for articles on anorexia, simultaneously angry and envious, poring over photographs of emaciated women, noting the dangerously low weights, calculating how many kilograms she would have to lose to get like that. But

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[83] Alexander, Aroni, Timewell & Minichello 1995: 35–6.

particularly, she remembered how significant the psychiatrist was to her making sense of her experience, how powerful his knowledge was in shaping her, how entangled in his language she became.

In the diverse literature on eating disorders there is much research into the 'causes' of these conditions, be it problems associated with the hypothalamus, chemical malfunctions in the brain, abnormal regulation of monoamine neurotransmitters, 'dysfunctional' families, incompetent mothers, women as victims of societal pressure, or women in protest, women resisting culturally prescribed gender norms, martyrs, 'hunger strikers'. Such complex and contradictory explanations affect the stories women tell about their experience with anorexia and with bulimia.

The student could see, now, that her own narrative—her own story—woven covertly *(overtly?)* through her writing was continuing to evolve as her research progressed.

> *Illness narratives edify us about how life problems are created, controlled, made meaningful. They also tell us about the ways cultural values and social relations shape how we perceive and monitor our bodies, label and categorise bodily symptoms, interpret complaints in the particular context of our life situation; we express our distress through bodily idioms that are both peculiar to distinctive cultural worlds and constrained by our shared human condition.*[84]

I asked women how they would tell the story of their experience with bulimia. Some were tentative. 'My reaction is—I'd rather not!!'[85] Most identified the complexity of their experience: 'It would take many pages and some parts I don't want to think of or even write down'.[86] Some started with causes, or 'roots' of the problem: 'I don't think there was just one cause of my experience … I think that it was a mixture of things that impacted on me and 'bulimia' became my way of coping or avoiding them'.[87] As one woman put it, 'In summary, the root causes of my eating problems were low self esteem, an unfulfilling life at the time and the belief that losing weight would help

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[84] Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988) xiii.
[85] Questionnaire 5, 2001.
[86] Questionnaire 6, 2001.
[87] Questionnaire 1, 2000.

cure both'.[88] Most women noted a lack of self-esteem as important. 'I have always had low self-esteem, and wanted to lose weight, even though I was never overweight (until I became bulimic)'.[89] Another woman explained:

> I cope with most things that are presented to me in life but on another level I eat to fill an emotional void, to deal with stress or feelings of lack of self-worth and / or anxiety.[90]

Interestingly, this woman goes on to highlight the lack of support she receives as a woman.

> I do not feel supported by any significant person in my life—I am the supporter of others.[91]

Despite more recent socio-cultural shifts in the ways we live and their effect on the way family responsibility is negotiated, family life is still considered the domain of women. Within the domestic sphere, women are still perceived as the 'supporter[s] of others'. This has particular implications when we consider the planning, provision, preparation and serving of food. As Dana and Lawrence suggest,

> [t]he provision of food and women's role as provider of food has a powerful symbolic as well as practical significance. The preparation and giving of food is one of the ways in which women show their love and concern for others in their lives. From our earliest years, women are socialized into nurturing, taking care of others. The ability to please and care for others is an important source of our self-esteem.[92]

Of course the irony is that 'in spite of their central role as providers of food, women are taught to be very cautious indeed in the way they eat it'.[93] Like so many women, the previously quoted respondent held the responsibility for the family's food. 'I prepare [food] for the others but I don't eat the same type of meals and can't be bothered cooking for me'.[94]

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88 Questionnaire 4, 2000.
89 Questionnaire 4, 2000.
90 Questionnaire 5, 2001.
91 Questionnaire 5, 2001.
92 Dana and Lawrence 1992: 36.
93 Dana and Lawrence 1992: 37.
94 Questionnaire 5, 2001.

> The conclusion we are bound to draw from the evidence about women's dual preoccupation with providing food for others on the one hand and limiting their own food intake on the other is that the majority of women have an uneasy, and in many respects unhealthy, attitude to food. This does not mean, of course, that all women have serious eating disorders. What it does mean is that it is 'normal' for women to be caught in a conflict about food and eating and that this conflict has to do with meeting their own needs and those of others.[95]

This conflict about food and eating is complex—much more complex than a preoccupation with being slim. As respondent five continues:

> I am only slightly overweight and I believe I have a realistic attitude to body size and shape so that's probably not the focus [of the bulimia] for me.[96]

Instead, she reiterated a lack of acceptance, respect and support.

> I feel I am not accepted as an individual, my ideas are not respected, it's just basic rights that are not supported. I cope with that on the surface, [I am] quite assertive about my needs at times, but while I fail to take the additional step of leaving [the marriage] or changing the situation I use food as a stress release.[97]

The student remembered how the psychiatrist was able to sum up her struggles so neatly. She remembered how significant he thought her boyfriend was, how weight and body shape were a focus. She remembers how he encouraged talk around these subjects, how he had the authority over the development of her story.

When considering the story of their experience with bulimia some women related experiences of childhood.

> It's hard to know where it began—the signs of certain behaviours were there in childhood. I used food for comfort a lot and would escape into my room to eat and daydream.[98]

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95 Dana and Lawrence 1992: 37–8.
96 Questionnaire 5, 2001.
97 Questionnaire 5, 2001.
98 Questionnaire 6, 2001.

> Being adopted is part of my history, and living for about 12-14 months in a busy bakery I suspect I would have been fed bakery food on a regular basis to keep me happy as the records show I was an overfed baby—over weight.[99]

Significant relationships were mentioned as important. 'It began in my late teens when I was fresh out of school and diving headlong into my first serious relationship'.[100] 'When I was 25, I was going out with a gorgeous 19 year old. In order to keep him (I thought) I had to look good. So I started dieting and losing weight'.[101] Most women wrote of unhappiness in relationships with men, one woman identifying her husband's 'misogynist behaviour', writing that he was 'argumentative, full of put downs [and] ... caustic remarks'.[102] However, for this woman it was important for her not to see herself 'as having a victim mentality—I am quite pro-active in many areas of my life ... I yearn for self-sufficiency, independence'.[103] One woman said, 'It is my secret that I am unable to cope or need to avoid things at times and that I am imperfect. I want a secret and I want to be different, I want to be me'.[104] Another woman wrote, 'It became my life. A dark secret I lived with and God forbid if anyone knew'.[105]

One woman explained how for her, bulimia became a means of expression:

> When I hit adulthood and left home for the first time, I used the same coping mechanism to deal with the big, wide world. When I first left home I lost a lot of weight and enjoyed how I looked—but I couldn't sustain it. Things were going wrong in my world, and I desperately needed my friend food again. It's hard to say which came first, the depression or the bulimia, but they would continue to keep each other company over the years. Once I discovered I could have my cake and eat it, and throw it up, I felt safe and OK again. I became my expression of everything ... happiness, sadness, success, failure ... for all the years I was away from home, bingeing was my friend and bulimia was my enemy—a kind of reward and punishment.[106]

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99 Questionnaire 5, 2001.
100 Questionnaire 2, 2001.
101 Questionnaire 4, 2000.
102 Questionnaire 5, 2001.
103 Questionnaire 5, 2001.
104 Questionnaire 1, 2000.
105 Questionnaire, 3, 2001.
106 Questionnaire 6, 2001.

She goes on to explain how bulimia had her separating herself, keeping a public façade of a competent, contented woman separate from the anger, fear, confusion and self-disgust:

> I lived two lives, and separated myself emotionally between them—every now and then, at Christmas or birthdays, the two would cross over, but it was a constant juggling act between the happy, outgoing me that everybody saw, and the terrified, angry one behind closed doors. Good versus evil—the good being the face I showed, the evil being the 'real me'.
>
> I was destructive across the board—I would scratch and pick at myself till I bled ... I'd purposely keep myself awake for as long as possible ... I'd steal from my friends ... I'd hit myself with disgust. The constant vomiting was hard to do 'discreetly', so I would keep the vomit in my room till I could dispose of it. I wouldn't clean my room, my car, myself sometimes. At my worst I would start bingeing and vomiting from the time I woke up until the evening, or until my stomach and mouth couldn't take it anymore.[107]

Another woman also commented on this separation of self.

> I operate at two levels—one which is capable and efficient and the other which says, 'Who are you fooling'. Most often I can ignore the second and focus on the positive, but at a deeper level which is connected to the bulimia—there is doubt and a lack of self worth.[108]

One of my questions inquired what the term 'bulimia nervosa' meant to the affected women. The following respondent contests what she sees as the totalising effect of diagnosis. As in the practice of narrative therapy, where problems are 'externalised'—seen as separate from people—this woman is most comfortable seeing herself as distinct from bulimia:[109]

> As a rule, I hate labels—the idea of being labelled 'bulimic' as opposed to 'someone who suffers from bulimia'. The words themselves look ugly. I could not use the label for many years and used anorexia instead. It is a label of shame, embarrassment, fear and a total lack of understanding.[110]

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[107] Questionnaire 6, 2001.
[108] Questionnaire 5, 2001.
[109] See Michael White, *Re-Authoring Lives* (Adelaide: Dulwich Centre Pulications, 1995).
[110] Questionnaire 6, 2001.

To varying degrees, this feeling is supported by all respondents. 'To me ['bulimia'] is a shameful word. When I hear it, it triggers embarrassment and I change the subject quickly.'[111]

Similarly, the next woman believes:

> [b]ulimia has a much more negative image [than anorexia]. It is hidden, but the opinion of bulimia is that it is disgusting and fruitless, unlike anorexia. It is not usually seen or understood at all.[112]

This woman goes on to note that the thinness associated with anorexia is considered most alarming to society, despite the symptoms of bulimia also having grave health consequences, even resulting in death.[113]

> [Bulimia] is not treated with the same degree of seriousness either, because it's not considered to be life-threatening (even though it is and can cause permanent damage).[114]

Responding to my question regarding the perceived public awareness of bulimia, the following woman found that

> [b]ulimia is not 'seen' at all. It is hidden because the person hides it. It is a secret way of coping and you are not seen as the epitome of society.[115]

As highlighted in Questionnaire 4, the following respondent believes that our society has an unhealthy fascination with the emaciation of anorexia over the private suffering of bulimia. As someone who has grappled with both conditions and seen her body size fluctuate, her opinions are particularly pertinent.

> [With bulimia] you are normal—physically you are not seen to be suffering therefore society does not offer you help or attention. I believe they view you as someone who has attempted anorexia and failed—someone who is lacking in control.[116]

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111 Questionnaire 3, 2001.
112 Questionnaire 4, 2000.
113 See www.osw.dpmc.gov.au/pdfs/health_wellbeing/ Looking_Risky_paperApril2003.doc
114 Questionnaire 4, 2000.
115 Questionnaire 1, 2000.
116 Questionnaire 4, 2000.

This woman analyses cultural perceptions surrounding the shape and size of the female body, concluding that such prescriptive ideals contribute to the shame associated with bulimia, affecting women's willingness to seek assistance.

> I believe that being thin is viewed as successful, [being in] control and viewed as normal. Purging is viewed as disgusting and out of control. People with bulimia are less likely to seek help for these reasons which I believe leads to silent suffering and suicides that could be prevented.[117]

She goes on to explain that what she understands as the similarities between bulimia and anorexia involve cultural ideals:

> I believe that people affected by bulimia are striving for the same ideal and are hearing the same 'voice of anorexia' (meaning the self-talk that you experience is the same). It does not matter what size I am, I still experience this self-talk or what I call the voice of anorexia.[118]

The difference, she finds, is that,

> I feel more desperate, depressed and alone with bulimia because no-one offers help and you are too ashamed and secretive to ask—you are on your own. With bulimia you are not only fighting the voice of anorexia—trying to work against it—you are struggling with this 'normal' body size. People with bulimia and anorexia are still struggling with the same thoughts, the same ideal, body hatred and low self-esteem but it is not visible to society.[119]

The difficulty is how women grappling with bulimia can express themselves in a cultural climate in which it appears the body has to advertise the presence of a 'disorder' (ie: by being dangerously thin) before a woman's distress can be taken seriously. As this participant stresses, '[p]eople with bulimia still experience starving—it is just not as visible'.[120]

Interestingly, the next woman relates having physical 'difficulty with the word [bulimia] and its meaning'[121] indicating the level of anxiety admitting to the condition:

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[117] Questionnaire 4, 2000.
[118] Questionnaire 4, 2000.
[119] Questionnaire 4, 2000.
[120] Questionnaire 4, 2000.
[121] Questionnaire 5, 2001.

> I had trouble pronouncing it when I first began to refer to it, or try and mention I had it to professionals—most probably an emotional reaction rather than a vocab problem.[122]

As she goes on to suggest, the cultural associations with women denying food are powerful symbols of strength, control and femininity. As two other respondents put it:

> Bulimia is not 'seen' in the same way as anorexia and has more hurtful stereotypes associated with it because bulimia is characterised by vomiting (lack of control: therefore negative) whereas anorexia is characterised by self-deprivation (will power: therefore positive).[123]

> Thinness is seen as good and a sign of inner strength, so people can understand (in their own minds, not usually truly understand) at least how anorexia can start. Some (including me when I was bulimic) even envy anorexic girls.[124]

Troy Cooper believes the preoccupation with anorexia springs from the cultural construction of femininity.

> Culturally, anorexia is admirable because it is perceived in women as control of the flesh and of sinful or dangerous bodily desires, and as a corollary an assertion of spirituality, which appeals to strong social and religious traditions ... Bulimia, however, is the descent into the flesh. It is the apparent indulgence of the flesh, followed by its manipulation and self-abuse.[125]

Anorexia is perceived to be about purity, control, self-sacrifice, denial, self-sculpture, mastering the body, leaving the confinement of the flesh, setting the spirit free—an extreme perfection of femininity. On the other hand, bulimia is seen to be about fat, loss of control, being dirty, greedy, gluttonous, animal, about the horrors of the body. It is little wonder women struggling with bulimia express such embarrassment, self-loathing and fear:

> I still have a problem admitting to others that I overeat and then vomit—to admit to 'starving' oneself seems more acceptable—but to gorge oneself is linked with greed, loss of self control, weakness etc—which I find difficult to relate or admit to ... I think the issue is not that I am afraid to admit to a mental health problem

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[122] Questionnaire 5, 2001.
[123] Questionnaire 2, 2001.
[124] Questionnaire 2, 2001.
[125] Troy Cooper, 'Anorexia and Bulimia: The Political and the Personal' ed. Marilyn Lawrence, *Fed Up and Hungry: Women, Oppression & Food* (London The Women's Press, 1992) 181.

> but rather to owning up to making myself vomit, owning up to having too much to eat—to being 'greedy' etc or have people think less of me—of being perceived as a weak person.[126]

The next woman's thoughts concerning society's perception of anorexia and of bulimia are telling:

> I think about [anorexia and bulimia] hierarchically with anorexia being a rung or two higher on the hard-core eating disorder ladder than bulimia. As a bulimic I felt like I had a second grade eating disorder because I lacked the will power to be anorexic. The consistency of body size was an indication of failure to me. I didn't want a mask of normalcy—normal was too fat![127]

The following woman appears to wrestle with ideas of choice. Implicit is her belief that bulimia is a 'disease' and therefore difficult for her to control and yet the socio-cultural perception of it as 'a disgusting and chosen behaviour ... akin to the 'snap out of it' school of thought re: depression' has her assessing bulimia as 'the darkest period of ... [her] life':

> I'm still embarrassed to admit that I was bulimic. I think that most people consider it a disgusting and chosen behaviour, not a disease. To me it means loss of control and any shred of self-esteem; the darkest period of my life.[128]

In describing their experience of bulimia, most women mentioned the pressures to succeed, to be the 'perfect woman', reinforcing that a socio-cultural exploration of bulimia is an appropriate inquiry:

> I believe my period of bulimia resulted from being overly sensitive to and unthinkingly accepting of certain cultural pressures.[129]

> [Bulimia] is a way of coping with the pressures of society ... I believe it is a way that I fight with my natural body shape and refuse to accept what I am meant to be because it is not what society accepts.[130]

One woman wrote that for her, bulimia involved:

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[126] Questionnaire 5, 2001.
[127] Questionnaire 2, 2001.
[128] Questionnaire 4, 2000.
[129] Questionnaire 2, 2001.
[130] Questionnaire 1, 2000.

> the superficiality of society ie: the only thing that matters to a girl is her size which must be less than size 10.[131]

Although popular culture was never stated as a cause of bulimia, most women recognised it as significant to how they thought about themselves as women.

> I was an avid absorber of any form of popular culture; movies, fashion magazines, romance novels, TV—the whole gamut … I had money and a relationship—surely I had achieved two of the fundamental elements of the perfect life. Even with the clothes and the cosmetics and the affirmation of having a boyfriend I was still miserable. Clearly, this must be because I still, in some way, did not measure up to the 'perfect woman'. Slimness must be the final category. Everyone who appears happy and fulfilled in popular culture is thin—that must be the key. What had been a lingering dissatisfaction with my body shape escalated into self-loathing. My thinking narrowed further (if that is conceivable) until all I thought about was food and denying myself food. It became an obsession. Everything else in my life became sublimated to the prime objective of being perfect and manifesting this perfection in my appearance. The cycles of deprivation / binge / purge began. I started taking laxatives to reduce bloating and my life danced along to an additional rhythm. It was my secret life, and although the glamour had long worn away, my mind was still at the mercy of forces from which I felt powerless to extricate it.[132]

This respondent explains how difficult it was for her to consider alternative ways of being, when the powerful cultural forces she felt pressured by were further perpetuated by her type of job and relationship.

> My job and relationship were doing nothing to my sense of self worth, in fact I believe they were holding me back, reinforcing my lack of confidence and condoning those social ideals to which I was trying so hard to conform. I felt that my boyfriend would be my only opportunity for a long-term relationship (and associated self-validation) and that if I didn't grasp this opportunity to leave home it would pass by, never to return. We married, and immediately my bulimia escalated as I found the pressures of marriage more demanding of conformity than living at home.[133]

She goes on to reflect on the classification of bulimia nervosa as an illness. For her:

> the term 'bulimia nervosa' refers to a medical condition, but even as a bulimic I have never identified with it. It sounds like a physical illness that can be treated with medication or cured. But to me bulimia wasn't an illness so much as a state

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[131] Questionnaire 4, 2000.
[132] Questionnaire 2, 2001.
[133] Questionnaire 2, 2001.

> of mind, a period of obsession that only I could end by breaking down the old state of mind and building a new one.[134]

I asked women if they had ever sought medical assistance for bulimia and, if so, how it affected them. One woman wrote that medical treatment 'ingrained into me that I had a 'mental illness'—a condition that I must be *helped* over'.[135] She continued that medical treatment:

> stigmatised me in my relationship with my husband and family ... [and] made me think that *they* [the medical staff] would cure me and [I] began to assume that I couldn't do it alone ... [I] can't think of anything positive that came out of treatment other than the reassurance that I hadn't permanently damaged my liver with laxative abuse.[136]

Another woman wrote of her experience as a patient in hospital,

> [The] in-patinet unit forced me to re-feed and saved my life, but the artificial controls did not teach me how to live in the real world. I was not taught to challenge my own behaviour, thinking etc, like I feel the narrative approach did. But it gave me a chance biologically but not mentally to maintain it ... One lady I saw was into family therapy or should I say mother-blaming and put my whole problem down to parental conflict—not a good way of trying to obtain support from the family.[137]

During interview, 'Jane' (see Appendix), describes the experience of hospitalisation as 'really awful'.

> The bed program was so demeaning. You sit on this bed and that's what you do all day. You can't shower. You have to use a bed-pan. I found that so degrading ... I took great delight in cheating on many, many occasions. Sitting on that bed was so insular. I sat there for nine months. It's not teaching me any skills of living in the real world. It didn't teach me about eating with other people because I ate by myself. Of course I'm going to develop weird habits! They wouldn't talk to me about my body. I felt huge. Because you're sitting on a bed, the weight goes on disproportionately and it goes on as fat, not muscle, because you're not doing anything. I found it so hard to deal with my body shape changing. Everybody else thought I looked so much better, but I felt so much worse ... I felt like all they

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[134] Questionnaire 2, 2001.
[135] Questionnaire 2, 2001.
[136] Questionnaire 2, 2001.
[137] Questionnaire 1, 2000.

> wanted to do was to fatten me up and shove me back out. It was pointless. Every single time I was discharged from hospital my weight went right down again.[138]

Although 'Jane' believes hospital saved her life—'Physically, they saved my life'—she became frustrated that her experience of treatment was not honoured, that her voice was not heard. She tried to suggest changes to the bed program to her doctor:

> but he just wouldn't listen to me and I think that's because I'm a client. I'm sick. What would I know? After that I got really pro-active and really quite angry with everything. It was called the 'long term bed program' but I started to write—I wrote 'the 'Jane' program'. I made suggestions for him—like how degrading it is for someone who's totally capable of running more laps than him to use a bed pan ... And that made me deceitful. I would cheat. I would cheat and think, you think you're so wonderful, but I'm pretty damn smart too, you know. I got away with it for months ... It was cheating in terms of their program. They thought their program was infallible, but I would have broken every one of their rules. I got up out of my bed. I rolled oranges out of my room into the kitchen; and even when I left the hospital I wasn't my goal weight because I was strapping bottles of water to my stomach. I guess that was my way of keeping some control. They wanted me to get to 50kg and there was no way I was getting to 50kg ... So I never got to my goal weight in hospital. They thought I did, but I didn't. Thinking back I guess it was my way of saying, 'Screw you! You can't make me do what I don't want to do!' ... I gained my weight out of hospital.[139]

I was interested in 'Jane's' story as one of resistance. Although I appreciate that medical intervention saved her and undoubtedly other women's lives, I find it interesting that she was active in 'keeping some control' when the odds were stacked against her. I have heard many stories of 'cheating' the strict rules and regulations of treatment programs for eating disorders. In considering 'cheating' as resistance, I believe it is crucial to discern whether the woman is clear about taking a stand against the appropriation of her experience and body, or whether the 'cheating' is as a result of anorexia / bulimia's firm hold. 'Jane' is adamant that her position is against the authority medicine had over her, her body and how it was perceived she should recover. I think it particularly significant that her account of reaching her goal weight is framed as resistance. 'Screw you!' she declares. It is important to 'Jane' that her weight gain and gradual steps towards recovery happened outside of hospital.

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[138] Interview 1: 'Jane', 2000.
[139] Interview 1: 'Jane', 2000.

Another respondent found medical treatment helpful to feel 'normal', using it to justify eating disorders as

> the same as any stress related problem (ie: alcoholism, smoking, other problems) [and] that it was a mental health issue—[I] saw it in context ... [as] a way of coping.[140]

It appears that what this woman felt hindered her recovery was the disgrace associated with bulimia.

> I think the issue is not that I am afraid to admit to a mental health problem but rather to owning up to making myself vomit, owning up to having too much to eat—to being 'greedy' etc or have people think less of me—of being perceived as a weak person.[141]

She went on to conclude that 'not being able to explore deeper issues' was a problem of medical treatment and that it was 'not a nurturing enough environment—too clinical'.[142]

Most respondents indicated that the opposing cultural associations with anorexia and with bulimia were an anxiety-inducing feature of treatment. 'Hospitalisation was a problem because I envied the thin anorexic girls'.[143] EDASA actively challenges the un-spoken hierarchy of eating disorders, supporting all forms of eating distress and yet this woman felt so affected by the cultural stereotypes that even visits to this organisation were threatening:

> ABNA [now EDASA] helped (except that I couldn't stop envying the anorexic girls, because they had the control that I had lost).[144]

Another respondent explains that alternative forms of support, education and assistance to those specific to the treatment of eating disorders were of most personal benefit:

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[140] Questionnaire 5, 2001.
[141] Questionnaire 5, 2001.
[142] Questionnaire 5, 2001.
[143] Questionnaire 4, 2000.
[144] Questionnaire 4, 2000.

> Basically, the best help I got was not directly related to eating disorders, but maybe that was just the best order for my healing.[145]

I was interested to read of ways in which women had re-thought bulimia as something on which they had relied, as a friend, a survival technique or an indicator that all was not well with their life.

> It is helpful in the sense that it reminds me that all is not well emotionally—I can shut down and lose touch with my feelings and the bulimia is a constant reminder that I need to change the situation.[146]

This woman explains how vomiting 'get[s] rid of anxiety, stress. Usually I feel better after vomiting. [It is a] coping mechanism'. She states how bulimia acts as an escape from reality:

> I usually lose touch with my rational self while overeating—shut down—as if I was to really think about what I was doing (or my distress) I wouldn't cope so well.[147]

'Ruth' explained in interview:

> now I start to look at [bulimia] in a grateful way. If I have the urges then I should be looking at what's going on in my life. It's a really good signal. It's a really good barometer of how my life's going ... I've accepted that I won't get rid of it. I'll learn to live with it like any other ailment you might have. The thing was, that it *was* a friend. It was a friend when I was so lonely. It was my friend for many years. Not so much now, but I actually missed it. I mourned. I think there's a mourning period. I mourned the end of bulimia. I had to let go of my friend and that was very tough. It was very hard to say, 'Gee I miss... throwing up into every hole in the house'! I missed it, but now I'm OK because I developed looking after myself.[148]

'Ruth' also spoke of negotiating her relationship with bulimia, of being the one in the position of power:

> I kind of think, 'no, you're not getting away with being my enemy. I'm going to turn you into a friend. So I'm in control now and you will be my friend not my enemy.' I think that's important. Then you don't fear it any more ... I still don't

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[145] Questionnaire 6, 2001.
[146] Questionnaire 5, 2001.
[147] Questionnaire 5, 2001.
[148] Interview 2: 'Ruth', 2001.

> like it [bulimia]. I still wouldn't—if I had the choice—invite it to the party. But if it's going to be there I may as well invite it.[149]

'Ruth' had also done some thinking about what it would mean to be involved in my research, what her motivation would be. She decided that speaking about her experience with others:

> takes away its [bulimia's] power again, because it's all about secrecy. I mean I hate the damn thing. I still don't tell most people in a heartbeat about it. But then that gives it power again.[150]

The majority of women who completed questionnaires identified themselves as recovered. They constructed their stories with the benefit of hindsight. 'To recover, I had to make major changes to my life. I applied to get into university. I got in. That changed my life!'.[151] For one woman in particular, recovery involved much thought about herself and her place in the world:

> I left [my husband] after nine months and returned to uni and home (temporarily) while finding my own feet. I had started to think and the more thinking I did the more I realised that I had been living my life according to someone else's assumptions and opinions, not my own.[152]

She indicates that the development of her critical awareness, of forging her own belief system and engagement with education became more of a preoccupation, enabling her to re-think her previous concerns.

> The more occupied I became with generating my own thoughts and opinions about life and the how and why of the way the world seems to operate, the less interesting food and dieting became. In fact, quite quickly I came to look on most of my previous concerns and values as superficial and facile and as a result I was quite eager to distance myself mentally from the place I had resided for those two years. In my case it seemed all I needed was a paradigm shift. Now I look on myself as lucky to inhabit this particular body and remember that period of my life only distantly, as if I were another person back then, a stranger whom I wouldn't necessarily like.[153]

This woman went on to reflect that:

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[149] Interview 2: 'Ruth', 2001.
[150] Interview 2: 'Ruth', 2001.
[151] Questionnaire 4, 2000.
[152] Questionnaire 2, 2001.
[153] Questionnaire 2, 2001.

> [f]or me, bulimia was a lack of self-esteem coupled with a lack of awareness of how constrained our society is by cultural constructions of ideal types, especially where the female body is concerned.[154]

Interestingly, it appears this woman's recovery has involved a growing consciousness and appreciation of the cultural construction of reality:

> If we want to achieve something it seems that we can only conceive of the means to do this by looking to those ideals and trying to mould ourselves to them, regardless of any intrinsic lack of fit or inappropriateness. We have a very strict definition in our culture of what constitutes a worthwhile, desirable woman and lurking in many people's minds are unconscious yardsticks against which everyone is measured. If you want these people to like and value you desperately enough, you will attempt to conform to their expectations.[155]

This woman is highly critical of this socio-cultural practice and introduces notions of empowerment and the right to self-determination:

> This is a very disempowering way to gain self-esteem as it puts the power of judgment in other people's hands, ensuring that the goal is unattainable.[156]

Her 'secret' to recovery is a direct challenge to socially prescribed ideals and a celebration of difference:

> To me the secret was to make my own yardstick independent of culturally constructed ideals against which to measure myself and to value any divergence from socially accepted ideals and culture-driven conformity as a sign of personal strength and integrity rather than failure.[157]

Another woman wrote about the experience as a quest to find and accept herself:

> It's definitely been a journey of discovery—I couldn't bear to be myself. From absolutely hating myself, I found a way to love myself. I still don't know why I had to go to such extremes. So much of bulimia was about loneliness, about filling a void. It was about frustration and especially about anger. It was the only way I could express my anger. It was my expression of pain. Even now, when I feel it knocking on the door, there's almost always the same line-up of emotions. I'm angry about something, I feel alone, lost or bored. I never leant on it in times of

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[154] Questionnaire 2, 2001.
[155] Questionnaire 2, 2001.
[156] Questionnaire 2, 2001.
[157] Questionnaire 2, 2001.

> real hardship (like when I miscarried or my friend died). In hindsight, bulimia was about self-acceptance … It was all about learning to be OK with me.[158]

This line of research into bulimia nervosa has involved women's experience of growing up female in our culture, in our time. I believe it offers new accounts of experience to sit alongside medical definitions and the meaning perpetuated through popular culture and that the concerns these women have identified hold implications for the treatment and prevention of bulimia. I have come to understand the effects of our culture's preoccupation with anorexia over other forms of eating distress, how women affected by bulimia have struggled with feelings of humiliation, embarrassment and confusion, how they have felt misunderstood and demeaned and how this has hindered their seeking assistance and their recovery. I do not aim to describe the definitive experience of bulimia, but to contribute to a more rich understanding, turning what is often perceived as an individual character flaw, a disease, a disorder, a personal struggle, a weakness, a shame, into a public discussion that critiques larger social structures and reflects on the effects of culture on identity and on how we seek to make life matter. I believe contextualising experience—socially, culturally, historically—can be empowering and healing. Therapist Matra Roberston believes that considering and discussing the meanings of eating issues may lead towards self-nourishment, independence and empowerment.[159] In her own practice she has witnessed women forge their own maps of recovery, the process itself being a mapping of the social construction of eating disorders:[160]

> If we regard anorexia and eating issues from an individualistic standpoint, if we invite young women's lives to be pathologised, then anorexia [and other eating issues] will continue to be seen as another individual disorder. On the other hand, if we consider anorexia and eating issues to represent 'canaries in the mine', we have different possibilities for action. If we consider that eating issues are warning us about the hazards of consumer culture, the hazards of individualism, the hazards of a global economy in which some groups enjoy abundance and other groups are deprived, the hazards of a resourcing logic that we are applying to our bodies, our lives and the planet, then perhaps there will be the potential for dramatic social change.[161]

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[158] Questionnaire 6, 2001.
[159] Robertson 1992: 76.
[160] Robertson 1992: 76.
[161] Gremillion 2001: 149.

The student read through her work again and again. Each time she was equally impressed, equally moved by what the women had written, with what they had been able to share. It was an irony that women who had been diagnosed as sick, labelled mentally ill, who had been made to feel a deep and dark shame about themselves and their struggles were able to demonstrate such clarity, such insight and self-awareness, such intelligence.

The student printed off a copy and weighed the paper in two hands. She wondered if she was getting closer to knowing what she was doing. She felt a long way from 100 000 words.

There was a message on the answering machine. It was the post-grad she had shared a coffee with those weeks ago. *Hi*, she buzzed. *I just thought I'd let you know that the Creative Writing PhD has been approved and you can officially change your topic from tomorrow. I'm going in on Wednesday to get it all sorted, if you're interested. It sounds really good. You still have to do a critical essay, but it's only 20 000 words, so it's not too bad. I reckon I've got about that done already... Anyway. Just thought I'd let you know. Give me a call if you want to meet up. See ya.*

The student played the message back and felt a smile creep over her face.

The student had already started writing a novel in the midst of her research-based PhD. It was called 'Eating Lolly'—'Eating Lolly' because as a girl she had written something for school, something about what she wanted to be when she was grown up and she had decided that she wanted to be a shop keeper so she could eat lollies all day—because eating lollies felt so good—and her mum had said, 'Oh no, you don't really want to be a shop keeper. Why don't you say you want to be a writer, because you're really good at writing stories.' She remembered dabbing out her hand-writing with liquid paper, re-writing the sentence: *When I grow up I want to be a writer*, but still secretly thinking of her shop with all those colourful lollies displayed in boxes under her front counter. The memory always made her smile.

'Eating Lolly' was supported and illuminated by her research, but it also provided a point of departure. It offered a space in which to write an alternative story, an alternative to the strictures of medical definition, an alternative to the ways in which she had struggled to write herself. She had started this writing in secret, when she should have been doing something else—something that her scholarship officially supported. In the beginning, 'Eating Lolly' was going to be a story about a young woman living through an eating disorder, but when she started writing, Lola Belle—Lolly—was not even born. The story she needed to tell was much bigger.

*

'Eating Lolly' follows the developing relationship between Mumma and her daughter, Lolly. It is about the mother-daughter bond, love, family and food. It is about living through developmental stages, through childhood, adolescence and forging identity as a woman in this particular western cultural context, about the experience of pregnancy and motherhood. I move into themes on hunger, about cooking, eating, feeding and being fed, about our culture's perceived separation between mind and body. I also explore the power of the medical discourse in shaping how we think and feel about our health and well-being and our experience with illness. 'Eating Lolly' is about a young woman forging her identity, about her endeavour to make meaning of life, to assume power over her story and the way in which it is told.

> There is no running away from the problem ... of Women as Body: of suffering from an overexposure of physical visibility as a body combined with an impoverishment of genuine recognition as a person. As long as a woman is essentially defined by her body and as long as her body is appropriated by men, she will always have a problem of feminine identity.[162]

There is a history of women's bodies and experience being pathologised, of women as objects of study by medicine, psychiatry, psychology and social science, of women's

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[162] Roberta Seid, 'Too Close to the Bone': The Historical Context for Women's Obsession with Slenderness', *Feminist Perspectives on Eating Disorders,* eds. Patricia Fallon, Melanie Katzman & Susan Wooley, (New York: The Guilford Press, 1994) 21.

behaviours being interpreted as deviant. Historically, the female voice and body have been devalued and appropriated to suit patriarchal frames of reference. Male medical 'experts' have had the authority to construct more genuine accounts of the female experience, narrowing, limiting and constricting the telling of women's stories, using a clinical language which denies difference, individuality and emotions; a clinical language which obscures the social and political aspects of diagnosis and the power relations of gender. In 'Eating Lolly', Mumma has been raised under the authority of medical knowledge, deferring to the mastery of her father, a general practitioner. Her father's power is in recognising, explaining, naming and working to correct the abnormal. His medical frame of reference supports him in viewing his daughter in a particular way. Mumma's experience of adolescence, of her developing body, sexuality and her unplanned pregnancy are pathologised—shaped and understood by her father's reliance on the medical model.

I chose to explore the frictions of mind and body for the area simultaneously troubles and excites me. I grew up longing for something—starving. *My grandmother's lamingtons? My mother's secrets? The true story of myself?* It seemed my hunger was never satisfied. Women's hunger is an intricate and elaborate language, involving both the physical necessity for food and the more tangled desires for the less tangible: love, respect, intimacy, success, acceptance, security, freedom. Women's hunger is constructed as dangerous, as requiring control; women's eating as improper, sneaking, shameful. I baked cakes when my parents went out, hid the sticky, half-baked secrets under my bed, sprayed Mortein to disguise the smell. In 'Eating Lolly', I had Lolly burying fistfuls of sugar in the scrub, hiding food scraps in her bedroom. I imagined this was about awakening desire, the intensity of physical yearning, a confusion and fear over the insistence of the body and what it means to be a girl—a girl growing into a woman. The language of hunger is learned, reciprocal and interpersonal. Food choice and preparation, eating and feeding can be especially effective ways of impressing and affecting others and can be an important part of the establishment of identity. Hunger and eating are social metaphors that can challenge authority

structures, especially family dynamics.[163] 'Eating disorders' can be read as revealing women's struggles for autonomy, self-expression and communication.

> Food is not the real issue here, of course; rather, the control of female appetite for food is merely the most concrete expression of the general rule governing the construction of femininity that female hunger—for public power, for independence, for sexual gratification—be contained, and the public space that women be allowed to take up be circumscribed, limited ... On the body of the anorexic woman such rules are grimly and deeply etched.[164]

I thought about Lolly a great deal. When would anorexia begin? When bulimia? At a certain weight? When particular behaviours were measurable against the categories of the current 'Diagnostic and Statistical Manual of Mental Disorders'? When a medical professional confirmed a diagnosis? I had already started the story before Lolly's birth. This seemed significant. I was writing her mother's story too—and her mother's mother's. Shaping this story had me think of my own life in a different light. I thought about my great grandmother and the secrets of her life kept, literally, locked in the closet. I thought about the gaps in the stories we shape as families. Secrets, shames, shadows—*hidden things*, Mumma calls them. These would be meaningful in Lolly's story.

The student thought over her own experiences, the stories she had come to think of as significant. She wrote them into her secret file. They were too fragile to be scrutinised in her critical essay and she had come to realise they didn't just belong to her. They were also the property of her family.

The process of research and of writing 'Eating Lolly' has had me reconsidering my own experience and reconstructing stories about my own life. In exploring this phenomenon, I am not interested in playing into a confessional, tell-all culture in which public revelations are encouraged for sport. I am not interested in wallowing in my own story, in centring myself as 'expert', or in reducing the experience of eating disorders. In this critical essay, I have moved from the objective scholarly

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[163] Donnalee Frega, *Speaking in Hunger—Gender, Discourse, and Consumption in* Clarissa (Columbia: University of South Carolina Press, 1998) 4.

[164] Jaggar and Bordo 1989: 18.

discourse—a traditional, research-based PhD, that preceded it—into a more embodied writing, a writing which locates my self in relation to my subject matter. I think from my body. I write from my body, from spaces in time, from my wanderings into memory. My academic imagination is informed by my own histories, by the work of a great variety of authors and by those women who were generous enough to participate in my research. It is also shaped by my observations of people, by listening, being aware, by snippets of thought shared over a beer, by significant friends, family, peers and strangers. The knowledge I produce is simultaneously real / imagined, fact / fiction, enduring / ephemeral. It is coloured by memory and by my dabbling in embellishment. I re-think, re-read, re-write. Over the passed few years I have been making stories and growing my two children—my first, a daughter, my son born into the final stages of PhD chaos. I remember someone wondering if it is harder to give birth to a book. It's different, it's the same, it dredges stuff up, it changes the world and you. I have changed. I will change. I am changing. This telling is transforming my story.

After wading through a draft of this essay, someone said the experience was like reading a notebook—a diary. *It's all bits and pieces, all here and there and all over the place.* I was disappointed. I was hoping I was demonstrating the complexities of exploring illness narratives—life stories—how they are made up by a diversity of influences, how they negotiate discourses, how they intersect, how they shift and change over time and remembering. My field work, my studies in narrative therapy, my early experiences as a counselor and my own re-thinking of disordered eating have happened simultaneously while writing 'Eating Lolly'. This has not happened in an orderly fashion. If I were writing a true account of my shifting knowledge, my altering positions as this writing process occurred, I should have to include many references to my pregnancies, to my experience of sharing my skin, stretching myself around my children as they developed, feeding them something of myself. I should have to include many references to my experience of motherhood and an extensive record of recipes I tried when my thinking was stuck. 'Eating Lolly' was fuelled predominantly by date and walnut wholemeal muffins. I don't know what that says.

This PhD has involved a process of working things out. This is a continuing process of finding a place, of making meaning out of lived experience: '[t]he recurrent effect of narrative on physiology, and of pathology on story, is the source of the shape and weight of lived experience'.[165]

[165] Kleinman 1988: 55.

Appendix A.

From: *The Diagnostic and Statistical Manual of Mental Disorders*, 1994.

Diagnostic criteria for 307.51 Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify *type:*
Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the mis-use of laxatives, diuretics, or enemas
Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (*DSM-IV, 1994*, 549-50).

Appendix B.

Copy of 2000 Questionnaire

constructing bulimia nervosa

introduction

My name is Corrie Hosking and I am a PhD student from The University of Adelaide. I am researching bulimia nervosa from a Cultural Studies perspective, considering and valuing the experience and understanding of women affected. I have found that a thorough exploration of bulimia nervosa has been overshadowed by the medical, academic and popular fascination with anorexia nervosa. I hope to explore various perceptions of anorexia and bulimia, considering their impact on the clinical treatment of bulimia and on the bulimic woman's sense of self. I believe in the importance of personal experience, of those affected having a voice and feeling empowered in relating their stories. I am very interested in speaking with women who have an experience with bulimia, listening to their story of becoming, experiencing, and recovering, discussing their thoughts, concerns, interpretation and understanding of their bulimia.

If you have / had bulimia nervosa I am interested in learning about your experience. Your time filling out the following 14 questions would be greatly appreciated. Your involvement would not only contribute to my research and to a greater understanding of bulimia nervosa, I hope it would also contribute to your own sense of self awareness. If you would like to speak to me regarding this questionnaire, or are interested in being involved in an informal interview at a later date, please feel free to contact me. You can reach me by email: **chosking@cobweb.com.au** by phone: (08) 83398074, or by mail:

Corrie Hosking,
11 Ashenden Road,
Aldgate, 5154

Once again, thanks very much for your involvement.

1. What does the label 'bulimia nervosa' mean to you?

2. How / why did you first identify yourself as bulimic?

3. How would you tell the story of your experience with bulimia?

4. Some people have said bulimia involves many private rituals. (For
5. example: doing things in a set way, the eating of particular foods, associations with particular foods, hand washing, teeth brushing.) Have you observed any rituals in your bulimia?

6. Have you ever sought help for bulimia? If so what kind? (For example: counsellor, therapist, psychologist, doctor, psychiatrist, in/out-patient at hospital.)

7. How did the help affect you?

8. What was the most and least helpful thing about seeking treatment?

9. Perhaps you have seen someone very thin and thought they might be anorexic. In this way anorexia is said to be public; it is seen. How would you respond to such statements about the visibility of anorexia?

10. Do you feel that bulimia is 'seen' in the same public way?

11. Some theorists have described bulimia as hidden behind a mask of normality and as being different to anorexia because the bulimic's body remains a 'normal' size. How do you feel about this comment?

12. It has been suggested that the bulimic woman does not want to make a public statement like the anorexic woman. She maintains a 'normal' sized body telling the world that she can cope with anything. How do you respond to these ideas?

13. Have you ever tried to interpret what bulimia is all about for you? If so, can you explain?

14. Have you done any reading on 'eating disorders'? What have you read and how did you respond?

15. Have you ever read anything specifically on bulimia that you felt described your own experience?

Information Sheet: ***Constructing Bulimia Nervosa—Information to participants***

The University of Adelaide
Faculty of Arts
English Department, Napier Building

My name is Corrie Hosking and I am commencing research as part of my PhD in the English Department at the University of Adelaide.

My study centres on women's experience of bulimia nervosa. I am interested to speak with women like you who are living with, or have lived through bulimia, listening to your story of becoming, experiencing and your thoughts on recovery. I am interested to explore your personal sense of how and why your bulimia evolved, how it impacted on your day to day life, whether you confided in any friends or family and if so, the response you received. I would also like to talk about when you chose, or were forced into seeking treatment and what that experience was like. I am interested to hear any of your reactions to meeting with other women living with 'eating disorders'. If you feel you are recovered or on the road to recovery, I would like to hear your reflections on how you felt that process began. Basically, I am most interested in your personal stories concerning bulimia, your own interpretations and thoughts (not your parent's, friend's, doctor's or therapist's).

My method of conducting the study involves you completing a questionnaire and then our organising a time convenient to you to meet for an informal conversation. I imagine the meeting to take between 30—60 minutes.

If you agree, I would like to tape our conversation. Your name will not be connected with the tape. This study is completely confidential. You can rest assured that nothing said will be reported in a way that any individuals, institutions or organisations could be identified. I will use invented names to attach to interview notes. After I have made notes and possibly transcribed parts of our recorded conversation, the tape will be kept in a secure place in The English Department at The University of Adelaide. All confidential data (tapes, notes etc) are to be kept secure for seven years, in accordance with privacy considerations, and then destroyed. If you are not comfortable being recorded, I will take notes as the conversation progresses. You are free to check the notes of our conversations (whether the conversation is tape-recorded or not), and you are also free to look over any transcripts made from tape. If you wish to do so, I would ask you to indicate this on the consent form.

You are free to change your mind and withdraw from the study at any time. No reason for withdrawing is required. There will be no obligation to answer all question or discuss specific issues. Participation is always up to you. Interview material is free to be recalled up until I have completed all the interviews.

You are encouraged to call or email me for more details or to discuss any concerns or queries. Please also refer to the additional contact details for The University of Adelaide's Human Research Ethics Committee independent complaints procedure.

I look forward to your participation, to share my own experiences and new ideas concerning bulimia nervosa.

Most sincerely,

Corrie Hosking

Appendix C

Interview 1: Talking with 'Jane'.

How was 'anorexia' made sense of by your doctor / psychiatrist?

You're sick. You've got an illness. It's in this book, the DSM-IV—look. You need to get well and to get well you need to put on weight and then we need to deal with the things that got you there in the first place. To get well you need to put on weight before we start talking to you because you're irrational. Your thinking is irrational because your body weight is so low. We need to get you to your ideal weight.

Did you agree that you were irrational?

In a way I think I was—when you get to such a low weight your mind goes into survival mode. You're not thinking as clearly. But I definitely wouldn't say you're irrational. I still got through university.

I didn't want to put on weight—that's for sure. I was just doing what I was told. Mum wanted me to see the psychiatrist, so I did ... He wouldn't talk to me about my eating and he wouldn't talk about feeling fat. I think he should have talked to me about it—he should have talked to me about why I thought I was fat, about where I got the ideas from. But it was taboo—you weren't allowed to talk about the fact that you thought you were fat ... You can't talk to someone with an eating disorder about feeling fat!

I was doing what I wanted—to lose weight, keep safe where no one could hurt me. I didn't want to gain weight. I didn't want to work through anything. I was doing fine. I was looking after myself. I had a lot of will power which a lot of people respected.

To me, I was the first person who had found this [anorexia] and this was my experience ... I didn't associate with an eating disorder. As far as I was concerned, I was bettering myself ... I hadn't read any books. [Anorexia] was my best friend. It looked after me. It didn't hurt me—it kept me safe. I was succesful. I could do something. I was really good at it and society thought I was good at it too. But there

were the little things—I didn't have much energy, I was cold. But they were just minimal.

You're doing exactly what society wants you to do. It says—be skinny, be in control, be neat, be perfect, be flawless. And fat says—sloppy, out of control—those sort of things. So, to be skinny is the epitomy. I guess I looked at myself and I thought I can't do anything about my personality ... better focus on the physical. That's being skinny ... Being skinny means being happy ... You're going to be happy. You're going to be skinny, but you're never skinny enough ... I guess you don't grow up like everyone else. You don't have to face all the things about growing up, so it keeps you safe and protected ... It was like having a friend that kept you comfortable, safe and protected you from the big, nasty, wide world ... Also, when you're really thin, you're numb to all the emotions. You're not at your full feeling capacity. It meant that I didn't grow up, that I didn't have a female physical body. I didn't have a boyfriend ... I didn't want one. I didn't want sex. That was being safe. You didn't get hurt. But you didn't have much fun or experiences, either.

I went in [to hospital] because I was tired of dieting and the stress it was causing myself and everyone else. I didn't want to gain weight. I wanted to gain control over my eating, to stop the starve, binge, starve, binge, starve...

I found it a really awful experience. I wrote to the person who was in charge of the research because the woman who interviewed me handled it shockingly. She said, 'You haven't put your weight on the front of your questionnaire.' Well, there was a reason for that. She pulled me over and whacked me on the scales. It was the middle of the day. I had all my clothes on. I was used to being weighed in hospital first thing in the morning, empty bladder, nighty. So she shoved me on the scales and of course I was much heavier. She wrote my weight down. There were three numbers on the front of my questionnaire: my case number, my weight and my height. I was reduced to three numbers. I wrote all this to the principal researcher and I never even got a reply.

The bed program was so demeaning. You sit on this bed and that's what you do all day. You can't shower. You have to use a bed-pan. I found that so degrading ... I took

great delight in cheating on many, many occasions. Sitting on that bed was so insular. I sat there for nine months. It's not teaching me any skills of living in the real world. It didn't teach me about eating with other people because I ate by myself. Of course I'm going to develop weird habits! They wouldn't talk to me about my body. I felt huge. Because you're sitting on a bed, the weight goes on disproportionately and it goes on as fat, not muscle, because you're not doing anything. I found it so hard to deal with my body shape changing. Everybody else thought I looked so much better, but I felt so much worse ... I felt like all they wanted to do was to fatten me up and shove me back out. It was pointless. Every single time I was discharged from hospital my weight went right down again. But hospital saved my life. They definitely did that ... Physically, they saved my life.

I remember saying so many times to my doctor that the bed program really needs some changes and he'd say, 'It's a 25 year old program. It's worked for 25 years.' That's my point—25 years OLD! It's OLD it needs to be changed. But he just wouldn't listen to me and I think that's because I'm a client. I'm sick. What would I know. After that I got really pro-active and really quite angry with everything. It was called the 'long term bed program' but I started to write—I wrote 'the 'Jane' program'. I made suggestions for him—like how degrading it is for someone who's totally capable of running more laps than him to use a bed pan ... And that made me deceitful. I would cheat. I would cheat and think, you think you're so wonderful, but I'm pretty damn smart too, you know. I got away with it for months ... It was cheating in terms of their program. They thought their program was infallible, but I would have broken every one of their rules. I got up out of my bed. I rolled oranges out of my room into the kitchen; and even when I left the hospital I wasn't my goal weight because I was strapping bottles of water to my stomach. I guess that was my way of keeping some control. They wanted me to get to 50kg and there was no way I was getting to 50kg ... So I never got to my goal weight in hospital. They thought I did, but I didn't. Thinking back I guess it was my way of saying, 'Screw you! You can't make me do what I don't want to do!' ... I gained my weight out of hospital.

I didn't want to be labelled [bulimic]—especially when I started getting bigger. I started getting really cross when I wasn't skinny. You don't have a problem any more as far as society sees it. That made me really angry because I think that I was

probably the most depressed and the worst I'd ever been, the most out of control, the most miserable, the most helpless I've ever felt and that was when I was 'invisible' as far as society saw me, because I fit in. Everyone was happy with my weight ... I really didn't identify with that label. It has such awful connotations ... No one wants to know about that experience ... You hide. It's very much hidden suffering, suffering inside a bigger body.

Recovery for me would have to be total unconditional acceptance of my self and my body, to care for that and what I put into it. I'm caring for my body and what I put into it because I'm pregnant at the moment. But I haven't got a total, unconditional acceptance of my body and my self. It's changing, though. I do have a different perspective. When I first found out I was pregnant the other anxieties were so much bigger than weight gain. I think everyone thought that would be my biggest anxiety, but it wasn't. There were so many other things to think about. The weight's still an issue ... But you're not damaging yourself, you're damaging someone else and you want to give that person the best opportunity. I'm not that selfish ... I'm not that hung up on body image to compromise the life of my child.

Interview 2: Talking with 'Ruth'

When you think back to the early days, when your problems with eating first developed, did you recognise you had an 'illness' which was called 'bulimia' / 'anorexia'?

When I lost the weight - initially I didn't think of the anorexia side of things. I just felt very pleased with myself and happy with the whole situation so it didn't seem an illness in that respect. Then I became depressed through a lot of things and that started manifesting itself in an eating way. I thought, actually, that I was copping out by calling it 'bulimia' in some ways, 'cause I actually thought I was going crazy more than anything. I thought I was losing it. I could no longer control myself and I also had this thing happening food-wise. I didn't really connect the two, but I thought if I'm going to call it something... I need to ask for help from some people. I couldn't say what was happening because I couldn't describe it so it's easier to say 'I think I might have this'.

Can you elaborate on the development of your relationship with food.

Apparently I was an incredibly fussy eater. Food was a drama—always. I was a very slow eater. I was always the last one at the table, raised by parents who said you've got to finish everything on your plate. As a baby I would—Mum always said to me 'I'm not surprised that you have bulimia in some ways, because you'd always chuck up your food.' I was very much a reflux—if I didn't want it, it would just come up and that's actually something—I've never been a fingers-down-your-throat kind of person. I can do it automatically, so it's very easy for me, unfortunately.

I can remember watching my Mother. There's a very strong Mother connection. Mum was always in the kitchen—always in the kitchen—always feeding. It's almost a text book kind of thing. I felt ignored a lot so I'd take food into my room all the time. It was either in front of the television—and usually alone in front of the television—or in my room, alone. Mum would give me a lot of food all the time. Mum, in fact, was a huge eater, like, very big, embarrassingly big, her plate. I'd watch her, when things would upset her, go straight to the cupboards and just eat. She'd eat her main meal

and then eat afterwards but in secrecy while she was washing the dishes—all that stuff. So I think I learnt early that if you're upset, then food's a good thing and I always think it was my way of relating to her, because she wouldn't sit and listen, she was always in her world. Food's always been an escape for me. There's no use bingeing if I can't drift off with it and relax.

Covertly and sometimes overtly, there's a lot of 'mother-blaming' in the literature on eating disorders. I'm just wondering if you'd be prepared to say anything about your relationship with your father.

That's probably one of the hardest questions you could ask me. It's only just occurred to me in the past couple of years, this strength—in terms of that male thing and I've always been angry at males to some degree. I think I took on a lot of Mum's anger towards my father—and frustration. But it's only very recently that I've discovered—and I used to sit talking to counsellors and they'd say, 'You're always talking about your mother—what's wrong with your father?' My father was very much on a pedestal—that kind of relationship. But I actually found my relationship with him probably more disappointing even than Mum, because he is a very perceptive, switched on man and he knew I was sick long before Mum did and ignored it. Whereas Mum, I don't honestly think... I don't think anybody's totally blind. I think she had far less ability to see it and far fewer skills to deal with it. My father actually chose to ignore it. So there are some problems there. I was very angry at the beginning of the year at my father and I know a lot of anger has come out in my relationships as well. I don't trust men. I don't have any reasons in a sexual manner—less in terms of the abuse side, but I almost don't trust them on the same level. From a lot of the reading and people I've spoken to I sort of think, wow—that's fairly entrenched.

That on-a-pedestal kind of thing—my father just adored me when I was born, which was wonderful, but Mum said 'it was the biggest disappointment of his life when he found out that you weren't coping.' He couldn't cope with the fact that I couldn't cope. He just couldn't deal with it. He couldn't look me in the eye or anything. He had set me up ~~to be up~~ to be perfect and I could never do that and that's all part of the eating disorder thing, the high standards. It's taken me years to break through those

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high expectations and they would have come from my father—definitely. Not my mother. There's a lot of responsibility.

Could you say more about what those high expectations were?

I've always been raised on your-best-is-good-enough and if you're not coping you just quit, you just get out of it. It's a real underlying thing. It's not to do with my career—that's how I translate it. It's 'the perfect girl'. Dad can't deal with the darkness. I could be high achieving, low achieving whatever, but there are so many sides to me. I was a tiny little thing with dark curly hair and he just expected that to be a doll all its life. His good memories of me are always of laughing and giggling. He didn't cope well with the cross-over from girl to womanhood I don't think—I think, but who knows. Dad doesn't have many skills emotionally as an adult. He's very dependant.

You mentioned the transition from girl to womanhood—was that a particularly difficult time for you?

Oh yeah. It was eighteen. I'd just left home. This all started when I left home. I was just so disillusioned with the world. I don't think I've ever really wanted to be a woman. It's just an absolute nightmare. I just couldn't cope. I was raised in a very loving warm family, but with no skills for the outside world—at all. So the transition into womanhood was fraught. I had no idea. That's where I started to separate, putting on the brave face, 'yes I'm coping'. I just couldn't understand it, when most of my friends were back here going to uni, meeting boyfriends and getting married I was sending myself off interstate to do jobs, living by myself—miserable as all hell—off overseas at twenty-one when I couldn't cope. These high expectations.

That's interesting. I chose to go overseas, too, thinking that I was going to re-invent myself over there, be someone new, find out who I was—all of that.

I found out that the person I thought I was I didn't like. Who's this horrible person that I've taken with me? My first trip over seas was just a nightmare. Just a nightmare. I was kicked out of a house that I was nannying in 'cause I had stolen food

and got sprung for it and blamed the child—that goes against everything that I am. Horrifying. The girls that I was travelling with ostracised me—you know, I was a mess. I wouldn't have wanted to hang around with me. Just a nightmare, which is such a shame because everyone goes for this adventure and it was all horrible things for me.

Have you got any thoughts on this idea of food as a coping mechanism?

I've got one friend that thinks her body's OK. Everyone, like my flatmate, she doesn't want to stay at home in case she gets into the cupboards. I'm an extreme version of her. I think food fills a void. It's a power thing. I think men have money, that's their power. We have our bodies and that's our thing of status. It's very entwined with who we are and how we're admired by other women. I think it gets passed on 'cause it's a cultural thing. But that did change. There was never a weight issue up until a certain point, really. We are still certainly the nurturers. All the women I know are the ones to say—I always say 'come over to my place and I'll cook for you' to my male friends. It's our way of being able to show we care and it is quite a status to be able to cook and the guys love it! Absolutely love it! You're in! I can't cook though—that's probably why I'm single.

You mentioned your sense of spirituality. I was wondering if you could elaborate on this in relationship to food and how you experience your body.

I was raised Catholic. When I say strict... fairly liberal thinking parents but, you know, we went to Church every Sunday, we went to Catholic schools and I was a very spiritual person, probably more so than the other kids in my family and would always question and so forth and always went to church and was glad for it. Soon as I left home I stopped going. I didn't even realise it at the time, but I think something was very much missing in my life and I didn't pay attention to that and it became really ugly. Now, part of the religion thing is punishment and guilt—guilt is very strong thing, especially for bulimia and especially for Catholics, so I was just waiting to happen in terms of the guilt. Food became a reward but also a punishment—especially the vomiting for punishment, that's punishing myself and that's guilt and that's for the evil that I was and any of the good that I was doing was

actually just me kidding the world. So essentially it was all evil and the fact that I was being nice to you was me trying to get something out of it. I didn't do anything for the sense of giving. It was always punishment. It was always bad. I was good or bad. If I vomited I was bad. If I was able to abstain for a day I was good. There was no middle ground for most—for all of the eating disorder. Certainly for as long as I felt that about myself. God probably didn't exist for me for a couple of years and if he did I was very angry at that and didn't want to know about spirituality, yet when I started to address it I had the fastest healing stage. I haven't gone back towards Catholicism, I've leant towards Buddhism a bit more because it's very forgiving, non-blame based. I consider myself very spiritual now. I totally believe no one can heal from an eating disorder without addressing all of it. But it's not religion.

You said that you associated the vomiting with bad. I'm wondering if you saw the process of vomiting as a cleansing thing at all. I ask because you made mention of vomiting in the shower.

I'd feel dirty with a full stomach and cleaner with an empty one. Absolutely. Just another thing on that evil theme: I did feel for a long, long time almost possessed by something else and I looked into a lot of past life stuff and kind of wondered if there was something being played out and still actually believe that too. I believe that I brought something into this life and will take something into the next. Some really unresolved evil came in with me... I probably don't like the word 'evil'. It's a bit demonic. You have all those images when you grow up and one way that was healing was to imagine bulimia being the devil on one shoulder and the real me being the angel on the other. So it was still a fight between good and evil.

Considering that image, would it be right to say that you didn't feel bulimia was you—your whole personality? I ask that because some women have commented that when seeking treatment they were labelled 'bulimic' as if that was all there was to them, not like they were an individual person.

I have a huge problem with that. A huge problem. Being labelled 'bulimic'—it's disgusting. It really gets up my nose. It's really unfair.

Would you be prepared to talk more about your experience of seeking help?

I was only in for two weeks. I put myself in for the initial, you know beginners stage. I can say it's one of the proudest times of my life, because I got in there and made the most of it. I borrowed books from their library and sat and read and wrote notes every day, went to their yoga class—the one yoga class they had—see that's a point in itself—their occupational therapy and then that was it. I had a therapist / psychologist who was younger than me, straight out of uni and, no disrespect, but this guy was not going to help me. Things like the yoga—I came out and wondered why they didn't have that every day—touch therapy, painting, more craft. You just stayed there and that's all you did, with all the other psychiatric patients. Terrible place. My other experience was at the ******* and she didn't even remember what we spoke about last time, so I'd spend the first fifteen minutes reiterating the previous meeting. At least humour me and pretend—or try to pretend! So damaging and I never sought treatment for another ten years after that—probably seven—~~b~~y why would I? By that stage I agreed that I was just being selfish and attention seeking—all that stuff.

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That really worries me that at the most crucial time for women to be finding their own voice ~~their~~ they're actually being treated as a textbook case—'Patient 785. Bulimic.' they're /

The thing is they're just feeding back into it, because that's what you feel like anyway. You have no identity. When you take on an eating disorder you have no identity and then they just reinforce that when you walk in. And the looks! You could see on the nursing staff—the spoilt brat thing. Attention-seeking, little pansy-wansy. I hear it out in public. There's very little sympathy for eating disorders. Very little.

Just start / stop eating—whatever the case may be. It's a matter of choice.

It's a choice and you're just worried about the size of your arse and you're just selfish and look what you're doing to everybody else ... They feel like slapping us, I'm sure, and saying, 'grow up, you idiots!'

I'm at the stage—and I have been for the last couple of years—what I'd call the recovery stage which is just as important—more important—than the illness stage.

Even that's fraught with problems. You go back to being 'normal' but you're still living with it. I've found that very difficult. Not that I got much support when I was sick, yet I got even less when I was supposedly well. I think there'll need to be a lot more addressing of that time. How do you go on and cope with it? Like an alcoholic. I envy alcoholics. The fact that you can go to an AA meeting. I was watching ER [TV show] and one of the characters had these regular AA meetings and you also have a sponsor and you can turn to them any hour of any day and I felt really sad 'cause there's nothing that I can turn to. How do you ring your friend and say, 'I really want this chocolate bar'. You know, it's like, 'And... your point is?' It's the hardest, hardest thing. It makes me proud of myself in some respects because I got myself through it. But in another way, I've had it since I was eighteen and ... my growth was stunted. Everybody else was going out in their twenties, going through their natural growth process, mine was stunted. I've hit thirty-three now and want to be doing the same things that should've happened when I was twenty-three. I've been going out, going to nightclubs. It's like waking up out of a coma and trying to start life again. It's very difficult and there's no real support for that either in terms of the eating disorder. There is if you... I found some really good help from this woman at ***. I'd gone there about a relationship and she was actually the one that kept referring to bulimia as 'That's the voice of bulimia'. I'd say this and this and this and she'd say, 'Sounds like that's the voice of bulimia' and I'd say, 'That's not me? Really?' It's that separation. It's ironic you've got to come back together and then separate again.

Now I start to look at it in a grateful way. If I have the urges then I should be looking at what's going on in my life. It's a really good signal. It's a really good barometer of how my life's going. A great example is when... I've had this on-off relationship with this man for four an a half years. It's over now, but we got back together towards the end of last year and I'd had this fantastic year. Last year was actually my time of letting go of the habit and all that sort of stuff. It was about Christmas time that we got back together again and suddenly this thing was out of control. I was in denial because it had to do with him. I'm not blaming him for it, but my psyche was saying, 'this is wrong'. I was grateful to it. It scared me and upset me that I had it again, but at the same time I thought, 'no thankyou, you bastard!'

I'm interested in how you've come to see bulimia as your internal barometer for how your life's going and if you have anything more to say about the idea of eating disorders being an attempt to cope etc.

I've accepted that I won't get rid of it. I'll learn to live with it like any other ailment you might have. The thing was, that it *was* a friend. It was a friend when I was so lonely. It was my friend for many years. Not so much now, but I actually missed it. I mourned. I think there's a mourning period. I mourned the end of bulimia. I had to let go of my friend and that was very tough. It was very hard to say, 'gee I miss... throwing up into every hole in the house'! I missed it, but now I'm OK because I developed looking after myself. It also makes me mad. I kind of think, 'no, you're not getting away with being my enemy. I'm going to turn you into a friend. So I'm in control now and you will be my friend not my enemy.' I think that's important. Then you don't fear it any more. That's the thing, isn't it? For a while, it's like, I'm so afraid it's going to come back. You're only fearing yourself, essentially, which is awful—to be afraid of yourself. That was one thing that came up a lot with therapists, the fear of yourself. 'You're so afraid of yourself, but you're in control of that so why are you afraid?' 'Yeah, but you don't understand. It just comes up. Your own stuff.' I still don't like it [bulimia]. I still wouldn't—if I had the choice—invite it to the party. But if it's going to be there I may as well invite it.

Is there anything else you'd like to add?

There is so much to say. I'd be interested to know... A couple of people I've told that I'm doing this sort of thing [being involved in research], it's like, 'Oh! I suppose you'll get a lot out of it as well.' I hadn't actually thought that way. I suppose if I get some feedback on the common threads. A couple of the things you've said today, I've thought, Oh really! Somebody else has said that! So that's interesting. I was trying to think what is the motivation for it [being involved in research]? It takes away its [bulimia's] power again, because it's all about secrecy. I mean, I hate the damn thing. I still don't tell most people in a heartbeat about it. But then that gives it power again.

You mentioned your involvement with ABNA (Anorexia Bulimia Nervosa Association). Do you have a sense of looking for a collective? Were you, in a way, looking for other people with similar experience?

I suppose there's always a part of me that is, but I've never actually found that person. I feel like I'm in a fairly unique position. Of all the reading, after all the people I've met nobody's had it for as long and as intensely as me—it was fifteen years. I still go to doctors and go, 'are you sure there's nothing wrong in that area!' I'm having a colonoscopy in June because I just can't believe that nothing's wrong up there. It's not so much finding other people [who have had bulimia] it's probably finding understanding from the people who went through it with me. I don't need to sit in a group and share experiences, but I really like... some stuff that I wrote for ABNA for their last newsletter I gave to Mum and that was very touching and moving for her and I thought, 'yeah it is actually important that you know what I went through' for some reason. It's all my adulthood up until this point. If you define 'adulthood', 'adult' equals bulimia and that's why I'm starting again. It's a whole new thing. I'd be interested [in hearing of other's experience] but it's not something that I'm craving.

I wondered how you felt about that because people have asked me when eating disorders become a social issue—a political issue—as opposed to an individual problem. You could see eating disorders as one end of the continuum of women's relationship to their bodies. There's that view that it's a trivial problem because women are encouraged to curb, control, moderate, measure and modify their eating in aspiration to the feminine ideal. Women are always going to worry about their bodies, to diet etc. It's 'natural' in this climate. I wondered if you think of your experience in those sort of political terms.

Yeah. I think that was the main motivation with working for ABNA. If anything I can give is a site for change, then I'm more than happy, because yes, it is a terrible sad inditement on society, that half the population can be devalued like that. But I still do it to myself. I still devalue my problems. It's not until I sit and write something that I think, 'Bloody hell! Bloody hell! What did I go through!' and it still shocks me to this day. I can't believe it. I was working in Canberra, doing a breakfast radio shift.

Now I'd be up at ten to four, of a morning—that in itself is bad enough! But as soon as I got home at mid-day I'd start bingeing and vomiting—all day—until ten or eleven o' clock, get up the next morning and I did it for six months. Every now and then I'll say to a friend, 'I don't know how I survived that! I don't know how I did that.' It astounds me. It makes me so angry that society goes, 'You're stupid. You're a stupid woman.' Probably, politically, I can't see me contributing back... you know, I don't want to be sitting there listening to someone who's going through it. I don't want to dwell on the past. How can we start helping before it actually happens. I'd like to see that happen with younger girls beforehand, redefining how we see ourselves. It's not changing. there's a slight shift with the weight thing, but again, that's a body thing. That doesn't address how we see ourselves. But you talk about anything [like that] and suddenly you're a feminist Nazi! Damned if you do, damned if you don't. You also don't get a lot of support from women, either. There's so much fear. One of the girls I was overseas with, she knew—I had told her before I left—not that it was her responsibility, but she did know that I had been suffering from bulimia and that I was hoping I'd be OK while I was away. She knew the whole time and it was getting worse and worse while we were travelling and she knew the whole way but I think she had just as many issues to deal with. So, she wasn't going to help me. She was just angry at me.

I don't feel like I'm out to save the world. When I say 'giving back'... it's kind of like... say someone's had a heart attack and then they volunteer at the hospital. Nah, nah, nah. I don't want to get caught up in all that shit. I don't want to stay there. I don't want to dwell on it. It's like I was saying before. But, unfortunately some information still has to get out there. I still can't cut through the shame—the 'revolting' part about it and the fact that I had such a chronic illness for so long and it's till not even spoken of—it is in my family, but not in my wider family. If somebody else had cancer for ten years... I find it incredible. No body mentions the word 'bulimia'. There is nothing pleasant about it, but that's all part of the illness. We actually choose something very unpleasant that going to be in your face. For such a perfect little child to choose such an ugly expression... It's got a long way to go. I don't see any improvements. To be quite dismal, I don't see any hope of change at the moment.

close up

It's not really the cultural climate that is supporting women feeling good about themselves. There are plenty of invitations for women to feel continually crappy about themselves.

That's right. You never measure up. I see women around me and... I can kind of sniff it out. You can kind of see behaviours and attitudes and think, 'That's a problem'. But even I think I would approach somebody if I thought they might be an alcoholic , but would I approach that person with bulimia? I don't think so. I don't know. Would I have wanted somebody to approach me? I don't think so. Where does the help begin? It has to begin in this way. It seems that you have to take yourself there and it's really interesting that you do because there are no other resources for you to do it and it's such a difficult one. Every day we have to eat. Every day we're hit with images. I don't think it could get any harder if you tried! That's the thing. Just listen to how hard it was—even if it is just for a bit of sympathy! I don't care! I mean for God's sake! I had to do all that, mop it all up and hate myself for years. Yeah, I wouldn't mind a bit of sympathy, actually! That bedside manner! I don't know if what comes out of that is a strong person. I'm sure there's a very admirable strength in both of us. We'll have to pat ourselves on the back! I'm very lucky that I have couple of very good people in my life now that do praise me and it catches me off guard.

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Errata: *Eating Lolly*—The exegesis

p. 18, line 1: 'being' should be been

p. 31, line 10: 'struggle' should be struggled

p. 41, line 23: insert full stop, line 25: insert 'when'

p. 75, line 10: 'passed' should be past

p. 87, line 30: delete 'to be up'

p. 88, line 30: 'over seas' should be overseas

p. 89, line 1: 'an' should be and

p. 91, line14: 'by' should be but, line 17: 'their' should be they're

p. 94, line 16: 'other's' should be others'

p. 95, line 27: 'No body' should be Nobody

p. 97, line 11: 'Crystallizationb' should be Crystallization