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Constructing Ourselves
Women, Eating and Identity

Francine Robillard

A Thesis

in

The Department

of

Sociology

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts at
Concordia University
Montréal, Québec, Canada

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ABSTRACT

Constructing Ourselves
Women, Eating and Identity

Eating disorders in general, and bulimia in particular, are phenomena which are becoming increasingly prevelant among women in North America. Although these behaviours have generally been categorized as mental disorders, this study takes a more sociological approach to 'eating disorders' and concentrates on the social elements intrinsic to such behaviour.

Relying on the conceptual frameworks offered by certain social constructionist sociologists of the body, this study explores the relationship between body, eating and identity. Emphasizing the element of choice which is intrinsic to the participants' bulimic behaviour, this work explores how the women in this study socially construct themselves around their 'disorder'. Unlike the more popular tendency to say that we are socially constructed beings, independent of our will, this work reveals that, in fact, we also socially construct ourselves based on the options available to us, at any given time and place in history.

Acknowledgements

This study could not have been completed without the participation and cooperation of various people. Most importantly, I would like to thank the women who chose to participate in this research and who gave so much of themselves during the process. What had been, up to now, a very private aspect of most of these women's lives is revealed in these pages. Their courage and honesty is admired and I hope that I have managed to do justice to their stories.

Also, I am very grateful and indebted to Dr. Caroline Knowles for her inspiration, her insight and her unwillingness to accept mediocrity. Thank you, also, to Dr. Anthony Synnott and Dr. John Jackson whose constructive criticism helped me to clarify and do justice to the ideas presented herein.

Finally, completing this work would have been much more difficult had it not been for the undying support and encouragement that I received from Ulysse St-Jean. For this, I am eternally grateful to him.

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Introduction

According to the latest Canadian statistics, more than 5% of the female population between the ages of 14 and 25 have an eating disorder (1993 Statistics Canada report obtained through National Eating Disorders Information Centre). This overall category of eating disorders includes anorexia nervosa (1-2%) and bulimia (3-5%). Although these figures are not epidemic in their proportions, these numbers nonetheless represent a considerable portion of the young female population in Canada. Translated into absolute numbers, the above percentage represents close to 180,000 young women who have been 'diagnosed' or labeled eating disordered. These statistics do not include, however, the percentage of women over twenty four who also have an eating disorder. When all is taken into consideration, then, one can see that eating disorders, have, become an issue of significant social relevance.

Perhaps due to their prevalence or perhaps due to an increased understanding and 'acceptance' of eating disorders, bulimia, anorexia and even obesity have become 'hot topics' in recent years. Unfortunately, the direction of much of the work produced in this area is either towards an increased medicalization of the phenomenon or it takes the tone of absolving those who are eating disordered of the responsibility for their behaviour, while 'laying the blame' on that abstract and inanimate object, society. What I hope to produce is a more sociological look at one of the classified eating disorders: bulimia. Having been bulimic myself for many years

and having a personal insight into the behaviour categorized as bulimia, I was interested in going beyond my own insights and applying theoretical knowledge to the world that I had, thus far, known only through experience. Interested in discovering how bulimia enters lived experience, and how it helps to shape one's identity, I have undertaken the task of investigating, through the stories of various women, what I consider to be socially relevant aspects of bulimia.

How does bulimia enter lived experience? To what extent does bulimia direct one's daily activities and how much does it impact on one's overall life choices? Furthermore, how relevant is the popular argument that seeks to absolve eating disordered women of the responsibility for their chosen behaviour? Is the social structure so overbearing that it has the ability to dictate the behaviour of a relevant proportion of the female population? Or is agency an appropriate concept, applicable to a discussion of eating disorders? Finally, do bulimic women, through their behaviour, reflect certain cultural narratives which encourage them, and other women, to be overly concerned with physical appearance? Such are a few of the questions which have inspired the work proposed herein. They, along with a number of others, will be explored and developed, with the help of the respondents and the stories they shared. What follows is a short overview of the frameworks of knowledge which have inspired this study as well as an introduction to the concepts and issues developed herein.

Theoretical Considerations

This thesis has been inspired, in large part, by a social constructionist perspective. This approach, which emphasizes the primacy of social norms, values and ideologies, states that individuals are molded through the social world. Individuals' practices are informed by the social reality which surrounds them. Although some social constructionist thought advocates a reductionist view of socialization, this work takes the approach that we, as human beings have the ability to build and to rebuild our social and personal identities and that, furthermore, we have the ability to interact with the social structure intended to shape us.

Because this work deals with women and the construction of their identity as it refers specifically to bulimia, feminist influences are also present within. Although feminist ideologies do not make up the predominant inclinations of this work, they are inevitably filtered throughout. This is because much of the work that exists in relation to women, eating and identity has been produced by women located somewhere along the continuum of feminist thought. Those which specifically address issues of eating, body and identity (Kim Chernin 1981, 1985, Susie Orbach 1986, Judith Rodin 1992, Chris Shilling 1993, Eva Szekely 1988, Naomi Wolf 1990) are important because they help to demarcate the gender narratives which inspire the behaviours and practices of women who engage in bulimic behaviours.

Selfhood and identity

Identity is a concept of inherent value to this work. How bulimia enters lived experience directly relates to the bulimic's identity. It speaks to who she is and how she experiences life as a woman in our North American culture. That the prevalence of eating disorders is a relatively modern phenomenon reflects the conditions in which many women live within our body centered culture. Furthermore, it speaks to the changing norms, values and practices which inform notions of female identity.

Contemporary theorists of self and identity will be explored in order to contextualize the theoretical influences of this research. The construction of identity is a central notion to this investigation. A brief review of existing theories of self and identity is important if an exploration of the ramifications of this process is to be undertaken in the analytical portion of this work. Because identity permeates much of this work, it is a difficult concept to compartmentalize. It is a thread which is woven throughout the more distinguishable concepts of this work and, as such, it adopts a somewhat more subtle presence than the other concepts being developed. However, it shall resurface within the conclusion, where it's intrinsic nature will be made evident.

The embodied self

The body, in this research, is considered an important component of identity formation. It is the 'vessel' through

which most of us experience life. The body, that physical entity which every human being lives within and from, is not only a natural and biological vessel, it is also an entity imbued with social meaning and symbols. It is the primary and most widely recognized component of being and, according to sociologists such as Anthony Synnott (1993), the body can be even be interpreted as self. In this light, the body becomes a very crucial concept to the frameworks of knowledge being developed herein.

A very thorough analysis of existing theories of the body and a discussion of their impact on sociological thought can be found in Chris Shilling's The Body and social Theory (1993). Providing an overview of social constructionist and, to some extent, feminist accounts of the body, this work serves to inform theoretical notions of the body in contemporary thought. An archeology of the body and its senses, as found in Anthony Synnott's The Body Social (1993) also offers key ideas around the body and self which are crucial to the development of this work. Others of Synnott's writings on the body, notably "Tomb, Temple, Machine and Self: The Social Construction of the Body" will help to delineate an historical interpretation of the body.

The concept of a gendered body is also relevant to this work. Approaching the social construction of the body through sex, Robert Connell (1987) argues that, beyond gender differences, sex differences are also largely socially organized. Using the concept of the gendered body will help to

exemplify the extent to which women and men are socialized differently. His work, therefore, will help to inform the underlying principles developed in the analytical portion of this work.

Eating disorders

Being defined as bulimic is the criterion by which the subjects of this research were chosen. Eating disorders are inevitably a phenomenon which requires specific attention. One of a range of eating disorders, bulimia might be considered as an extreme expression of what Eva Szekely calls the 'relentless pursuit of thinness' (1988). Traditionally, treatment of eating disorders in popular literature has focused on the psycho-medical aspects of both anorexia nervosa and bulimia (Handbook of Eating Disorders 1986, Body Traps 1992, The Obsession 1981, the Golden Cage 1979). Although this medico-pathological approach to eating disorders will be problematized, it nonetheless represents an important component of this work because it offers an understanding of eating disorders that is widely accepted and which, consequently, organizes the experiences of many bulimic women.

In order to more fully understand the social dimensions of being bulimic, however, it is important to listen to the women who are bulimic and to read the stories that they tell. How these women interpret their experience and how they relate their eating disorder to their concept of self and self-development are issues which will be developed through

interviews and, subsequently, the textual analysis of their stories. Although much of the information on eating disorders will ultimately come from the women themselves, there are nonetheless important sources which address this issue in different ways. Kim Chernin (1985), Eva Szekely (1988), Susie Orbach (1978), and Tilmann Habermas (1992), for example, all take a socio-political look at eating disorders. To varying degrees, these theorists locate eating disorders within a continuum of weight and food preoccupation and they explore the consequences which medicalization has on those women so defined.

Conceptualizing choice and agency

There is a debate in sociology over whether reality is external and independent of individuals or whether individuals participate in the creation of their reality. Social constructionists usually adhere to the second possibility. They stress that social reality is constructed and reconstructed by actors and that "social phenomena do not simply have an unproblematic objective existence, but have to be interpreted and given meanings by those who encounter them" (Davina Allan 1993:684). In support of this position, Anthony Giddens states that "reflexive awareness ....is characteristic of all human action" and that "agents are normally able, if asked, to provide discursive interpretations of the nature of, and the reasons for, the behaviour in which they engage" (1991:35). This notion that we, as social actors,

actively create our own social reality is one which I will attempt to establish in this work. Rejecting the notion that we *are socially constructed* by an unweilding social structure, I will endeavour to show that, in fact, we *socially construct ourselves*.

A trend in much of the literature on eating disorders, women and identity has been, in the recent past, to assign victim status to those who experience eating disorders. Often painted as unwitting victims of social pressures too great to ignore, women have often been depicted as robots of an oppressive social structure. My position here is not to negate the fact that social structures do inform women's - and men's - choices. Social norms, values and expectations invariably influence the lives of social beings. However, it is important to remember that social beings are also social agents; individuals who have the power to actively choose, within the context in which they live, the circumstances by which they live. Some of the concepts inherent to a social constructionist approach sometimes overlook the very reality of agency. Anthony Giddens has succeeded in imparting the relevance of being active, not passive, social agents. It is therefore important that this work retain the notion of agency as a central component of its premise. Strong reliance on social constructionist theorists should not, therefore, indicate a rejection of agency but, rather, the two should be contextualized as interdependent components of social reality.

Methodology

A more detailed account of this research's methodology is provided in a further chapter. At this point, however, I shall briefly introduce the approach used. Qualitative in nature, this research will adopt a method similar to the interpretive interactionist approach propounded by Norman Denzin. According to Denzin, "the focus of interpretive research is on those life experiences that radically alter and shape the meanings persons give to themselves and their experiences" (1989:10). For the purpose of this work, bulimia is considered the life event which has helped to shape the meanings appropriated by women who engage in bulimic behaviours. This, however, should not be interpreted as meaning that bulimia is the only characteristic through which these women define themselves. For the purpose of this research, however, bulimia has been designated as that experience through which the concept of identity and self will be explored.

A mix between symbolic interactionism and hermeneutics, this method aims to make sense of human experience (Denzin 1989:14) which, in some way, is deemed problematic and which influences one's conception of self. The meanings which bulimics ascribe to their experience, and how this impacts on their conception of self, is central to this research. Denzin's method is appropriate because it encourages an approach in which meanings, especially as they are constructed by the participants in questions (1989:21), are central. Thus, the interpretation of these meanings, although largely the work of

the researcher, begins with and is generated by the participants.

As one person's reality differs from the next, and as people often construct different "descriptions" of reality (Stanley 1992:42), interviewee focused, semi-directive interviews were chosen. This is because open ended and interviewee directed interviews allow the participants to explore the construction of *their* reality without being constrained by the *researcher's* conception of reality, as might be the case in strictly structured, interviewer oriented interviews. A more detailed look at the process of recruiting participants is provided in the methodology chapter which appears at a later stage of this work.

Finally, the analysis has been undertaken as a way of both providing a space for these women's voice to be heard as well as one where interpretation of their stories is possible. Not always an easy task, the intermingling of both author and biographer's voice is an attempt to extrapolate a certain analytic meaning to the stories provided by the respondents. Using the theoretical concepts inherent in this work, the analysis is intended to provide a human face to these more conceptual ideas.

Conclusion

How people interpret and conceive of themselves has a lot to do with how they present themselves in public, how they interact with others and, ultimately, how they operate within

the larger social system. How women with eating disorders interpret and conceive themselves has a lot to do with how they experience their world. Exploring bulimics as micro representations of the effects of cultural narratives which inform contemporary society is a way of exposing these narratives and evaluating their effect on a large segment of the population.

Giving women who live with bulimia the opportunity to explore the relationship which they have created with their bodies and with their disorder is a way of giving these women a voice. Without a voice, women who have traditionally been depicted as victims continue to be victims. Allowing women who actually live with bulimia to voice their experiences is a way of, on the one hand, empowering them, and on the other hand, informing popular notions of bulimia with first hand accounts of those who have experienced it.

CHAPTER ONE

Modern Conceptions of Identity and Body

As a certain academic interest in the body has developed in the recent past, there has emerged an interesting pool of literature from which to approach the subjects being explored in this research: the body and the self. Unlike previous generations of sociologists who focused primarily on the objective and immaterial elements of social existence, present day sociologists of the body are making room for the individual and her body within the realm of sociological inquiries. Furthermore, many of these sociologists adhere to the idea that bodies and selves are relevant to sociology because they are each socially constructed entities.

These sociologists postulate that our selves, as well as our bodies, are socially constructed. Each entity, although intrinsically linked to the other, also individually appropriates social and cultural symbols and meanings. These notions are important for the work at hand because they assume that, through our bodies, we inherit social meanings and symbols and, in the process, become social beings. Does this mean, therefore, that the actions in which we engage through our bodies are necessarily reflections of social symbols appropriated through the social structure? That is, do we shape our bodies, as we would shape ourselves, based on the appropriation of certain cultural narratives or symbolic meanings? Moreover, must we assume that socially constructed

bodies and selves simply reveal the successes of an unweilding social system which imposes values, norms and expectations on its citizens without allowing for personal choice and incentive? The weakness of some of the social constructionist arguments is that by depicting individuals as socially constructed, they sometimes fail to take into account the concept of human agency and the idea that we may, to a certain extent, socially construct ourselves.

What follows is a brief exploration of the development of the sociology of the body, with its struggles and accomplishments and as well as an overview of work produced by contemporary sociologists of the body. Certain theories of the body and self will be examined in order to delineate the important role played by the body in the development of self. Furthermore, I will argue that, although many of the concepts inherent in social constructionist approaches to the sociology of the body are valid and important, one cannot overlook the importance of human agency in the process of self development.

The body and sociology

Until very recently, the social sciences produced very little on the body as a site of meaning and significance. Historically, the tradition has rejected the notion that the body might be both a genuine social entity as well as a valid source of investigation. Like any field in the production of knowledge, sociology has generally adhered to a philosophy in which the mind/body dichotomy still prevails. This hegemony of

reason encouraged a disregard for the body as a valid site of inquiry. Mind over body is the doctrine which has, thus far, influenced the direction taken by the social sciences and, consequently, by sociology (Shilling 1993, Smith 1987, Turner 1992). However, sociology has not neglected the body completely. Its concern with structure, for example, and the nature of human action has implicitly dealt with human embodiment. Furthermore, in dealing with agency, we are ultimately dealing with the body, albeit rather tacitly (Shilling 1993:9).

It is this practice of dealing only implicitly with the body which has lead Chris Shilling to characterize the body as "an absent presence" in sociology (1993:24). Within those areas in which the body has taken on a more explicit role, for example within the sociology of disease and medical sociology, it has nonetheless been treated as the vehicle from which to study the more fundamental phenomenon of, for example, disease, or its causes and effects. In these instances, the body is present, but it is still not the site from which meaning is derived. Rather, the body becomes important only in so far as it is the unit or the receptacle which carries with it (not within it) the sources of sociological meaning. In this sense, the body matters enough to form the 'hidden' base of many studies (i.e. social inequality, social mobility, racism, etc.) but it has rarely been dealt with as an explicit object of sociological inquiry, in and of itself.

The body and sociology: A misnomer

This absent presence, as Shilling describes the relationship of the body in sociology, may be explained by David Morgan and Sue Scott (1993) who explore the tenuous nature of doing a sociology of the body. Long considered the domain of the natural sciences, the body remained, until recently, an invisible and unspoken entity within social science research. Even today, as the sociology of the body is gaining recognition as a valid area of study its foundations are challenged.

Scientific endeavors and the pursuit of 'objective' knowledge have generally been guided by an ideological hegemony (Smith 1987, Scott & Morgan 1993), driven by the Cartesian tradition of mind over body. As such, dealing with what Dorothy Smith would call the everyday, or, in this instance, the body and all its associations to nature, emotions and materiali y, appears to contradict the basis of abstract and objective pursuits of knowledge. A concrete, material entity, the body seems antagonistic to the ideological realm of the social sciences. Focusing one's intellectual energies on an entity which represents the most basic human denominator is still deemed, by some, as trivial and inconsequential to the more ideological (hence, more conceptually relevant) phenomena usually investigated by the social sciences.

The dichotomy between the individual and society, which has been the basis upon which the discipline of sociology has been based, may also inhibit efforts to take the sociology of

the body seriously. Conventionally, the body has been considered an object which rests outside of the realm of the social world (Scott & Morgan 1993:14) and rather than recognizing it as an integral element of society, traditional sociologists have dichotomized the two. The time has come, however, when the body and society can no longer be interpreted in such dichotomized terms. And, despite the difficulties which still remain when attempting to do a sociology of the body, the value and sociological significance of the body have begun to take shape.

The body and sociology: Why now?

In recent years, the body has come to occupy a significant place within the social sciences. Although several reasons exist for this growing interest in the body there are two which seem particularly relevant to this time in history. On the one hand, the second wave of feminism served to emphasize women's need to 'reclaim their bodies' (Shilling 1993:30). Susie Orbach's Fat is a Feminist Issue (1st ed., 1978) is one of the first attempts to come out of this movement which specifically addressed women's body awareness and women's need to reclaim their bodies. In this, and other such literature, the female body is the focus of a political discussion. For Orbach and many feminist writers of her generation, women's bodies became one of the foci of their agenda. Considered sites of political power; women's bodies began to be interpreted as the birthplace of discrimination and oppression. As such, the body (and most

particularly, women's bodies) increasingly became understood as a site of political and social significance and began to represent struggles of control and representational social images.

On the other hand, the rise of the consumer culture has imparted a new attention on the body as yet another commodity to be manipulated on the markets. According to Naomi Wolf, the body has become a further source of insecurity through which consumer culture can be mediated (1990:47). Furthermore, the commodification of the body indicates a way in which contemporary consumer societies have generated a state of constant insecurity with regards to the way people are expected to look and present themselves. In consumer culture, the concrete, physical body has become an important source of presentation (Shilling 1993:35). Having become a commodified object, one used and repeatedly represented in marketing and consumer ploys, the body has taken on a new, more central role in the development of self and identity. This notion is interesting in light of this research because it addresses an issue to be explored later on: the body and its role in one's sense of self and identity.

Identity and reflexivity

Modernity, as it is interpreted by Anthony Giddens, has had a profound effect on social realities at both the institutional and personal levels (1991:1). Not only have social institutions undergone monumental transformations

throughout the period he calls modernity, but personal realities have also been affected. According to Giddens, modernity is characterized, first and foremost, by a reflexivity which "consists in the fact that social practices are constantly examined and reformed in the light of incoming information about those very practices..." (1990:38). The conditions of high modernity undermine traditional meaning systems (the process by which we invest our actions with meaning) and stimulate a sense of high reflexivity (1991:181). Stating that selves are 'not passive entities' (1991:2), and that self-identity is a 'reflexively organized endeavour' (1991:5) whereby individuals are forced to negotiate between lifestyle choices in their endeavour to carve out an identity, Giddens further links modernity with the self as a reflexive project.

More important to this work, however, is Giddens' insistence that not only has identity become a project of a reflexive nature, but the body, itself, has also appropriated this reflexive characteristic. This notion is relevant to the work presented here because it suggests the individuals' growing attention to and preoccupation with the body is in fact part of an overall reflexive time. Interpreted as an entity with unlimited possibilities for change, improvement and development, the body has joined the self as a project mirroring the reflexive nature of our times.

The Body and reflexivity

Like the self, "the body is becoming a phenomenon of choice and options" (Giddens 1991:8). Graced by the virtues of modernity, which include the never ending possibilities provided by technology, and the ever growing wants and desires inspired by developed consumerism, the construction of the body indeed becomes a credible reality.

Attempting to establish a link between the body and the self, Giddens refers to the body as "the vehicle of the self" (1991:60). Not necessarily equating the body with the self, he nonetheless identifies the intrinsic relationship between the two. Accordingly, the body becomes more than simply the shell within which the self resides, as George Herbert Mead (1937) had previously suggested, but it is, in fact, a key determinant in the development of self. Furthermore, as the self becomes an increasingly reflexive project, so too does the body. Each one influencing the other, both entities reflect and, to a certain extent, feed off the other. As the women I interviewed suggest, the body has increasingly become an important reflection of one's self.

Furthermore, Giddens' declaration that the body has become a reflexive project can be validated, to a certain extent, by the very behaviour which so many of us engage in, on a daily basis. Improving our bodies to improve our health, to reduce stress or to improve our outlook - our selves - has become the norm rather than the exception in our culture. The women that I interviewed recognize, to differing degrees, the importance

of the body "as a vehicle of the self" (ibid.) and they represent, perhaps, (as do many of us) an expression of Giddens' thesis. Giddens' attention to the body, however, is not sufficient to sustain an adequate or sufficient sociology of the body. His explorations of the body as a sociological entity are limited and his interest lies primarily in the self. The body, in his theory, plays a somewhat more peripheral than intrinsic role. What follows is a more detailed inquiry into the body, especially as it pertains to social constructionists.

SOCIAL CONSTRUCTIONISTS AND THE BODY

The body as a site of meaning

Particularly interested in the body are those sociologists which recognize the influence of social factors upon the construction of bodies. These scholars, social constructionists for the most part, propound a link between the body as an object of sociological inquiry and the self.

The approach, in sociology, which conceives of the body as a socially constructed entity attempts to define it as a receptor, not a generator, of social meanings. In its extreme form, it puts forth the notion that the body is somehow "shaped, constrained and even invented by society" (Shilling 1993:70). Following this view, not only is the body socially constructed, but self-identity, also, is informed by society. For example, they suggest that when someone is consistently defined and categorized in a certain way, that person will eventually take on the characteristics by which s/he is

defined. This view applies to both body and self identification.

As receptors of social meanings, individuals have the capacity to absorb and appropriate social symbols and messages and, in fact, we develop an ability to self-interpret and define ourselves accordingly. As George Herbert Mead (1937) postulated, individuals only become social beings through an interaction with the social system which is intended to mold and shape them. Social constructionists, therefore, adhere to this argument and, in so doing, often downplay human agency. This is a problem which must always be kept in mind and which must be avoided when considering 'social problems'. Social constructionist arguments which rely too heavily upon the impact of social structure and disregard human agency can too easily fall into scapegoating, or blaming, society as though it were an entity in and of itself, with influential forces beyond control. This critique applies to many of the radical feminist arguments which equate, for example, young women's lack of self esteem or the prevalence of eating disorders with the overbearing influences of patriarchy (Hoff Sommers 1994). Disregarding not only the viability of agency, these arguments also undermine the women for whom they apparently speak and represent.

Although sociologists of the body such as Robert Connell, Anthony Synnott and Susan Bordo approach the body from a variety of positions, they nonetheless concur that an equation between body and self is relevant. Whether it be explored

through the concept of gender or through an emphasis on the body as a site of consumerist initiatives, the sociologists of the body presented below all accept that body and self are intrinsically linked. An important development since the time when the body and self were esteemed to be two separate and independent entities, these scholars have succeeded in exploring the relationship (sometimes equation) between body and self.

The gendered body and the negation of biology

Robert Connell (1987) explores a sociology of the body which centers on the concept of the gendered body. This concept emphasizes the idea that social categories qualitatively define bodies in ways that cannot be justified organically. Accordingly, women and men are biologically more similar than they are different from one another (1987:71). The differences which come to represent us are, therefore, not biologically determined but are, rather, socially organized. These differences have come to inform what he calls 'gendered bodies'.

Connell postulates that gendered social practices not only change the meanings attached to people's bodies but that they also conspire to physically alter bodies based on gender lines (1987:73). Social practices shape women's and men's bodies in ways that help to reinforce certain images of masculinity and femininity. For example, girls and boys are encouraged to engage in gendered practices which inevitably impact upon their

physical development. Boys are more often than not encouraged to engage in activities which promote physical challenges, while girls are conventionally steered towards more passive and introspective activities. These practices not only help to carve out socially defined 'genders' but they also conspire to shape and determine boys and girls' bodies. As such, the standards by which women's and men's bodies are defined are organized more socially than biologically and such standards become accepted as natural and mandatory.

Connell further believes that social desirability and the construction of bodies go hand in hand. How we perceive, categorize and value women's and men's bodies helps to legitimate, and inevitably, to reproduce social inequalities. Certain feminists such as Naomi Wolf would have us believe that a conspiracy exists which dictates the strict standards of female body acceptance. More specifically, she uses the concept of socially constructed bodies to state that, in order to adhere to the North American standards of beauty, women are 'starved not by nature but by men' (1992:208). In other words, in order to reproduce or to sustain social inequalities, men have defined unattainable standards of female beauty. Connell's argument avoids Wolf's scapegoating tendency and serves, rather, to explore the intricate relationship between how bodies (and selves) are constructed and how these constructions can further serves to legitimate and to sustain inequalities. Curious as to the extent to which bulimic women have internalized the dominant gender ideology around beauty

and in order to discover the extent to which their behaviour is tied in to their attempts to achieve and maintain the socially prescribed standards of beauty, I will explore this issue further on in this paper.

Following Connell's approach, bodies are shaped more by the construction of gender, a socially prescribed category, than by the absolute essence of sex. As follows, gender itself is constructed around discourse, practices and ideology which rely upon the embodiment of social categories and socially delineated gender attitudes (Shilling 1993:113). In order to adhere to the dominant gender ideology, then, Connell states that we must negate and transcend biology. "My male body does not confer masculinity on me; it receives masculinity as its social definition" (1987:83). In order to reflect and adhere to the social and cultural ideals around gender, humans learn to manipulate nature. Linking both body and gender, Connell begins to postulate a link between body and self. Through the embodiment of social and cultural ideals of gender, a relationship between body and self is born.

The body social

Anthony Synnott, who also deals with the social construction of the body, suggests that our bodies, as well as our body parts, are permeated by cultural symbolism (1993:1). The body, as such, is the prime symbol and determinant of the self (1993:2). Furthermore, because the body carries so much cultural symbolism and because it is a prime constituent of

personal and social identity, Synnott equates the body with the self by observing that we are all 'embodied'(1993:3). Similarly, Carol Gilligan states that the body is a "repository of experience and desire" and a source for self-realization (in Goldstein 1991:22). We reap our meanings from the social and cultural realms and we cannot help but to take in and incorporate those meanings within the body. It is with his emphasis on embodiment that Synnott succeeds in making his sociology of the body interesting. Accordingly, our bodies become the receptacles of social meaning and as human beings capable of taking in these social and cultural meanings, we do so; not with the mind but, rather, with the body.

The body social, as Synnott refers to our embodied selves, is something which we have, yet, at the same time, it is what we are (1993:4). This is a wonderful way of depicting the subject/object dichotomy of body and self while, at the same time, retaining the interconnectedness and interdependence of the two/one. Although Synnott distinguishes between the body social and the body physical (1993:5), he nonetheless privileges the social aspects of the body and creates a sociology which embraces the body as more than a simple receptacle of social meanings. His interpretation of the body social privileges the body over the mind. Going beyond simply finding a relationship between body and self, Synnott paints a picture of the body *as* the self and rewrites the traditional dichotomies between body/self and body/mind.

Synnott's contribution to the field of sociology is an important one for it helps to delineate the important - and until recently neglected - relationship between body and self. If the body appropriates social meanings, and if the body and self are synonymous, then we, as social beings, appropriate social meaning through the body. If this is the case, therefore, do women who engage in bulimic behaviour represent a form of being socially constructed through a construction of their bodies? Is this body construction a conscious one? As many a feminist would attest to, women are encouraged to reflect the social ideals of beauty, but does this mean that by appropriating cultural meaning through the body, we unconditionally accept and reflect the expectations of a patriarchal society? Does appropriation of symbolic cultural meanings necessarily translate into an inability to engage with those symbols? These issues will also be explored more fully at a later stage of this work.

Body/self construction in consumer culture

Taking Synnott's concept of the social construction of the body one step further, Susan Bordo (1991) states that, fueled by consumer capitalism and the dominance of Western ideals of technology, pursuing modern ideologies of self has now developed into the new 'postmodern' imagination of freedom from bodily determinism (1991:106). This means that the body has become, in this time of high modernity (to use Giddens expression) a source of self-development. Bordo supports the

notion that the body is more than a receptacle for the self. She states that the body has now also become a form of self-actualization. Furthermore, modern technology and the pervasive influences of a consumerist culture serve as the impetuses which provide individuals with the freedom of *self*-transformation (1991:109). Bordo believes that a discourse of body consciousness, which has been fueled by a mass consumer, scientific and capitalist culture, has come to determine, or at the very least, influence, the process of individual self-actualization.

According to Anthony Giddens, (1991) the technological advances available as a result of high modernity create unprecedented possibilities for the body's emancipation from nature. No longer taken as a biological given, the body can now be shaped and manipulated into what our idea of self has become. It can be the means by which certain ends can be obtained. Giddens' argument suggests, therefore, that the body is both equated with the self and is the vehicle for self-actualization. With access to modern technologies and the influences of western consumer culture, our bodies, and our self-identity can be reconfigured.

This argument is the perfect example of where agency and choice come into play. Unlike some social constructionist tendencies which describe human beings as mere sponges of social norms, expectations, rules and meanings, Bordo and Giddens' argument supports the idea that choice and personal freedom dictate a 'manipulation' of the body. Those people who

choose to undergo, for example, liposuction or breast implant surgery, do so consciously. In an effort to construct the body of their dreams (and by extension, based on this argument, the self of their dreams), people are *choosing* to take advantage of the technology available to them. Some might argue that those people who choose to construct their bodies by using the technology available to them are unaware of the extent to which they have internalized social norms and expectations which encourage them to feel the need to reconstruct their bodies, but the fact remains that, when anyone takes advantage of the means available to them, they are socially constructing themselves, not *being* socially constructed. That a consumerist culture encourages or sanctions such behaviour is an argument in and of itself, and not one to be debated at this juncture. However, the relevance of Bordo and Giddens' ideas is that as humans, we have the capacity to manipulate our bodies in an effort to socially construct ourselves, and many of us indeed choose to do so.

Conclusion

As has been shown above, the body has long been an 'absent presence' within the discipline of sociology. Gradually, however, the body has been incorporated within the discipline as a valid site of social significance and has been recognized as an intricate and invaluable component of the self. As Giddens describes them, both the body and the self have become

self-reflexive projects within the period known as modernity. Both are sites of development and growth.

Social constructionists develop this argument further by stating that human beings are receptors of social meaning which we appropriate through our bodies in order to develop a self. Robert Connell uses the concept of gendered bodies to describe the extent to which, in appropriating social meanings, we negate biology. Anthony Synnott equates the body with the self and qualifies it as the prime recipient of symbolic meanings. Finally, Susan Bordo and Anthony Giddens use technology as an example of how we have transcended bodily determinism and learned to manipulate our bodies to carve out socially sanctioned selves.

Although these arguments all have some intrinsic value to them, one must not overlook the importance of human agency and individuals' ability to interact with and react to the symbols which are meant to socialize us, to construct us. It is true that we become social beings by incorporating social and cultural meaning systems, but we cannot disregard the extent to which we may also act upon those meanings systems. Having been appropriated as part of each individual's socialization process, these cultural and social symbols do not, however, remain stagnant components of self. They are sometimes challenged, sometimes rejected or sometimes, we chose to work with them as best we can. This notion of interaction with the meaning systems meant to socially construct us indicates a reciprocal relationship which takes into account human agency.

Recognizing the value of both social constructionist and structuralist arguments, what will be developed in a later chapter is an attempt to incorporate the essential elements of the two in order to postulate a relationship between the individual and the social and cultural system which informs her choices and behaviour.

For the time being, however, I will turn my attention to eating disorders. Delineating the extent to which bulimia has become a phenomenon filtered through medical discourse, I will explore the consequences of such interpretations and will present alternative views to the medicalized treatment of eating disorders.

CHAPTER TWO

Understanding Eating Disorders

There has been little discussion, thus far, about one of the central issues of this research, eating disorders. Although intrinsic to this discussion, eating disorders generally, and bulimia specifically, are not the phenomena being studied in and of themselves. They serve, rather, as a point of specificity, as a point of reference for the inquiry into the role of the body in the development of self. For this reason, the following discussion will serve mainly as a brief introduction to specific issues which surround the debate around eating disorders. It will focus upon the use of the term eating disorders, as well as upon the pathologizing of the behaviours which comprise the category eating disorders. Brief in its scope, this chapter serves mainly as an introduction to the behaviour which is common to the participants of this research.

Problematizing 'eating disorders'

Although problematic, the term eating disorders is used in this discussion because it is the most widely recognized, 'scientifically' sanctioned characterization of behaviours such as bulimia and anorexia nervosa. Furthermore, it is the only name, to this date, which has been assigned to the behaviours associated with anorexia, bulimia and sometimes compulsive overeating and obesity. Despite its overwhelming use, the term 'eating disorders' should be put into question. As part of a medical, psychological narrative, the term 'disorder' invokes

images of derangement, disturbance and madness (Kirkpatrick 1987). It carries with it innumerable connotations and associations to sickness and pathological disturbance. Although many of the women interviewed for this project will attest that bulimia is a behaviour that often requires medical attention, its pathological characterization serves little purpose other than to qualify the behaviour as aberrant and to relegate it to the realm of the expert intervention. The expression 'eating disorders' is problematic because it shrouds the behaviour of a very large number of individuals in a medico-pathologized imagery which connotes, among other things, an acute psychological disturbance which resides specifically within the individual. I find it appropriate to include the term 'eating disorders' within quotation marks as this serves to demarcate and to accentuate the tenuous nature of the expression as it now exists and is being used.

Eating disorders: A brief definition

'Eating disorders' is the general category commonly used to define phenomena such as anorexia nervosa and bulimia. Each of these behaviours are unique in their manifestations and, according to medical discourse, the etiology of each varies.

Attempting to delineate the prevalence of eating disorders generally, and bulimia specifically, is a very difficult task. On the one hand, women may engage in bulimic behaviours for many years without ever having recourse to the expert systems which would classify them among the numbers of 'sufferers'.

Furthermore, because bulimia engenders less medical complications than does anorexia and therefore requires less 'emergency' or 'urgent' medical attention, bulimics can realistically avoid the medical system which would tabulate them within their statistics.

On the other hand, the numbers which do exist, and which, it is worth stating, are quoted profusely by feminist scholars and writers, have been found to be erroneous. The statistic commonly used by such feminists as Gloria Steinem and Naomi Wolf suggests that 150,000 women die of eating disorders, specifically anorexia nervosa, every year (Steinem 1992, Wolf 1992). This figure, however, is grossly mistaken. After having investigated what appeared to her as an unimaginable mortality rate for anorexia, Christina Hoff Sommers tracked down the initial source of this statistic to discover that what the American Anorexia and Bulimia Association had actually reported, in 1988, was that there are between 150,000 to 200,000 sufferers of anorexia AND bulimia reported each year (Hoff Sommer 1994:12). The latest Canadian figures, compiled by Statistics Canada in 1993 and obtained, by telephone, from the National Eating Disorders Information Centre in July 1995 indicate that of the 3,830,505 women between the ages of 14 and 25 in Canada, 1 to 2% of this population are deemed to be anorexic and 3 to 5% bulimic[1] . These figures represent only those women who have

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[1] These are unverified statistics, the actual study from which they stem not having been scrutinized by this author.

had or who are presently in treatment and who, therefore, have been counted by representative organizations.

Although names have changed over the years, from nervous atrophy in the 17th century to anorexia hysterique in the 19th century, the phenomenon today referred to as anorexia nervosa can best be defined as one of 'self-inflicted starvation' accompanied by a 'morbid and persistent dread of fat' (Strober 1986:237). Bulimia, on the other hand, describes the phenomenon whereby individuals binge on large quantities of food to then rid themselves of the calories ingested through purgative methods such as forced vomiting, the use and abuse of laxatives and diuretics, starvation or excessive exercise (Boskind-White & White 1986:354).

Conceptualized through a different theoretical framework, 'eating disorders' have also been assigned less medical, more socio-political definitions. Kim Chernin, for example, describes them as "issues of weight and body size as a cultural problem with female power" (1985:xv). Eva Szekely states that 'eating disorders' "have been constructed as diseases that reflect moral, sociocultural judgments" (1988:36) and hence, are intrinsically the reflection of social and cultural values and expectations. These definitions attempt to downplay the medico-pathological characteristics assigned to 'eating disorders' and to locate them, rather, within the cultural context in which they reside. They are not, however, the most recognized, nor are they the most condoned definitions of 'eating disorders'. Overshadowed by medical discourse, these socially inspired,

alternative approaches to 'eating disorders' have usually remained unexplored and invalidated by the 'scientific' community.

'Eating Disorders': Medicalized[2] phenomena

"Eating disorders...are not merely problems with food. They are psychological disorders." (Siegel et al. 1988:8). "The majority of patients with bulimia nervosa present a variety of neurotic symptoms. ...it has been suggested that bulimia nervosa is a form of affective disorder." (Fairburn et al. 1986:395). These are but a few of the ways in which 'eating disorders' such as anorexia nervosa and bulimia have been defined and characterized in the relevant literature. Having been defined as medical and/or psychological problems, it is not surprising that 'eating disorders' are characterized as pathologies, garnering the attention of medical and psychological expert systems. As such, terms like "the hunger *disease*"(Bruch 1979:1 - emphasis added) are commonly used to describe the phenomena of food preoccupation. Although doubt has recently been cast upon the validity of medicalizing 'eating disorders' (Szekely 1988, Habermas 1992), the fact remains that 'eating disorders' are commonly referred to and considered individual, medico-pathological disorders.

Even those people who question the medico-pathological discourse that surrounds 'eating disorders' use words such as 'symptom' in their discussions of the phenomena (Lawrence

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2 While the term 'medicalization' is used, it also serves to refer to the pathological construction of eating disorders and its psychiatric interventions.

1984:16). Unfortunately, the consequence of using such language is that 'eating disorders' continue to be defined as individual pathologies. This virtually obliterates the possibility of interpreting 'eating disorders' as circumstances of the wider, social context within which they are expressed. It encourages a reductionist interpretation which limits the phenomenon in question to the individual; "her weakness, a personality defect or her arrested development" (Szekely 1988:174). Eating disorders, through this type of interpretation, become individual pathologies, effectively discrediting any of their socially or culturally rooted motivations and influences. Furthermore, such an approach fails to recognize that individuals "learn to become their bodies" within a specific and definite social environment (Szekely 1988:178) and, consequently, "obscures the socio-political roots of women's oppression" (Szekely 1988b:17). The behaviours associated with 'eating disorders' are not produced in a vacuum and, therefore, should not be treated as such.

Another circumstance of treating 'eating disorders' as pathologies and of defining them as illnesses is that it can "diminish the attribution of responsibility" for those engaged in the behaviour (Habermas 1992:61). Although I am not suggesting that the blame, shame and guilt which normally accompany behaviours such as bulimia are positive, I nonetheless believe that the circumstance of absolving one of

their responsibility has the negative effect of creating a sense of victimhood and, ultimately, powerlessness.

As Anthony Giddens has pointed out in much of his work, social actors are not passive entities (1991) and we all, whether consciously or unconsciously, act according to the circumstances within which we find ourselves at any given moment. That these circumstances are tenuous, confusing and ridden with mixed messages for women living in North America is not cast in doubt, but the fact nonetheless remains that we actively (not necessarily consciously) choose the paths by which we live. By absolving the women who are 'diagnosed' as 'eating disordered' of the responsibility of their actions, we are also effectively stripping them the power required to address their choice of behaviour.

The term illness connotes a certain lack of control over one's condition and a lack of responsibility for one's situation. It also requires that the 'diagnosed' individual abdicate to medical expert systems. Unfortunately, this often culminates in the victim discourse which frequently surrounds analyses of 'eating disorders' and, inevitably, paints those who experience them as powerless. This is regrettable because it serves to maintain women within the sphere of the powerless and, effectively, removes all possible notions of agency within the discourse of 'eating disorders'.

However, the converse may also be introduced as an argument against the medicalization of 'eating disorders'. As Eva Szekely explains, when 'eating disorders' are medicalized,

"the final responsibility for prevention and cure rests with the individual, and in the end, only the 'victim' is to blame" (1988b:9). Contrary to the above deconstruction of the medicalization of 'eating disorders', this argument serves to demonstrate the lack of social and cultural responsibility inherent in the designation of 'eating disorders' as individual, pathological illnesses.

Although this argument has also often been used to designate the 'sufferer' as a victim of oppressive social conditions, in this instance, it rather serves to illustrate the role that social and cultural imperatives do have on the development of 'eating disorders'. It also points to the need for the social practices, values and norms which inspire such behaviours to change. As suggested above, individuals do not live in a vacuum. This suggests, therefore, that social influences are indeed relevant in the discussion of 'eating disorders' and that they cannot be ignored by assigning blame and responsibility *solely* to the individual as medico-pathological discourses do.

What the seemingly contradictory arguments above point to, therefore, is the need to take into consideration both the individual's level of choice and the social imperatives at play within the discourse of 'eating disorders'. Neither individual women nor society at large are solely to *'blame'* for the onset of 'eating disorders'. Both must be considered contributing agents in the playing out of 'eating disorders', and both must act to eradicate the conditions which breed such

behaviours. Unfortunately, however, the medicalization of 'eating disorders' renders this impossible because it limits the level of responsibility one is able to assign to each of the components at play in these circumstances.

Finally, the medicalization of eating disorders also serves to render exotic a behaviour which is, ultimately, not unique and which does not 'afflict' only certain, predisposed individuals. Women do not necessarily belong to one or another mutually exclusive group - 'eating disordered' or non-'eating disordered'(Szekely 1988b:9). The majority of women are located somewhere within the continuum of 'eating disordered' behaviours. Dieting and a preoccupation with weight loss are not the exclusive domain of persons deemed 'eating disordered'. A vast majority of women experience such preoccupations, to one extent or another. That only those who meet the criteria of medico-pathological diagnostic indicators are 'diagnosed' as sick serves to ignore the endemic concerns women in western culture have with weight loss and thinness, and further exoticizes the behaviour of those individuals who are located at one extreme of the continuum. The need to create dichotomies between 'eating disordered' and non-eating disordered women serves a purpose. In essence, this enables the 'relentless pursuit of thinness' to continue while condemning only those women who 'cross the line' in their attempts to adhere to the standards of beauty espoused by our modern consumer oriented culture. In creating 'sick' vs. non-sick categories, we are essentially advocating the behaviour

of the majority while only sanctioning those deemed extreme in their behaviour. This, therefore, enables the culture of thinness to strive and to flourish, while admonishing only that minority which demonstrates a distorted or 'pathological' 'pursuit of thinness'. Ultimately, therefore, dichotomies serve to perpetuate the status quo.

As Mervant Nasser suggests "thinness has come to symbolize certain cherished notions within this culture" (1988:574). Many women (and men) have learned to aspire to the symbol, and the connotations attached to it, which is so cherished. 'Eating disorders', in this cultural context, become extensions of "normative and culturally acceptable modes of behaviour" (1988:574). They are not necessarily exotic and strange behaviours adopted by a pathological few, but rather, they may be interpreted as an extension (albeit a severe extension) of the continuum upon which many women in North American culture find themselves.

'Eating disorders' as social disorders?

Finally, is it worth considering the extent to which 'eating disorders' are in fact social disorders. Although never sufficiently emphasized in the medical literature, it is nonetheless important to point out that 'eating disorders' cannot be reduced to the expression of certain pathological behaviours. They are also expressions of the social and cultural conditions within which women are located. The "values, norms, ideals and expectations" by which we live our

lives are inevitably "socially and culturally constituted" (Szekely 1988:13) and it is these values, norms and ideals which contribute to the behaviours associated with 'eating disorders'. According to Kim Chernin, "the body holds meaning" (1981:2). As such, the body is also the vehicle by which social values, norms and aspirations are expressed. These expressions, therefore, are intrinsically social.

As George Herbert Mead (1937) has pointed out, individuals become social beings only through other social beings and through an interaction with the social world. This means that we learn our norms, values and behaviours from the outside, from the world which makes up our social environment. If then, women are increasingly preoccupied with their bodies, and the size of their bodies (some to the extent of adopting extreme behaviours such as anorexia nervosa and bulimia) then is it not valid to suggest that they may be reacting to, or acting upon the conditions of their social existence?

This argument, albeit valuable, should, however, be used with caution. Too easily have feminist writers addressing the issue of 'eating disorders' fallen into the trap of assigning victim status to bulimics, anorexics and overeaters. Calling 'eating disorders' a social problem can easily serve to depict women as the scapegoats of society, and, although social norms, values and expectations do need to change in order to stop the 'relentless pursuit of thinness', we cannot lose sight of the responsibility that women, themselves, have in stopping these behaviours. Society is not a concrete entity

which acts independently of its members. We all, as social agents, have a responsibility to eradicate the behaviours adopted in the 'relentless pursuit of thinness'.

Consequently, assigning the label 'social' to characterize 'eating disorders' should serve to reflect the social roots inherent in the behaviours associated with 'eating disorders'. It should not be used to reinforce the victim rhetoric which, unfortunately, has often become the consequence of this approach.

Conclusion

The concept 'eating disorders' has been deconstructed, with the emphasis being placed upon the medicalization of the term, as well as upon its social contextualization. Words are powerful tools and the names we assign to ideas, actions and behaviours have consequences which reach far beyond mere linguistics. Furthermore, the connotations attached to labels are never without consequence. In the present discussion, the connotations attached to the concept 'eating disorder' have a reductionist effect, limiting the scope of possible interpretations to medico-pathological ones. This, however, has not completely prohibited alternative interpretations of 'eating disorders' to be developed. Recently, discussions have emerged which point to and accentuate the social dimension of behaviours associated with the 'relentless pursuit of thinness'. This work hopes to contribute to the emerging discussion of 'eating disorders' which privileges the

social and personal aspects of the behaviour rather than the over-emphasized, medicalized interpretation of 'eating disordered populations'.

In the next chapter, I will describe the methodology which I used to produce this work. I will introduce the approach and discuss the advantages, as well as the disadvantages, of using a methodology which revolves around life stories.

CHAPTER THREE

Methodological Approach and Process

Biography/Life Stories

As single lives are always imbedded with the life stories of others, and as self stories derive from "cultural, ideological and historical contexts" (Denzin 1989a:73) biographies transcend the supposed boundaries of individual lives and become rich sources of sociological inquiry (Stanley 1993). Biographies also serve as first-hand looks into what it means to be socially constructed (Evans 1993) because they represent a form of analysis which interprets the personal, emotional and social accounts of selfhood. Through biographies "the formal categories of social life are given human meaning" (Evans 1993:12). Furthermore, biographies can serve to give voice to the 'other', to validate the experiences of those who have traditionally not had a voice within mainstream traditions (Evans 1993). Biographies, therefore, can provide an accurate recounting of one's story while also ensuring a forum from which the teller's story may be heard.

Whether one uses biography or not, however, the final analysis nonetheless remains that of the sociologist. The 'other' may be present within the analysis, and thick description (Denzin 1989b) and extensive inclusion of the speaker's voice within the text may help to bridge the gap between speaker and spoken-of, but one must not pretend that

the final product is not, ultimately, the researcher's. Nonetheless, it remains important to incorporate, as extensively as possible, the voice of the 'other' within the text in order that this 'other' may have her voice represented, even if only marginally, and in order to produce an account of experiences which are as authentically recounted as possible.

Narrative

Intrinsic to biographies is the notion of narrative. Narrative, as described by Hillary Graham (in Cotterhill and Letherby 1993:74) is a technique which "allows the respondents to 'tell the story' in whichever way they choose, and importantly, validates individual experience and provides a vehicle through which this experience can be expressed to a wider audience". Cotterhill and Letherby state that, according to Graham (1992), the narrative technique helps to reduce the possibility of exploiting the respondent because the onus is placed upon the respondent and the freedom is provided for her to divulge as little or as much information as she is comfortable in giving.

Denzin (1989b) distinguishes between various types of narrative: the personal experience story, the self story and personal histories. The personal experience story relates the self of the teller to specific experiences which have been lived, while the self story is a "narrative that creates and interprets a structure of experience as it is being told" (1989b:38). This form of narrative relates not only to the

present, but also to the past and future because it recounts events that may have been lived previously and which may and, undoubtedly do, have an impact on future lived experiences. Finally, personal stories are a form of narrative which is embedded in the larger narrative of life stories. Personal stories encompass both personal experience stories and self stories and they serve as reconstructions of a life, usually based on interviews and conversations. Personal stories are a form of narrative which attempts to reconstruct a person's biography or complete life story by starting from the teller's personal stories (Denzin 1989b).

This thesis uses Denzin's personal experience stories. It utilizes open-ended interviews to collect the stories of women's specific experiences with bulimia. I am not attempting to reconstruct their complete life story, nor am I intending to write these women's biography. Rather, the interview process served as an opportunity for certain women to share their stories and discussions revolved around specific issues suggested by the researcher. The extent to which issues were discussed, however, remained the decision of the participants.

Although Denzin points out that personal experience stories relate specifically to experiences which have been lived - in the past tense- the stories which were collected for this project did not always, or rarely related exclusively to previously lived experiences. All of the women interviewed were still engaging in bulimic behaviour. The interviews, therefore, did not become sessions of long term recollection

but rather, sometimes developed into the recounting of freshly lived, and often difficult, experiences. This produced emotional and difficult exchanges, at times.

Epiphanies, those "moments and experiences which leave marks on people's lives", (Denzin 1989b:15) were of central importance within the stories being told. In the case of the women I interviewed, I interpreted their first experience with bulimia, as well as subsequent, established patterns of bulimic behaviours as epiphanies. This is because, based on the fundamental premise of this research, the bulimic experience, as a whole, seems to represent those 'moments ... which leave marks on people's lives' (ibid.). It seemed appropriate, therefore, to have bulimia in general and the pattern of bulimic episodes and behaviour as the focus point around which the telling of stories would revolve.

Self-Disclosure

Pamela Cotterhill and Gayle Letherby (1993) espouse a way of doing biography which includes auto/biography. That is, they support the notion that disclosure, on the part of the researcher, is acceptable and appropriate within the research context. Disclosure, or self-engagement may serve to provide valuable insight into the issue being explored. It allows for the researcher's personal experience with the issue at hand to become part of the process and, therefore, to feed the process with a valuable source of intuition (Cotterhill and Letherby 1993:73)

Everyone chooses research subjects on the basis of personal interest and relevance and the notion of objectivity so adamantly espoused within the social sciences only serves to cloud the reality of self-interest. Furthermore, it obliterates any possibility of self-disclosure or involvement within the process because objectivity dictates that researchers disregard their lived experiences as sources of inspiration and knowledge (Smith 1987). "In the social sciences, the pursuit of objectivity makes it possible for people to be paid to pursue a knowledge to which they are otherwise indifferent" (Smith 1974:9). This sarcastic reference serves to illustrate not only an awareness of the ambivalent nature of objectivity, but it also serves to justify a researcher's personal interest and motivation in investigating her research subject. When one has accepted that the issue being investigated is, in fact, motivated by personal interest and, perhaps, personal experience, then self-disclosure becomes an honest extension of the inherently subjective nature of most social sciences research.

According to Dorothy Smith (1987), women's everyday lives and experiences have traditionally been deemed inconsequential in sociology. This is because "interests, perspectives, relevances leaked from communities of male experience into the externalized and objectified forms of discourse" have dictated the areas of relevant study within the discipline (1987:7) and these have traditionally centered on more abstract forms of knowledge production. If this is in fact the case, women who

have been excluded or marginalized in research priorities may very well feel hesitant or reluctant to divulge personal information within the context of an objectified, distancing research process. Self-disclosure serves, at this juncture, to break down the walls of distance and objectification ingrained within the process and to foster an environment of open and safe dialogue. One cannot pretend, however, that the power relationship intrinsic to any research process will be completely eradicated through disclosure. Most respondents are aware of the underlying power relationship that exists between herself and the researcher and although disclosure might help to balance out the power differential, it will not wipe it out completely.

Finally, self-disclosure must never be, and never was, imposed on the participants by the researcher. This exchange should occur only as a result of a participant's request. Overstepping the inherent boundaries of the research process is not appropriate.

The public nature of disclosure

In relation to the present study, disclosure was an important consideration. Having first hand experience with bulimia and knowing how difficult it may be to talk about, especially with strangers, I chose to talk about my personal experience with those respondents who questioned me. More so than anorexia, bulimia has traditionally been interpreted as a shameful, sometimes disgusting behaviour. As such, bulimics

often feel uncomfortable discussing the particulars of their experiences with people who do not understand, who cannot 'relate' to their behaviour. This well known fear encouraged me to disclose my own past experience with bulimia. Feeling that it would reassure the respondents of my level of understanding, empathy and, to a certain extent, relatedness, I offered the information to those who asked.

The Participants

It had been my intention to meet with and interview 20 women who were self-identified or 'admitted' bulimics. Unfortunately, only eight were actually interviewed. Of course, a sample of eight women does not represent the whole of the 'eating disordered' population, nor does it come close to representing the female population of the Montréal area. It is not my intention, however, to produce a piece of work which pretends to be representative of the experiences of bulimic women as a whole. The intent is to explore and to present the experiences of the eight women interviewed. These women, ranging in age from 18 to 45, represent, at the very least, the perspectives of women of different age and social status groups.

Gaining access to women who live with bulimia is not an easy task. Having decided early on not to have recourse to hospitals and treatment centers to find my respondents (reasons are discussed in "Problems" section below) I chose to recruit them through the local arts and culture newspapers as well as

through the University media and posted advertisements placed in strategic locations around the city - most notably around the Universities. With this approach, the onus was placed upon the respondents to decide whether they were comfortable enough in talking about their bulimic experiences to contact me and to share their stories. As such, my sample was selected for me. The women who came forward were all, save a few, interested in my description of the project and all chose to meet with me for an interview. I did not select eight women from a pool of possible respondents, nor did I administer a survey or questionnaire to ensure that they were, in fact, 'clinically diagnosed' as eating disordered. The women who chose to come forward were asked some basic questions about their bulimic history (i.e. how long they'd engaged in the behaviour and whether or not they were presently in treatment). These questions were intended to satisfy my need for women who had had more than a passing acquaintance with bulimic behaviour. All the women who contacted me met this requirement and most were interviewed.

The process

One of the basic assumptions of interpretive interactionism is that asking the 'why' question is detrimental to the process of understanding. As such, the 'how' question is used in its place. That is "how is social experience organized, perceived and constructed by individuals" (Denzin 1989b:24). More specifically, and for the purpose of this

research, more relevant, how does bulimia enter lived experience? What role does it play in women's lives and how tied in to their sense of body awareness and self-awareness is their bulimic activity? These and other substantive areas were examined within the interview context.

Open ended, semi to non-directive interviews were conducted with eight self-identified bulimics. As one element of this research project is to have the women in the study explore the relationship which may or may not exist between their body, eating disorder and self-identity, it was important to give them the opportunity for introspection. As I was asking these women to ponder issues which they may not have explored previously, it was important to provide them with a space within which contemplation and dialogue were encouraged.

As 'reality' is not the same for everyone and as people often construct different 'descriptions' or stories about themselves and their reality (Stanley 1993:42, Denzin 1989a:75), interviewee oriented interviews became very important. This format offered the participant the freedom to explore the construction of *her* reality without being overly constrained by my conception of reality. It also offered the respondents the opportunity to 'lead' the interview. This process, however, is not always conducive to quick, 'to the point' interactions. A discussion of the problems encountered as a result of this method are provided in the 'Problems' section of this chapter.

The interview

Each interview took place at Concordia University. This location was chosen mainly for its accessibility to private quarters. The respondents were given the choice to conduct the interview elsewhere but all agreed to meet at Concordia University. A private room was used for all interviews and so confidentiality was assured. This aspect was very important given the respondents desired request for anonymity.

Interviews varied in length but the average time was approximately one hour. This depended upon the ease and ability with which each respondent could share her story. For a few of the respondents, the interview represented the first time that they discussed their eating disorder with anyone. It was their 'coming out' if you will. As such, these interviews were more difficult. The interviews were all taped. Each person was explained the reasons for taping the interview and, given the assurance of anonymity, none of the respondents objected to this.

Problems encountered during the process

Accessibility

One of the major problems encountered during the research process was having access to women who were willing to share their personal stories for research. The stigma attached to bulimia inevitably creates a certain reluctance on the part of respondents who may have a story to tell but who feel unable to share what is usually a very private and somewhat shameful part

of their lives. Bingeing and purging almost exclusively occur in private and are events which bring shame and disgust to those who experience them (Seigel et al. 1988). Not only pertinent to the actual bingeing experience itself, these feelings transcend the bulimic 'episode' and often generate overall feelings of shame and disgust. As such, many bulimics are unwilling to come forward and divulge their 'secret' to others.

Further hindering my access to bulimics has been my unwillingness to approach medical and psychological institutions directly. Many reasons exists for this. On the one hand, having access to bulimic women through established institutions such as hospitals and psychiatrists would have involved the long and arduous task of getting through institutional ethics committees. Although the act in itself was not enough to dissuade me, the length of time which these processes often take did. Having had to submit the research proposal to numerous ethics committees and boards of directors could have taken several months and, unfortunately, deadlines prohibited me from truly considering this option.

On the other hand, my initial, and sustained hope was to reach those women who freely chose, for whatever their personal reasons, to participate in my research project. Gaining access to them through treatment services made me wary of the amount of choice these women may or may not have had in participating in the project. I am not suggesting that official treatment facilities would have denied their patients/clients free choice

to participate or not in the project, but third party access did make me somewhat leery. Furthermore, I sensed a certain amount of vulture-ability in taking this approach. Although I am aware of how routinely this approach is taken and of how acceptable it truly is, I nonetheless felt a certain level of discomfort at having access to a group of women who were benefiting from services intended for therapy purposes. Finally, very few treatment centers actually exist in the Montréal area and the amount of respondents that I may have had access to through these centers would not necessarily have been large enough to warrant the delays that such an approach would have engendered.

Dealing with human respondents

The major problem encountered around the interview process itself was one encountered in all research involving human 'subjects'; that is, the actual presence of the respondent during the interview. Although only eight women were interviewed, many more had contacted me and showed an interest in participating in the project. Some decided, upon hearing of the process and intent of the project, that they were not comfortable in talking about their eating disorder. Others expressed an interest in the project and set up appointments but, for reasons unknown to me, did not present themselves at the scheduled time and place. Because the women contacted me, and because of the anonymity that I assured them, I did not feel comfortable in asking them for their telephone numbers so

that I may call and confirm the interviews the day before. Instead, I asked the women to contact me should any changes occur that would make them unable to attend. Although everyone agreed that they would, some inevitably did not. As such, several scheduled interviews were relinquished. Sometimes frustrating and discouraging, this was one aspect of the research process which I had not anticipated. Had all the women that I'd been in contact with actually shown up for their interview, I would have been closer to my target group size. This was, however, a good lesson in the difficulties associated with research involving living, breathing and emotional participants.

To Tell or not To Tell

Having lived with bulimia myself, and knowing the unease with which bulimics experience their 'disorder', I felt it was important to share my own lived experiences with the respondents, if only to let them know that they could speak freely and without shame of their experiences.

On a few occasions, respondents did questions me about my reasons and motivations for exploring bulimia and in such cases, I shared my own experiences with them. Although I anticipated that this would ease the interview process and reassure the respondents of my understanding and ability to relate to their experiences, this was not always the case. On one occasion in particular, the respondent assumed that, because of my own experiential knowledge, she was not able to

provide me with much more 'information' than I already had. Assuming that I must already "know everything that there is to know", this respondent held back, to a certain extent, on sharing her own personal experiences, views and interpretations of living with bulimia.

I had not anticipated this problem. Consequently, I ensured that further disclosure be prefaced with the explanation that every experience was unique and that it was the uniqueness of their lived experiences that I was interested in discussing. Once this became known, disclosing my own experience with bulimia seemed less like a liability.

The method - its disadvantages

Although the method I chose promised to offer the respondents the most freedom in recounting their stories, it was not without its problems. For example, giving respondents the latitude to lead the interview, to take it in whichever direction they were comfortable with, sometimes lead to very long, not altogether fruitful, interviews. By providing respondents with the freedom to share the parts of their story which they chose, I also set the stage for discussions which sometimes strayed from specifics. Furthermore, for this method to be truly beneficial, an awful lot of time is required. More than one interview would ultimately make the process richer, but considering the length of most of the interviews as they were, this was not a viable option. Open ended and interviewee directed interviews may offer more freedom to the respondent

but they also sometimes degenerate into long drawn out discussions of issues which are not necessarily relevant to the research at hand. As such, this method is one which, to be most effective, requires a lot of time and much freedom to re-interview respondents more than once.

Also, this type of research can unfortunately result in participants' believing that your responsibility towards them goes beyond that of the research context. Seeing as the interview takes the shape of a discussion more than an question-answer session, it is perhaps easier for participants to mistake the tone of the interview for a more informal 'therapy session'. Clearly explaining the nature of the research relationship as well as delineating each person's role within the process can help to ward off the possibility of misunderstandings.

Conclusion

Reading lives, as Denzin describes the active process of biography (1989a:68), is an interpretive, hermeneutic approach to doing qualitative sociological research. Inherent to biographies are the narratives present within them. The process proposed herein suggests that reading lives is an important tool for understanding the meanings which women with bulimia attribute to their experiences. Furthermore, the auto/biographical component which may be present within the process affords the researcher the opportunity to engage in an exchange or dialogue with her respondents rather than the one-

sided question-answer session conventionally practiced in social science research. Although this auto/biographical component of the research process is not without it's problems, under the right circumstances it does represent a legitimate and more egalitarian form of doing life stories research.

In this context, reading lives is a way of inviting the respondents to explore the relationship that they have developed with their 'eating disorder' in a non-therapeutic, non-medicalized fashion. Providing women who live with bulimia a space to explore and voice their lived experiences is a way of informing popular notions of bulimia and 'eating disorders' with first hand accounts of those who experience them. What follows are the result of this process. The stories, shared with me by eight women of varying ages and backgrounds, are presented and interpreted in light of the previous theoretical discussions around 'eating disorders', body, choice and self and identity.

CHAPTER FOUR

Key Concepts and Meanings: A Textual Analysis

The time has come to examine the extent to which the conceptualized notions explored in the previous chapters can be used to analyze concrete everyday experiences. Interviews were conducted with eight bulimic women. All of them were asked the same broad scope questions (see interview guide - Appendix A) and given equal opportunity to discuss the issues and topics presented in these questions.

The questions asked during the interview process were such that they encompassed certain themes and concepts that were relevant to the theoretical portion of this work and the analysis has been organized around these specific concepts. What bulimia is, how it enters lived experience, the role of choice and the cultural narratives which inform these women's choice are explored in the context of the stories that these women have shared with me. Having extracted portions of the interviews which directly relate to the issues explored conceptually, what is presented below are portions of the women's stories and an analysis of those stories as they pertain to the concepts inherent to this work.

Key to this study is the question of how bulimia enters lived experience. By this I mean what is it and what does bulimia mean for the women who experience such behaviours? Also important to the work at hand is whether agency is a key component of bulimic behaviours. Anthony Giddens (1979, 1990)

has repeatedly emphasized the active nature of social actors, as well as the reflexive nature of self-development in this time of modernity. Are these notions apparent, and are they relevant to the experiences of women who engage in bulimic behaviours? Finally, are bulimic women reacting to or perhaps reflecting certain cultural narratives through their behaviour? The textual analysis proposed herein will attempt to answer these and many other questions.

The Participants

Angela is 30 years old and has "been bulimic, off and on, for the past fourteen years". Angela has sought out therapists who could help her understand and deal with her behaviour but she feels that she "didn't get anything from it". She describes herself as "indecisive, anxious, untrustworthy with myself and emotional, very emotional".

Sophia is 18 years old and has been bulimic for approximately one year. She has yet to seek therapy and believes that she can "get over it" by herself. Also, Sophia feels uncomfortable with the prospect of talking about her behaviour with others. "I don't really like the idea of going to talk to someone. It's kind of a lot easier, even though it's a lot harder, not to talk about it". Sophia describes herself as "a student, kind of stressed out with school".

Sandy is 23 years old and she has engaged in bulimic behaviour for approximately seven years now. On a waiting list for therapy, Sandy is ambivalent about her decision. "I

don't know if I really want it but they've (treatment centre) accepted me". She describes herself as "somebody with a lot of goals and ambitions" who tends to "analyze [her]self too much".

Bulimic for approximately nine years, ***Roxanne*** has been through therapy and feels that "c'est ça qui m'a aidé le plus, c'est la thérapie comme telle". Describing herself, Roxanne says, "Je suis le genre de fille, bon, j'aime beaucoup voyager, j'fais beaucoup de voyages et j'suis très sensible".

Rachel is 22 years old and has been bulimic for approximately 5 years. "I went to a psychologist, two or three times, but it didn't help me because I think that I didn't feel very comfortable." Like Sophia, Rachel says "I want to treat myself". Rachel is a secretary who came to Canada recently to study. "I want to study nutrition. I want to learn more English and French and after, I want to study that".

Bulimic for approximately two years, and coinciding with her arrival in Canada, ***Mireille*** is 45 years old and has not sought therapy for her behaviour. "Je pense quand même connaître mon problème donc j'essaie de le résoudre moi-même." Dealing with the stresses and anxieties related to her immigration, Mireille describes herself and her new life as one where she is "à la recherche perpétuelle de repaires".

Janet is a 22 year old student who has been bulimic for approximately 6 years. She has had various forms of therapy in the past and is presently undergoing counseling which she

describes as "the first time I was going to counseling for ME" and no one else.

At thirty four, ***Dorothea*** has been bulimic for close to 20 years. She has tried various forms of therapy because "un moment donné, quand je sens que ça avance plus, j'essaie d'employer d'autres méthodes". Dorothea describes herself as "une personne excessive. J'ai beaucoup de bonté, beaucoup d'amour, beaucoup d'aide à donner. Et puis j'me vois comme une personne très émotionelle".

These descriptions serve only to briefly introduce the participants and to provide a glimpse of how they see themselves. These women, who have generously shared their stories with me, all have experiences which reach far beyond that which is presented below. It would be unfair to assume that their overall lived experience is indeed that to which it has been reduced in this work. For the purpose of this research, however, reducing their overall lived experience to analytic categories is, to a certain extent, inevitable. I hope, however, that despite this abstraction and dislocation, I will do justice to their stories and succeed in painting a picture of these women as accurately and as respectfully as they would hope.

Section I

Bulimia: What is it?

Although everyone has heard of 'eating disorders' and chances are good that most people know someone, or knows someone who knows someone who is or has been anorexic or bulimic, the fact still remains that it is impossible to know exactly what being bulimic or anorexic might be like without direct experience. It is obviously very difficult for anyone to grasp the concrete development and living out of a bulimic episode, for example, without having some direct contact with such an event. It is for that reason that I have chosen to include an example of one participant's bulimic episode. Dorothea spoke so candidly and in such detail about a particular incident that I have decided to include its description so as to help locate the reader within the realm of a bulimic episode.

> "Ça peut être un pain - c'est incroyable tout ce qui rentre, t'sais, c'est incroyable. J'essaie de me rappeller là. Là je commence avec les trois tomates, deux casseaux de lucerne, un pied de célerie. Bien là, je ne veux pas garder ça, alors là, j'part. Je prends des noix, je prend un peu de café parce que là j'ai froid. Là j'm'en va chez Métro. Là chez Métro, j'me presse dans ce temps là. Ça presse dans ce temps là. Là, chez Métro, ouvre les sacs de chips, mange les chips pendant que j'm'en va avec le carosse. Ouvre la liqueur parce qu'il faut que je mélange ça avec de l'eau parce que sinon ça reste 'jammer' là, j'suis pas capable de vomir. Ça fait que là, je prend, j'embarque plein d'affaires dans le panier. Ça fait que là je prends une tarte au sucre, une tarte aux fraises, un demi casseau de crème glacée, uhm, je prends un sweet and sour stir fry congelé, je prends une mini pizza que je mange, d'ailleurs, chez Métro, juste avec la sauce, ça goûte la merde. Je prends un petit chose de beurre, je prends des

> pretzels pizza avec le beurre. J'avais pris un morceau de viande crue, j'aime ça manger de la viande crue, mais je l'ai laissée là parce que ça montait trop cher. J'me suis dis, j'vais économiser un peu. Je reviens chez nous, je fais ça, je fini, buvant de l'eau en plus - ça me prends, une fois j'm'étais pessée. 15 livres de nourriture, 15 livres. Fait que là, j'me remplie, j'me remplie jusqu'à temps que j'en peux plus, t'sais là, et puis tout le temps que je mange comme ça, j'vois pas rien d'autres. Tout le temps, j'me remplie, remplie et puis ce que j'fais de ces temps là c'est que j'attends un peu parce que mes intestins marchent plus très bien à c't'heure. Ça fait qu'en étant pleine comme ça, ça flush en bas alors j'attends, j'attends que ça décende. Ça me fait du bien. Ça fait que là, j'me fais vomir et puis chaque fois que j'me fais vomir, j'prends plus mes doigts, j'prends du Scott Towel que je tourne autour des mes doigts parce que ça marche plus avec mes doigts."

Although bulimic episodes vary from individual to individual and the above cannot be interpreted as a homogenized version of overall bulimic episodes, it nonetheless paints a good picture of what most bulimic women experience during a binge. The urgency involved, the food consumed that would otherwise not be eaten and the physical ramifications of repeated bingeing and purging are all represented in Dorothea's story.

The medicalization of bulimia

The consequences of rendering certain behaviour as medical problems have been discussed in a previous section. What follows is a more detailed exploration of the concrete ramifications of such a practice on the women who actually experience the so called 'disorder'. One of the very interesting consequences of the medicalization of 'eating disorders' is the language used to talk about and to describe

the behaviour. "It", "the problem" and "the disease" are all terms used over and over again to describe bulimia by the women whom I interviewed. Not being able to personalize their 'disorder', and having been well versed, either in therapy or through their own understanding of how 'eating disorders' are interpreted, these women spoke of bulimia as a distinct entity with a life of its own. Sophia explained how "*it* went away...and *it* started coming back". " I don't want *this problem*" stated Sandy. Language not only names and defines phenomena, but it also constructs a discourse and an interpretation of the object or matter in question. The women I interviewed had certainly appropriated the medico-pathological discourse which surrounds 'eating disorders' and the language they used to talk about and describe their behaviour certainly reflected this.

The popular interpretation of 'eating disorders' as a disease has been well appropriated by the women whom I interviewed. Not only did they refer to their behaviour as an 'it', a 'problem' and a 'disease', some of them even referred to highly medicalized phenomenon in relation to their experiences. Janet, for example, spoke of 'remission' and 'relapses'. In looking for an explanation for her behaviour, she wondered "if it's because of my hypothalamus. I used to wonder, gee, did I wreck that because I know it controls your menstruation and thirst and all that".

Furthermore, several of the women interviewed appeared very concerned that their behaviour be 'diagnosed'. They

believed that, until their behaviour had actually been confirmed as an illness, they would not be taken seriously. "I think I heard somewhere that if you throw up within every two weeks, or something like that, then you're bulimic", commented Janet. Sandy worried that perhaps she was not as sick as she needed to be to receive treatment:

> "I guess that since yesterday" she said, "since the episode yesterday, throwing up blood or whatever, I guess I feel bad in that respect that maybe I should be worse. Like, I don't know, I have all my blood tests coming back on Friday and I think that if it shows nothing, then they won't take me seriously."

After having thrown up blood, Sandy still worried that perhaps she would not be diagnosed as 'eating disordered' and would, therefore, not be eligible for treatment. The power of naming something an illness, as well as the power of medical discourse, is apparent in the concerns brought forth by several of the women whom I interviewed. Naming the behaviour as something concrete and feeling desperate to have their behaviour diagnosed, these women have appropriated the medical discourse around 'eating disorders'. Conversely, they have defined and they experience their behaviour through the lenses of medical discourse.

Who's responsibility is it?

Qualifying bulimia as an illness or a pathology also has the consequence, in some instances, of diminishing feelings of responsibility in light of the behaviour in question (Habermas 1992:61). Traditionally, pathologies have been constructed as

forces upon which we have no direct control. Illnesses *happen to* us and as such, they are conceived of as forces embedded with their own power and destiny. To construct 'eating disorders' as an illness results in certain feelings of helplessness and lack of responsibility towards one's situation. In speaking of her imminent admission to a therapy program, Sandy admitted that she wants the treatment centre to "solve the food problem":

> "I guess I want to go there and to have them help me stop the bingeing. I guess I know that they're supposed to try and change how I think. I just want to go there because I'm not getting where I want with bulimia and I can't seem to stop that, and I can't get there another way and, I guess, if they can help me control my eating, I think I'll be able to control it to the point where I'll lose weight". Also, "I've decided that I don't think right about it but I can't change it and I guess that's their job, to do that."

Sandy clearly sees her 'treatment' as *their* role, not hers. And why wouldn't she? After all, the popular interpretation of 'eating disorders' tells her that she suffers from a disease. Diseases, in our culture, are *cured*, and this by someone qualified to do so. Having been made to understand her behaviour as an illness, an invasive condition over which she has little control, the bulimic woman invariably learns to abdicate her power and her responsibility to the expert system which defined, or 'diagnosed' her as ill.

Roxanne also relied on expert systems to 'solve her problem'. She believed that once her therapy had terminated, she was cured. "Après ma thérapie, je me suis dis 'je suis

guéri', mon problème de boulimie était réglé et puis tout va bien aller finalement". In this sense, therapy is interpreted as the cure and once the cure has been administered, the problem, the illness, goes away. Of course, this is not always the case. Although Roxanne felt cured after her therapy, she was still actively engaging in bulimic behaviour at the time of the interview. Disease and sickness coloured Dorothea's interpretation of her bulimia as well. "Oui je suis boulimique, oui, je suis malade mais il faut que j'me rentre dans la tête que j'serai pas toujours comme ça." Comparing bulimia to yet another medicalized phenomenon, Rachel states: "I think that bulimia is like alcoholism, or like drugs, it's the same, you can't control yourself. Like, when you are alcoholic, it's the same".

The practice of medicalizing or pathologizing certain behaviours does not, at its outset, intend specifically to remove responsibility from the individual. It does not, furthermore, set out to willfully or intentionally create dichotomies; that process of clearly differentiating between two separate and distinct categories (i.e. sick vs. healthy). Unfortunately, however, these circumstances are often the result of such practices and their consequences are detrimental to the people being described in such medicalized ways. Removing a certain level of one's responsibility by assigning the 'sick' label to them invariably also removes one's willingness and ability to empower themselves and to rewrite the patterns which have, thus far, come to define them

as, for example, bulimic. A solution to this problem, however, does not easily come to mind. The women interviewed would be the first to admit to the pathological nature of their behaviour. To suggest that 'eating disorders' be de-classified as 'disorder' or disease would not solve anything. However, the consequences of medicalizing a behaviour are nonetheless very real, as has been shown above, and must be considered when, for example, bulimic women begin the process of ending their behaviour. If women with 'eating disorders' are allowed to understand their behaviour as a direct result of their choices, then they might begin to tap into and to recognize the strength and resources which they have and which they can use to end their behaviour. When a woman is encouraged to believe, however, that her behaviour is the result of some abstract, outside force - such as an illness - then it becomes much easier to rely on other outside forces to solve the problem than it is to depend on one's personal resources to end the behaviour.

The mind/body dichotomy

Earlier on, I explored theories of self, as well as theories of the body, in an effort to demonstrate how these modern notions of body and self have developed. As Anthony Synnott has pointed out, emerging philosophies or sets of ideas do not usually replace existing ones, but rather, they live side by side, attempting to co-exist while competing for legitimacy, often over long periods of time (Synnott

1992:80). An example of this is that although Descartes' philosophy of self supported a supremacy of mind over body and clearly delineated between these two entities, and although these beliefs have, to a certain extent, been challenged by twentieth century thinkers, Cartesian convictions still inform much of western thought (Smith 1987). These long standing ideas co-exist along side modern conceptions of self which, as Dorothy Smith suggests, emphasize a more body centered understanding of existence, rather than one which privileges the mind. As the testimonies presented below will indicate, these ideas of unity of self, as they are espoused by modern day theorists, have not necessarily replaced old ones, as Synnott has suggested, but appear, rather, to co-exist along side them.

The question of unity of self (body and self) was somewhat ambiguous for the respondents. Overall, they reported more of a dichotomous relationship between body and self than the unified relationship conceived of by contemporary theorists of the body. As we will see, although many of the bulimic women interviewed did not necessarily adhere to a strict hegemony of mind over the body, as suggested by Cartesian philosophies of self, many of them nonetheless expressed a dichotomized experience of body and mind, rejecting, if you will, the more modern conceptions of self which espouse a unity of body and mind, of body and self.

Dislocation and Objectification

Interested in discovering if the bulimic woman's concern with her body would lead to an over-emphasis or a privileging of her body over her mind, I asked the respondents whether they felt they had a relationship with their bodies and if they did, how they would describe or characterize it. In opposition to what many modern theorists of the body believe about the unity of mind/self and body, some of the women interviewed expressed a clear distinction between living in their body and their mind. In a striking example of how some of the women experienced a dichotomy between mind and body, Mireille stated "J'ai pratiquement pas, bien, pour l'instant, je pourrais dire que j'ai divorcé avec mon corps. J'ai divorcé avec mon corps. J'le regarde plus, je ne l'aime plus, c'est comme s'il y avait deux partie: il y a ma tête et puis mon corps". Similarly, Dorothea spoke of her body as though it were a distinct entity, separate from who she is. "Je m'appercoie des fois que mon corps est là et puis j'y prend pitié. Ce pauvre", she says, referring to her body as 'that poor thing', "il m'a suivi tout ce temps là, continué à faire sa job. J'en ai plus conscience, mais pour beaucoup d'année, non, j'en ai pas eu de corps et puis j'l'ai toujours détesté, j'l'aimais pas mon corps". Further emphasizing the alien nature of her relationship with her body, Dorothea states "tu sais même pas c'est qui ce corps là parce que tu le reconnais même pas dans le mirroir". Reflecting what Saint Francis of Assisi believed about the body ('We must hate our bodies with

[their] vices and sins') (cited in Synnott 1992:88), Janet stated "I hate my body. I hate it. Not necessarily because I always think it's fat, it's like, I think of it as the cause of all my problems. I have felt, uhm, separated from my body".

The body, as the object of discontent, perhaps, for these women, represents an entity outside of the self. It is an object which lives independently of the self and which, to a certain extent, has the ability to control one's emotions, actions and, of course, sense of self. The concept of the body as the self is not one which most women could not freely accept. The ideas of more traditional thinkers, however, seems to characterize the relationship which many of the women have with their bodies.

The 'illness' and the body: 'others' issues

The affirmation made by Janet above not only indicates a separation between body and self, it also emphasizes the level of non-responsibility inherent in the construction of 'eating disorders' as disease. In separating her body from her self, Janet is succeeding in attributing her 'problems' to her body. In so doing, she continues to believe that some *other*, separate and distinct entity is responsible for her 'condition'. Sandy also echoed this interpretation of her body and self, in relation to her 'eating disorder'. Referring to her body, she states:

> "it controls my life, by what I eat and by how I look and I how I feel about how I look. That's one reason I think I'm putting off teaching aerobics, 'cause I don't see

> myself teaching up in front of a class how I look. I think that if I improve how I feel about myself by improving how I look, then I will be able to be a better instructor".

The 'it' to which both Janet and Sandy are referring is the body. It is that entity from which they feel alienated, yet which appears to have the ability to control and dictate their behaviour and their feelings about themselves. And although modern day theorists of the body tend to equate, or at the very least, insinuate a very close relationship between body and self/mind, some of the women interviewed appeared unable to accept or to incorporate that link within their own experiences.

As many feminists have argued (Smith 1987, Currie and Raoul 1992, Szekely 1988) the permeating nature of Cartesian understandings of the world must be challenged. Not only does a privileging of the mind over the body negate much of what has traditionally been considered as part of the realm of the feminine (Currie and Raoul 1992:3), it also perpetuates the belief in a dichotomized relationship between body and self. As the women I interviewed indicated, the body and the mind/self are often considered distinct and even opposing entities. Until we consolidate body and self as one, or at the very least, until we learn to appreciate the virtues of each, we cannot hope to overcome the dichotomized beliefs and practices which have led, among other things, to the denigration and devaluation of that which belongs to or reflects the feminine realms of existence.

Bulimia as lived experience

How does bulimia enter lived experience? What does it mean and what does it come to represent to those experiencing it? How does it affect one's daily life and to what extent does it help determine one's overall experience of self? When one considers the lengths to which bulimics are willing to go in order to sustain their behaviour - the secrecy involved, the time and money spent engaging in the behaviour, the increased isolation and risk of being discovered - it becomes evident that, although destructive, this behaviour is important to them.

Coping mechanism

For some women, bulimia enters lived experience as a coping mechanism, a tension release. As Mireille indicated, bulimia only became an issue for her when she immigrated to Canada and was faced with the daily stresses of adapting to a new and foreign lifestyle. "...je pense que je connait ce problème là parce que, tout simplement, c'est le fait d'être partie de mon pays". Bulimia did not play a part in Mireille's life when she was 'home'. She says that it has only become an issue since she's come to Montréal. When she becomes anxious and stressed, she eats. "Dès que je sens quelque chose, je suis engoisée, op, je vais tout de suite au frigidaire et je me mets à manger alors que je n'ai pas faim. J'ai toujours besoin de quelque chose dans la bouche, de manger". The first

time she consciously recognized her behaviour, Mireille was undertaking the uncertain process of applying for refugee status, a process which entailed very stressful and anxiety provoking hearing procedures. When asked if she could remember her first experience with bulimia, Mireille answered, without hesitation, "ça commencé quand j'ai demandé le statut réfugié". Eating, in Mireille's case, became a way of dealing with the stress and uncertainty of her future, of dealing with the constant reminders of her life and lifestyle in Canada as opposed to back home, and of starting her life over under difficult and unsure conditions.

Echoing Mireille's interpretation of bulimia, Angela states: "It's been my choice", she says "or my understanding of how to deal with who I am. It almost seems that it's been there when I haven't known how to deal with my emotions". Later, Angela explains it as such: "It's like, I don't know, it really isn't a good word for it, I don't want to say escape, but I think that's what I do with it. I run from the responsibility of my actions." The ultimate tension release, bulimia represents both the possibility of releasing stress and anxiety by eating, as well as by vomiting. For many bulimics, it is the actual act of vomiting which is most comforting. Somehow, this is believed to relieve all the built-up emotions captured within. Sophia also characterized her behaviour as a way of dealing with stress. "Bulimia came out of my stress", she says, and "it kind of releases stress because it's physical".

Women and Food

Dealing with stress through food might be interpreted as the response to the ambivalence many women feel towards food. It becomes a narrative which reflects the belief that some, like Kim Chernin (1986) and Geneen Roth (1992) for example, have postulated with regards to women and their relationship to food. As the traditional nurturers and primary caregivers for our families, women have, for a long time, been assigned the responsibility of food concerns. Shopping for, deciding upon and preparing food are generally activities bestowed upon women. Confronted with both the main responsibilities for food purchase and preparation and the standards of feminine beauty espoused in North America, some women have developed an ambivalent relationship to food (Chernin 1986). On the one hand, food is the source of energy and life, the nurturing substance provided to others and to ourselves. On the other hand, it can become a source of anxiety for weight and body conscious women; the necessary evil which threatens our 'relentless pursuit of thinness'. Food, under these circumstances, can come to represent a source of anxiety for many women. For bulimics, it also becomes the means through which many anxieties are lived out.

Companionship

The bulimia as coping mechanism narrative also takes on other characteristics. For some, bulimia can be defined as a companion, an activity which keeps them company and which, at

times, gives them comfort. "L'action de manger passe le temps, ça fait juste passer le temps" says Dorothea. Of course that which gives them comfort is first and foremost the food; that component which nurtures and feeds.

> "D'un côté" says Roxanne, "t'sais, tu dis, 'eh, je vais manger tout ce que je veux, je vais me faire *plaisir*' et puis, t'sais, quand tu commence une crise là et puis t'as, bon des fois ça commence mal mais c'est la jouissance de dire 'je vais manger tout ce qu'il y a dans le frigidaire puis j'vais arrêter de penser'".

Roxanne's statement also paints bulimia as a coping mechanism, but this time, it is also characterized as a companion. Considering the ambivalent relationship women have to food, however, this companion is a dangerous one. Although eating provides Roxanne comfort and happiness, she is acutely aware of the impact that her overeating has on her body.

> "Ah, c'était incroyable! Aussitot que j'étais down ou quoi, je pouvais passer à travers des sacs de biscuits puis du macaroni, puis, mais, bon, c'est sur que j'me disais 'j'suis petite' mais je me disais, 'eh!, ça pas de sense, faut que j'fasse de quoi sinon je vais engraisser, j'veux pas engraisser'".

Food, for Roxanne, as well as for many women, represents both nurturance and joy, while at the same time, it represents the source of their 'problem'. Perhaps the arguments postulated by Roth and Chernin are not far off the mark. The fact that 'eating disorders' are more prevalent in women than in men may have its roots, in part, in the fact that women do have an ambivalent relationship to food and this relationship serves as the tool through which anxieties, loneliness and stress are lived out.

Displacement

Bulimia might also enter lived experience as a scapegoat, as the ultimate reason - the 'illness' - for avoiding certain life situations. As discussed above, the concept of illness has the ability to become the ultimate absolver of all responsibility (Habermas 1992). Bulimia, in this instance, may act as the ultimate absolution enabling women to avoid those situations which may be difficult or challenging. Sophia, a woman who exuded a love for music and who appeared to genuinely long for a classical education in this field spoke of bulimia as a reason for not attending the program to which she had been accepted. Says Sophia "I got in (to University) but, because I'm like this, I couldn't go". Roxanne also spoke of having to put off University because of the stress it might create and because of her known reaction to stress. "J'sais même pas si j'vais être capable de faire mon bac., parce que ça va être trop stressant, trop de pression". Can bulimia become a coping mechanism which also acts as a scapegoat? Does bulimia become the reason behind avoidance? Rachel, who came to Canada to study, says that her bulimia has interfered in her life to the extent where she has not been able to do well in school. "It interferes too much in my life", she says, "it interferes too much. My studies too. Because I learned French last year but I didn't learn it, it's more difficult for me than my sister."

Dorothea also illustrates this point very well.

"C'est toujours la même chose. Pas capable d'être en groupe même si c'est l'fun, être obligé de s'en aller. Ça arrache le coeur. Jamais capable de rester en groupe. Toujours être obliger de s'en aller, s'en aller." More blantanly, Dorothea later said "J'm'appercoie que c'est un moyen d'me cacher. J'm'appercoie, maintenant, que j'me suis cachée derrière ça des année."

Bulimia, as illness, can easily become an 'excuse' for avoiding situations and even emotions. Angela says: "I didn't learn to do a lot of things, uhm, or how to cope with a lot of things growing up so that's what I go to. That's all I know, at this point." Although this scenario does not support the idea that these women became bulimic in order to avoid certain situations, experiences or emotions, it nonetheless illustrates the ramifications of labeling behaviours as pathological. This practice not only removes a level of responsibility on the part of the woman, but it also provides a valid and socially (or at least medically) sanctioned escape from life.

The organization of the day

Dorothea expresses how bulimia enters her lived experience by controlling her life and by dictating her every action. "Du moment où j'me réveille au moment où j'me couche le soir, c'est l'obsession. J'vas tu manger? J'vas tu pas manger?" Here too, bulimia represents the scapegoat, the coping mechanism which allows one to undertake or to avoid

experiences as the 'illness' dictates. "Ça contrôle ma vie. Ça contrôle qu'est-ce que je vais faire tout à l'heure" says Dorothea. Because one cannot fully function during or immediately following a binge/purge session, the bulimic activity eventually comes to determine other aspects of one's life. If one binges and purges twice a day, as Dorothea usually does, and if a session lasts a couple to several hours, as Dorothea's do, then much of one's daily activity revolves around the planning, acting out and recuperating from the binge/purge session. What follows is a detailed account, given by Dorothea, of how bulimia and its activities enter lived experience at a very basic, daily level.

> "L'histoire c'est de se remplir jusqu'à temps que t'es plus capable, puis après ça, aller vomir. Ça fait que là, ça, ça dure deux, puis trois heures, puis quatre heures - un gros deux heures mimimum... là, tout est croche, tout est sale. Le linge, c'est sale, c'est une énergie effrayante. T'sais là, tu vomis puis il faut tout nettoyer la chambre de bain après, faut tout laver le linge, là il faut tout ramasser les vidanges, les affaires et tout. Le chocolat dans l'char, les miettes, toute traîne."

Sophia also described the extent to which bulimia has become an integral part of her everyday experience:

> "I just got into this routine of waking up at 10:00, going to the store, coming back and I'd watch different shows, like talk shows or whatever, 'till about noon and there was nothing good on t.v. -I was t.v. addict too, for that month - and then that's when I'd puke and stuff and then, and then I'd go back to the store or whatever and then at 1:00 other shows would come on and I'd watch 'till like 7:00 at night and I'd, I couldn't concentrate so I wouldn't really do anything but I'd stay up 'till like 2:00 or 3:00 in the morning and then, I would just, that would happen every day".

Such hectic schedules play havoc with one's possible daily activities and they impinge upon the possibility of creating other experiences. Bulimia, under these circumstances, provides the bulimic woman with a valid justification for avoiding any and all other life experiences while, at the same time, keeping her busy and preoccupied. It takes a lot of energy, as Dorothea stated, to go through such routines regularly. It also takes a lot of energy to try and avoid such scenarios. Sandy explains that her bingeing and purging usually occur at work. "The easiest place for me seems to be at work because nobody does know and I always have the time factor whereas if I go home, it just seems too, I think about it too much. I have time to think about it".

Finally, Roxanne describes the extent to which bulimia, whether it be its concrete manifestations through bingeing and purging or through its overwhelming presence in one's life, takes over a great part of one's existence.

> "Puis, c'est là que c'est dangeureux parce qu'à place de dire, 'c'est pas grave, demain je vais manger comme il faut', c'est comme, 'eh là!, faut que j'me retienne, faut que j'me retienne, faut pas que j'mange. C'est comme ça prends, ça me prends, si j'ai fait une crise une journée, ça va me prendre une semaine à m'en remettre, t'sais. Ça fait qu'imagine si ça fait une semaine que tu manges, c'est horrible, t'sais!".

Not only does the behaviour take up much of one's day, but the grief, agony and pains that one goes to in order to avoid the behaviour and to recuperate from binge/purge episodes is incredible. Although I described these women as not being defined solely by bulimia at the beginning of this

chapter, these stories certainly indicate the extent to which bulimia does colour their lives and the extent to which their bulimic behaviour has come to determine, at the very least, their everyday experiences.

Conclusion

As a lived experience, bulimia enters these women's lives at a very fundamental level. It determines many of their daily activities and also plays a role in orchestrating more far reaching life decisions such as where one lives, whether one will attend University or whether one will maintain and nurture friendships. Although these women would not define themselves solely in terms of their 'eating disorder', the behaviour associated with it certainly helps to formulate the direction in which they take their lives. What follows is an exploration of the extent to which this situation is a choice on the part of the women involved. It explores the concept of agency as well as the cultural narratives reflected by these women and their behaviour.

Section II

Agency & Choice:
Their relevance within the bulimic narrative

Agency, as Anthony Giddens defines it, refers to a "continuous flow of conduct", "a stream of actual or contemplated causal interventions of corporeal beings in the ongoing process of events-in-the-world" (1979:55). Agency refers to the concerted actions undertaken by social agents within a specific social structure. Giddens' theory of structuration addresses the interdependence and interrelationship between action and structure. It is this concept which inspired me to question the level of choice inherent in bulimic women's behaviour.

Although the victim argument which characterizes many 'disorders' such as bulimia seems to suggest that the overbearing social structure, the one which imposes strict standards of beauty on women, is the motivating factor, or the culprit, in the prevalence of 'eating disorders', this argument does not adequately address the concept of agency and choice. The idea that women actively engage in the behaviours associated with bulimia and are not forced or coerced into their behaviour by an overbearing social structure is not provided for in arguments which rely exclusively on structure as a motivating factor. It would be foolish to suggest that social structure has no influence on individual choice, however. It is, after all, that which helps shape members of society, to socialize them. But as human agents, we do have

the ability to, at the very least, interact with that social structure. We are not robots forced to adhere to the norms, values and expectations of society without reflection and choice. That those choices may be limited and that options may seem few and far between is not put in doubt. However, within that space of interaction between individual and social structure, there is room for choice.

Taking agency into account in a discussion on 'eating disorders' helps to locate the power and responsibility within the realm of the individual, not the abstract world of society and social structure. Once an individual is able to locate choice within herself, then it becomes much easier to make opposite choices - in this case, the choice to end the behaviour. This does not mean that simply choosing to end the behaviour will result in an abstinence from bingeing and purging, but it does begin to locate the power within the individual and it may help to begin the process of 'recovery'. Recognizing that one's behaviour is a decision empowers one to make different choices. Locating that power within the allusive, abstract social structure makes change seem hopelessly overwhelming. Unfortunately, such an understanding of agency and appropriation of choice is often overlooked in the traditional literature dealing with 'eating disorders' and the result often appears to be a scapegoating of society and social structure, rather than a constructive discussion about the actual choices made by those defined as 'eating disordered'.

However, the ambivalence between choice and lack of control was most clearly expressed by the women interviewed. This is because, to a certain extent, the act of eating uncontrollably is difficult to explain. These women do not know why they use food as a coping mechanism and their inability to stop when they feel they should only adds to their feelings of loss of control and lack of choice. Sophia explains the lack of control over her behaviour as her sign that 'something was wrong'. "I tried to stop but I couldn't and, uhm, that's when I thought, when I tried to stop, that there was something definitely wrong. I still couldn't stop it." Sandy also speaks of her inability to understand why she binges and purges. "I don't know why I eat a box of cookies in, like, ten minutes. I don't know why, but that's the part I want to stop, that out of control part". This inability to understand their choice of action will be dealt with later on in this section. It suffices, at this point, to state that these women are, indeed, quite ambivalent about the question of choice.

Choice, control and power

To say that women play an active role in their decision to engage in bulimic behaviours is controversial, but it is one which cannot be denied. According to the DSM-IV, after persistent experience with the binge/purge cycle, episodes are no longer "characterized by an acute feeling of loss of control" (A.P.A 1994:546). The fact that some of the women

interviewed spoke of planning binges attests to this. Roxanne explains that "j'suis rendu où les fins de semaine, je me permet des crises". This may indicate that, at least in some instances, a conscious decision is made to engage in bulimic behaviours. Because bingeing and purging has become a habit, a way of dealing with whatever may be happening in one's life at that time, and because it has been incorporated as a 'permanent' pattern, it becomes easy to accept the behaviour as a 'normal' part of one's existence. Both Janet and Sandy's statements speak to this.

> "But on the whole", says Janet, " I think, the way I used to think about it was that it became part of my life and it was normal, it was a normal way to live. Like, I knew that it wasn't the way that everybody else was but it was just the way that I had to be and I had accepted that and it became normal to me, it became a normal part of my life".

Sandy echoes Janet's appropriation of her behaviour as normal.

> "I guess throwing up isn't one of my favourite things to do. It just was getting easier and easier and easier and I'm doing it more often and, I don't know, I guess I like to do it - I don't like to do it, but after I do it it makes me feel, I'm glad I did it."

It does not necessarily follow, however, that women *consciously* choose bulimia. Given a choice between being healthy or slowly endangering one's health through the dangerous binge/purge cycle, most women would undoubtedly choose health. However, as indicated by Roxanne, once the behaviour has been learned, whether it is as a dieting mechanism like Sandy admits, "I don't know why I started doing

it, I guess to lose weight" or as a response to stress or uncomfortable emotions as Roxanne states, "aussitôt que j'étais down, je pouvais passer à travers des sacs de biscuits", each successive binge/purge session becomes, at a certain level, the choice of the women who engage in it.

This issue was one that brought about the most contradictions within the women I interviewed. Although the question of choice was directly addressed to them at one point during the interview, it also came up at other times, without solicitation. During those unsolicited moments, most women indicated a lack of control over their behaviour, hence, a very limited choice of action. According to Rachel, "it's out of your control, it's like alcohol, like drugs. It's the same. You can't control yourself." In recounting an event when someone told Dorothea that she had a choice to engage in or to end her behaviour, she admitted to having, at that time, adamantly rejected that person's suggestion. "Fuck you bucko!" she says as she recounts her first confrontation with the issue of choice. "I have a choice? No, I don't have a fucking choice", she said in a very agitated manner. Janet and Roxanne also both spoke of the lack of control, the lack of choice that they have in engaging in their bulimic behaviour. According to Roxanne, "t'as pas le contrôle de manger. T'as le contrôle de l'éliminer après, mais t'as pas le contrôle". Janet said that she began to realize that bulimia was "taking control of you and your mind".

Based on these statements, it is obvious that the women I interviewed felt helpless in the face of their "compulsion". "C'est compulsif, des fois tu te sens impuissant", said Dorothea. The only woman who indicated that she did have a choice, without being asked directly, was Angela who stated that bingeing and purging, like ending the behaviour, is "just a decision" and that, furthermore, "deciding not to binge and purge...was my only victory to go by in life". Choosing, therefore, was for her a positive endeavour which empowered and motivated her.

Practical Consciousness

One component of action or agency delineated by Giddens and which may be relevant to this analysis is the notion of 'practical consciousness', a notion which refers to "tacit knowledge that is skillfully applied in the enactment of courses of conduct, but which the actor is not able to formulate discursively" (1990:57). Applied to action, practical consciousness refers to that state in which we find ourselves when we undertake actions which we cannot consciously explain or rationalize. This appears appropriate in light of the question of choice as it was addressed directly to the women I interviewed.

As noted above, when speaking candidly and without solicitation, most of the women indicated that their behaviour was out of their control, that they did not, in essence, have a choice of action. When asked directly, however, most of the

women indicated, without hesitation, that they did, indeed, have a genuine choice in engaging in their bulimic behaviour. Does this, therefore, speak to the practical consciousness to which Giddens refers? Because they cannot formulate a rationalization for their behaviour, and because they cannot discursively reason the actions that they've engaged in, the women I interviewed may have seen very little option but to answer yes to the question of choice. Did they feel that they could not, in good consciousness, answer anything but yes to the question, as it was asked? Their ambivalence was accentuated, however, by the qualification which most of them made to their answer. "Bien oui j'ai le choix" says Mireille "mais je peux dire que la boulimie, dans mon cas, est la plus forte, la plus forte. C'est des moments très rares où je suis, où je me sens assez forte pour faire face à ce problème là, c'est très difficile". Angela conceded that "there's a small part of my personality or my character that says 'yes, you have a choice', so I suppose that I do have a choice, but it's something that I barely see anymore". Similarly, Dorothea accepts that the choice is hers. "Oui, c'est mon choix, c'est mon choix de rester dans ma marde, t'as toujours le choix", but she too qualified her answer to reflect the ambivalence inherent in that question: "mais je m'apprécie pas encore assez, j'm'aime pas encore assez pour le faire." Janet decided that she does have a choice whether to engage in her behaviour or not. However, for her, the ramifications of not bingeing and purging seem too great.

> "You can act on your impulse or not, but for me, I have to think of the consequences of acting this out or not... What's more important, to slip up like that but then be functional for the rest of the day, or to fight it, to spend the whole day fighting it. I guess you've got to weight what's more important for you at that time."

Perhaps another issue which is relevant here and which may help to clarify the ambivalence expressed towards the concept of choice is a methodological one. The questions that we ask and the ways in which we ask them serve as an inevitable precursor to the answers that are generated. Norman Denzin (1989), for example, states that the research question, and by extension, the questions asked during interviews, should always be phrased as 'how' questions, rather than the causal 'why' questions. The fashion in which I addressed the issue of choice during the interview was obviously reflected in the type of answers that were given me. Asking, as I did, "Do you feel that you have a genuine choice to engage in or to stop your bulimic behaviour?", may have pigeonholed the respondents to answering only in the fashion in which they did. Although the causal 'why' was not explicitly part of the question, one might still assume that its implicit nature was reflected within the question. Asking if someone has a choice to engage in a certain behaviour or not may in fact sound a lot like, 'why do you do it?'. Such questions never garner very rich responses because people are very rarely able to articulate a reasonable answer to a 'why' question. And, as indicated above, ambivalence is a very real component of the behaviours associated with bingeing and

purging. The women do not know why they binge and purge. As such, the impact of the question, as it was asked, may have substantially predicted the types of answers garnered.

Choice and cultural narratives

Finally, are there certain cultural narratives which inform the behaviours that accompany the 'relentless pursuit of thinness' (Szekely 1988)? Jeremy Rifkin, in his book entitled Algeny, states that "with increasing reliance on technology, humanity begins the slow process of wrestling itself away from complete dependency on nature. Technology also gives people power to redirect nature..." (1984:41). This power of which Rifkin speaks is one which allows humans to transcend nature and, in so doing, to recreate the very idea of humanity. Rifkin wrote Algeny as an exploration of the increasingly powerful worlds of bioengineering and biotechnology in order to examine humanity's growing ability, not only to transcend nature, but also to recreate nature in its own image and to its own specifications. Less dramatic forms of these attempts to transcend nature exist everywhere and they inform much of western thinking. Plastic surgery is a good example of this less dramatic form of transcending nature.

'Eating disorders' may simply be an extension of this pervasive notion that nature, in the form of the body and the self, can constantly be improved to fit the requirements or the ideals of the day. Perhaps 'eating disorders' can be

considered a manifestation of the rapidly changing possibilities of body transformation. Because so much is possible in our modern western world, bulimic women might be considered representations of the cultural narratives which inspire and encourage the belief that we can transcend nature and achieve perfection. In light of all the possibilities available to us today, it is becoming increasingly difficult to live within the body assigned to us by nature.

As Robert Connell (1987) and Chris Shilling (1993) have demonstrated, gender is an important factor in the discourse around body and identity. Our social existence, our practices and experiences are filtered through gender. In keeping with the above argument, and because we live in "a society where appearance is considered to be women's major asset, where what women are able to do matters far less than what they look like, where people are raised never to be satisfied in the midst of plenty" (Szekely 182), it is no wonder that women comprise the largest group of individuals with 'eating disorders'. In an attempt to embody the current social and cultural ideals of femininity which emphasize thinness and beauty (Odette 1993), while undoubtedly having appropriated the belief that perfection is within reach, many women have become embroiled in the 'relentless pursuit of thinness'. Sandy most clearly reflected this way of thinking. "My ultimate goal is to lose weight". Later on, she qualified her feelings by saying:

> "I don't know what the deep down reason is why I'm doing it, not doing it, but just wanting to lose weight. I don't know why I want to be thin. I guess just because I think it will make me happy and that's the perception I get, maybe, from society. I know it's not true but it looks good and it's nice to dream."

Sometimes, it is this overwhelming emphasis on thinness which informs women's behaviour. Not to contradict my above argument around the question of choice and agency, this discussion around cultural narratives serves mainly to locate the source through which some women filter their choices. Although I do not believe that the social standards by which we judge and evaluate women are the direct source of women's bulimic behaviour, it cannot be denied that these must change, and the emphasis on women's appearance must be replaced by more substantial, less superficial values.

Being introduced to the means of eventually becoming the 'ideal woman', Janet has experienced the 'relentless pursuit of thinness' since a very early age. "My mom used to put me on diets as a kid. I think I went on my first diet when I was seven or eight". As a child, Janet was introduced to one of the characteristics by which some people define women: their beauty and size. She learned from an early age what I means to be a woman in North American society and, by virtue, made her choices in order to attempt to live up to these standards.

Sandy out rightly admits that bulimia represents her attempt at attaining that ideal. "When it all comes to an end", she says, "my ultimate goal is to lose weight...I don't know how I'm going to get there. If it's through bulimia, then that's how it is." Rachel also echoes the cultural ideals of

femininity, with its emphasis on thinness. "I don't want to be fat", she says, "I was always scared of that". Is it truly the fat which Rachel is afraid of, or does she fear not being able to adhere to the cultural ideals of female beauty? Angela also spoke of the influence of certain cultural narratives. "...so I moved away" she says of her decision to move to another city, "and I wasn't going to come back until I lost a lot of weight. That was sort of my 'I'm running away until I look good enough to come back' kind of thing. 'Cause that's how I felt I'd be accepted." Sophia also spoke of the impact of certain cultural narratives on her feelings of insecurity about her body :

> "... I don't feel comfortable around guys, uhm, I don't think I like guys, but I still don't feel comfortable. I don't feel comfortable around, like, thin people. Like, my sister's friends are very thin and I just feel so big around them, even though I'm not enormous, but still. I guess I'm not very comfortable, and not when I'm by myself, but when I'm with other people that are my friends. Like, right now, you're not looking at my body but sometimes people do and that makes me feel very uncomfortable."

Finally, Dorothea reflects a certain adherence to cultural ideals of femininity also. Having begun purging as an attempt to lose weight, Dorothea's experience with bulimia has since developed into a way of life. For the past twenty years, she has binged and purged almost daily. Dorothea admits that, although begun as an attempt to lose weight, her bulimia no longer represents that. "Moi, je veux engraisser, j'aime pas ça comme ça". However, different notions of femininity still manage to determine her experience of

bulimia. In speaking about the havoc created by a binge session, Dorothea says "Ça fait pas féminine, ça fait cochon, ça fait vraiment pas la fille féminine qui prend soin d'elle". As such, not only are current ideals of feminine beauty helping to direct many women's 'relentless pursuit of thinness', but cultural notions of femininity have also served to inform Dorothea's self-denigration in light of her bulimic experiences.

Whether it be through the painful rituals of plucking unwanted eyebrows or the destructive practices associated with bingeing and purging, our attempts at beautification nonetheless reflect the cultural narratives which inform our experience of the world. Informed by those permeating stories of who we are and what we should be, we, as women especially, engage in practices which are, to varying degrees, unpleasant and unhealthy. This does not mean that we do not have a choice to engage in or not engage in such behaviours. The cultural narratives which inform our behaviour do just that; they *inform*, they do not dictate them. Regardless, as social beings, we are all, as Mead has pointed out (1937) shaped and molded by the wants, needs, desires and expectations of the generalized other. We all learn the value of 'playing by the rules' and reflecting the cultural narratives which are in place, at least in part, to inform and direct our self-development and actualization.

Sandy explained this seemingly contradictory argument best when she said:

> "I definitely think, I don't know if I should say this, but I definitely think that society plays a role in how we, as women, whatever, think and act and stuff. But, I don't know how much that plays with me. I don't know why I'm doing this, why I want to be thin. I don't know if it's because that's what I think, I'm not doing it because that's what I think society wants. I guess I'm doing it because I look at people in society who I wish I could look like."

Conclusion

As Sandy and many of the women have indicated, the role of cultural narratives cannot be denied, at least as a superficial motivation for their behaviour. This does not mean that Sandy and the others have been coerced into their behaviour, but it does reflect the relationship between agency and structure. As individuals, we have the ability to choose the actions which we feel, at the time and for whatever reasons, are an appropriate response to the influences emanating from the social or cultural realm. One cannot automatically conclude, however, that cultural narratives are solely *responsible* for these women's behaviour. Rather, the above testimonies imply that their behaviour is based on larger issues than those alleged within medico-pathological interpretations of 'eating disorders' and point to the need for a reevaluation of those cultural narratives which emphasize superficial over substantial components of being.

Conclusion

Identity is a concept which has permeated the whole of this discussion. Although not blatantly explored it has made its presence felt throughout. In their description of their daily routines, of the appropriation of their behaviour and in their discussion of choice, these women have all spoken about their identity, about who they are and how they have carved out a self.

While the present work has focused solely on the bulimic aspect of these women's lives, it would be unfair to define them based solely on their bulimic behaviour. Their testimonies have indicated the extent to which their behaviour has contributed to their identity, at this point in their lives, but identity is a fluid concept, one that changes over time. Though their identity cannot help but be coloured by their bulimic experience - after all, it takes up so much of their time, energy and personal strength - these women can, and do, define themselves in other ways.

Dorothea says, "je la vois la fin. Un jour, je ne vomirai plus...je veux pas être mal, toujours comme ça." Although Dorothea has been bulimic for longer than any of the other women I interviewed, and although she expressed, throughout her story, a strong sense of attachment to her behaviour, she no longer wants to define herself through her bulimic behaviour. She sees that, one day, she will look at her life through different lenses. This indicates the complex

web that her, as well as the others' behaviour, has spun around her life and identity. On the one hand, the women that I interviewed cannot deny how intricately linked their behaviour has become to who they are. On the other hand, they themselves do not necessarily define themselves exclusively in those terms. The self-descriptions provided by the participants, parts of which have been included at the beginning of the previous chapter, did not include the category 'bulimic'. At this stage of their lives, their identity may be filtered through bulimia, but most of them accept that this is not the person that they will remain. Says Rachel, "I want to change my life, I want to feel good, you know. I don't want to be bulimic because I know it interferes too much in my life". It interferes too much with who she is and who she wants to be.

The body and identity

As the growing discipline of the sociology of the body reveals, the body can no longer be considered a mere biological vessel. It is an entity imbued with social and symbolic meaning. It is the living matter through which we all experience life and through which we all, ultimately, learn to define ourselves. Even though the women represented in this study did not reflect the growing belief in a unity of body and self, they did illustrate the extent to which their body has become relevant in determining who they are and how they experience themselves.

Not only filtered through their bulimic behaviour alone, many of the women I interviewed indicated the extent to which their identity is tied in to the relationship they have with their bodies. Using their body as the vehicle through which to live out their behaviour, it cannot help but be elaborately interwoven into their sense of self.

"I'll be happy when I look good". These words, spoken by Sandy, indicate the extent to which the body may be important in these women's sense of self and identity. Although a dichotomous relationship appears to have instilled itself within their overall experience of self, many of the women's identities are filtered through this alienated relationship. Mireille spoke very candidly of the consequences, on her identity, of the dichotomous relationship between body and self.

> "Alors c'est là que les conséquences sur le corps sont - je vis, disons, séparé de mon corps. Le rapport, la conséquence est désastreuse parce qu'il y dichotomie, en quelque sorte, et ça n'arrange pas du tout ma personalité, ça m'éloigne de moi-même."

Mireille's experience of her self is intricately linked to her relationship with her body. Feeling alienated and disassociated from her body, Mireille also feels alienated from her self. In this instance, then, bulimia, as it is lived through the body, characterizes the relationship which Mireille has developed with her self. It is that which impedes her ability to harmonize body and self; that which, ultimately, defines her experience of self.

The cultural implications

Identity, like any other social category, is inspired by certain factors. In the case of the women presented in this study, bulimia is one of the factors which helps to shape their identity. However, it can be said that their bulimic behaviour is also inspired by certain cultural narratives and these, too, help to inform one's choices, one's behaviour and, ultimately, one's experience of self.

Having been characterized or 'labeled' 'eating disordered', these women have, for the most part, been described as victims. Victims of the behaviour over which they have no control, and victims of the cultural imperatives which inform that behaviour. Although these arguments are relatively commonplace, they are, nonetheless, very harmful. On the one hand, they strip the women in question of the power to make alternate decisions (more on this later) and on the other hand, such arguments enable the cultural narratives which inspire the behaviour associated with the 'relentless pursuit of thinness' to flourish.

Characterizing one behaviour as sick and another, less extreme behaviour as being within the realm of health, creates dichotomies. The consequence of categorizing one group of women as 'sick' and 'treating' them for their 'disorder', and the other as 'normal', is the perpetuation of both the less extreme behaviours (persistent dieting, regular and perhaps excessive exercise, plastic surgery) of a large proportion of North American women, as well as a perpetuation of the norms,

values and beliefs which inspire 'the relentless pursuit of thinness'.

This practice of medicalizing 'eating disorders' not only serves to perpetuate, at a certain level, destructive behaviours and the cultural narratives which inform such behaviours, but it also serves to inform and to direct the 'eating disordered' woman's experience of her 'illness' and of herself. The language used during the interview process was quite revelatory of the relationship these women had developed with their 'eating disorder'. Depersonalizing their behaviour by referring to it as an entity in and of itself and referring to it as an inanimate object served to free the women of a certain sense of responsibility for both their present and subsequent behaviours. Being 'victims' of a 'disease', the women were able to experience their 'disorder' as a 'condition' over which they have little control. In essence, then, labeling them as 'sick' strips them of the opportunity to appropriate their choices and, subsequently, to act on those choices.

Choice and identity

As Rachel expressed earlier, to end her bulimic behaviour is to change her life. Without, however, the possibility of appropriating her actions as her own, she, and others, may have a very difficult time 'changing their lives'. Controversial as it may be to acknowledge and emphasize the level of choice bulimic women have with regards to their

behaviour, it nonetheless serves to grant them ownership of those decisions. Furthermore, by depicting women with 'eating disorders' as powerless victims of a social system which imposes strict standards of beauty and thinness, we are also, ultimately, stripping these women of the power they need to challenge and act against those standards.

Finally, to acknowledge that these women have actively participated in their life choices and decisions is to recognize the extent to which they, and others as well, have socially constructed themselves. These women, whose identities may be intricately linked to their bulimic behaviour for the time being, are not being socially constructed as the result of overbearing cultural narratives but are, in fact, socially constructing themselves based on the choices and options, limited that they may seem, that are available to them. I think that once this can be understood, these women, who expressed a desire to end their behaviour, will begin to be equipped with the tools and the knowledge required to make alternate choices

> "the only thing that I kept in mind was that *I was deciding not to binge and purge* and so that was my only victory to go by in life".
>
> (Angela)

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APPENDIX A

NAME: AGE: EDUCATION:

1. First off, I'd like to ask you if you have ever had any therapy pertaining to your bulimia? What was/is your experience of therapy like?

1.2 Now, perhaps you could tell me a bit about yourself. Perhaps you could imagine that you had been asked by a publishing company to write your autobiography. Could you tell me what you think you might include in your in it?

1.3 Now I'd like to ask you if you would like to share with me what your earliest childhood memory is, or perhaps, what the strongest memory you have of your life so far? (question only asked if 1.2 did was not developed)

Now I'd like to ask you a few questions which are more directly related to bulimia, if you don't mind:

2. Can you recall your first bulimic experience?

2.1 Can you perhaps talk to me about your experience of bulimia as a whole, how it has or has not become a part of your life?

2.2 If you were able to personalize your bulimia, would you say that it was a friend, a foe or either? Explain.

2.3 Do you feel that you have a genuine choice to engage in or to stop your bulimic behaviour? Could you explain that to me?

Now, the last section pertains more specifically to your body. Do you mind if I ask you a few questions which are more directly related to your body and to yourself?

3. Can I ask you if you have a relationship with your body?

3.1 If you have a relationship with your body, how would you go about describing it? (positive, negative, ambivalent?)

3.2 Finally, if I asked you to choose four adjectives or characteristics which best describe you, at this point in your life, which ones would you suggest?