

Article

**'@ the Doctor's Office':
pro-anorexia and the medical gaze**

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Abstract

The pro-anorexia movement (which advocates eating disordered practices as a legitimate lifestyle and identity choice over the internet) has provoked intense public furor since it emerged in the late 1990s. This concern hinges on the status of anorexia as a disease, situating pro-anorexic discourse as not only diseased but dangerous. A critical feminist and Foucauldian reading of this material analyzes the complex negotiations of medical surveillance undertaken by participants in the movement. Disrupting medical knowledge and usurping the medical gaze, participants produce a virtual clinical space that elides medical authority over anorexia and individual anorexic bodies. By intervening in the pattern of medical gaze-diagnosis-treatment in order to teach individuals how to perform a 'normal' body, pro-anorexic discourse exposes both the instability of diagnostic criteria and the limits of medical surveillance.

Since it emerged into virtual space in the late 1990s, the pro-anorexia movement has provoked intense debate in mainstream culture and criticism from the medical profession. Made up of a series of cross-referencing and continually changing websites, the movement is generally understood to advocate anorexia and other similar eating-related practices as a legitimate lifestyle and identity choice. Individuals – primarily women – participate in the movement largely anonymously and pseudonymously, sharing 'tips and tricks' for weight loss, diet and exercise regimes, and 'thinspiration' materials (intended to promote or sustain weight loss) online, with personal blogs, poetry, chatrooms and, most recently, Youtube and Facebook postings expanding their virtual exchange. A loosely articulated 'Ana' religion of prayers, benedictions, commandments and psalms modelled after Judeo-Christian religious doctrine personifies 'Ana' as their charismatic leader, with 'Ana' signifying their embodied struggles and also becoming the identity participants take on in their commitment to eating disordered practices and identity. With its explicit imagery and content, the movement has been condemned by parents, child advocates and physicians, resulting in many pro-anorexic websites being shut down, only to emerge elsewhere in virtual space.

Working from a critical feminist and Foucauldian perspective, I analyze the shared discourse of these websites in order to reveal the complex ways in which pro-anorexic individuals negotiate their experiences of medical surveillance and authority. Pro-anorexia has emerged – but simultaneously disappeared – into what Kevin Robins calls the 'nowhere-somewhere' of cyberspace (2000: 135) precisely because the defiant voices of these women are rejected in mainstream culture. Ironically, the disembodied spatialization of the internet – idealized as an escape from the 'meat' of the body¹ – closely aligns with the goals of 'pro-anas' (as participants in the movement often call themselves): they enter this disembodied venue to rid themselves of the bodies with which they struggle. But, then, they are silenced again by socio-diagnostic censure. Their voices are unacceptable in mainstream discourse, as well as on

¹ This particular notion of the physical body as 'meat' is generally traced to cyberpunk writer William Gibson (1984). The abandoning of this 'meat' is now taken up in cyberpunk culture as the 'ultimate experience.' For further discussion and examples, see: Balsamo, 2000; Clark, 1995; Haraway, 1991; Robins, 2000; Stelarc, 2000; and, Stone, 2000.

the internet, and their virtual exchange is censured on the basis that it is not only dangerous, but potentially infectious. Within this production of a doubled disappearance, performed against the punitive impetus of medical discourse, a resignification of anorexia is potentially enabled, if not entirely achieved.

Moreover, this resignification hinges on the pro-anorexic disruption of both medical authority over anorexic discourse and the medical surveillance of particular 'anorexic bodies'. Specifically, this disruption parallels the medical epistemological framing of the clinical exchange – the pattern of medical gaze-diagnosis-treatment as the discursive mechanism by which pathologization occurs. Producing a virtual clinical space, pro-anorexic materials detail diagnostic criteria and 'teach' individuals how to perform a 'normal' body in order to evade the regulatory authority invested in the medical gaze. Within the space of the clinic, the medical gaze mediates a diagnosis of anorexia. Within the space of the internet, the gaze is turned upon pro-anas marking them as both diseased and deviant. Within pro-anorexic discourse, however, this medicalized surveillance and its resultant regulatory impetus are usurped and disrupted by pro-anas who seek to interrupt the punitive force of their own medicalization.

Disrupting Disease



Figure 1: The 'Pro-Ana' Ribbon (Wasted Shadow)

First, the intense public furor over pro-anorexia hinges on the status of anorexia as a disease. Seen as blatantly dangerous by many, pro-anas are rejected for refusing the dominant medicalized interpretation of disordered eating – that anorexia nervosa, bulimia nervosa, and other eating related disorders are illnesses that need to be cured. While pro-anas themselves debate the meaning of their identity and sometimes even take up a 'disease discourse,' the public backlash against them centres on their specific use and interpretation of 'anorexia'. To those within the pro-anorexia movement, 'anorexia as disease' morphs into 'Ana' as identity and lifestyle, religion and practice. As with the 'pro-ana' ribbon shown above, 'Ana' is resignified beyond its diagnostic labelling in the doctor's office. To those against pro-anorexia, such interpretations precisely point out the diseased state of individuals involved with the movement. Despite these differences, pro-anorexia is intimately entwined with the medical discourse on anorexia, appropriating its terms for other purposes but never quite escaping its punitive force.

This force begins with the medical logic of pathologization. In *The Birth of the Clinic: An Archaeology of Medical Perception*, Michel Foucault (1994) describes the discursive expression of modern medical epistemology as the separation of that which is pathological from that which is normal. The medical gaze – and, specifically, the anatomo-clinical gaze – mediates this process of pathologization. The trained eye of the physician is turned upon the individual. If pathology is detected, the individual becomes a medical object; and, once a medical object, the individual is drawn into the realm of medical control (1994: esp. 34-36). The silent, observed body reveals its disease under the medical gaze and, within the imbalanced exchange of the clinical moment, discursively positions the individual as a passive object subject to medical intervention.

This gaze materializes medical authority over normalized (and normalizing) understandings of the body through diagnostic criteria. For 'anorexia nervosa,' these criteria include: 'an intense fear of gaining weight or of becoming fat', even though one is underweight; refusal to maintain a normal body weight for age and height; a body mass equal to or less than 17.5; a disturbance in one's perception of body weight, size, or shape; denial of the seriousness of one's current body weight; and, amenorrhoea (no menstrual period) for at least three consecutive months (Abraham and Llewellyn-Jones 2001: 26). The legitimized

authority to determine whether an individual meets these criteria rests solely with the physician. If met, the diagnostic label of anorexia nervosa is applied to the individual, initiating medical treatment.

With anorexia and other feminized disorders, however, the diagnostic process is layered with socio-historical and socio-cultural hierarchies. Illustrating the collusion of medicine and patriarchy, medical epistemology draws on the Enlightenment masculinist construction of the ideal individual. Specifically, this convergence produces a normative prescription for what Foucault calls the 'model man', by which medical authority extends across the realms of 'health' and morality, individual and social relations, the normal and the pathological (1994: 34). The medical gaze is thus not only diagnostic, but also disciplinary, charged with extending '*the medical bipolarity of the normal and the pathological*' to all of social life (1994: 35, emphasis in original). In attending to the 'normative posture' of society, medical discourse implicitly positions 'woman' as the unhealthy, abject foil to its model man. Discursively pathologized, woman's unruly body and irrational mind then warrant her containment via masculinized medicine: medicine's self-given authority over the female body harnesses the Cartesian positioning of woman as a passive – yet irrational – body-object (e.g. Bordo 1993; Jordanova 1999; Lupton 2003; Shildrick 1997; Walker 1998).

Similar power-laden knowledges are entwined with the particular contemporized medical discourse of anorexia, exposing the cultural convergence of health and beauty (e.g., Chernin 1981; Chernin 1985; Eckermann 1997; Gremillion 2003; Lester 1997). Susan Bordo, for instance, suggests that anorexia crystallizes our cultural ills, 'from our historical heritage of disdain for the body, to our modern fear of loss of control over our future, to the disquieting meaning of contemporary beauty ideals in an era of greater female presence and power than ever before' (1993: 139-140). And, Helen Malson argues that anorexia nervosa must be understood 'as a multiply produced object of discourse and as a category that is particularly relevant to women, to the (discursive) constitution and regulation of femininities, subjectivities and the *female body*' (1998: 33, emphasis in original). Mervat Nasser, for example, highlights the emergence of eating disorders in non-Western cultures as a cultural symptom of the globally changing demand for particular female bodies (1997: 95-97, 104-107); and, Becky W. Thompson (1994) reveals how the eating problems of often 'invisibilized' women – women of colour, lesbian women, poor women – serve as coping mechanisms by which to mediate the traumas wrought from their particular disempowered identities.

As a power/knowledge apparatus, however, medical epistemology mutes these social and cultural realities. While many examples illustrate that medical practice is beginning to acknowledge the needs and concerns of the individual in its treatment of disordered eating (e.g. Andersen, Bowers and Evans 1997; Draper 1998; Fairburn, Marcus and Wilson 1993; Goldner 1989; Tiller, Schmidt and Treasure 1993; Vandereycken and Beumont 1998), the long historical trajectory of the medical pathologization and abjection of women continues with the psychiatrized construction of anorexia as a distinctly 'feminized' disease. The clinical exchange, in which diagnosis occurs, both harnesses and expands the power-laden knowledges infiltrating feminized identities – in particular, the hegemonic constitution of the thin feminized aesthetic through hierarchies of ethnoracialization, western affluence, heteronormativity and youth. As Foucault suggests, 'the body is a biopolitical reality; medicine is a biopolitical strategy' (2000: 137). Medicine, in other words, is a key disciplinary apparatus producing the docile bodies required of modern social relations. And, in what he identifies as the non-reciprocity of the clinical exchange (Foucault 1994: 110-111), constructed via asymmetric hierarchical power relations, the pathologizing triad of gaze-diagnosis-treatment becomes a productive discursive mechanism that expands the regulatory impetus of medicine beyond the discrete space of the clinic and into what David Armstrong calls the 'undifferentiated space between bodies' (1983: 6). In the case of anorexia and other feminized disorders, this non-reciprocal exchange thus invokes the historical reiteration of women's passification and objectification.

For instance, the disciplining of the individual anorexic patient to regularizing medical standards of treatment and recovery mirrors the historical constraining of women's bodies, identities and voices.

Extending Foucault's disciplinary panopticism, the standard medical approach to disordered eating employs, for instance, techniques of routinization and surveillance in treatment to produce appropriately disciplined feminized bodies (e.g. Bell 2006; Gremillion 2001; Gremillion 2003; Sesan 1994). And, the uni-directional, hierarchical structure of traditional treatment protocols generates what Robin Sesan calls 'the oppressive nature of inpatient [treatment] settings, which all too often replicate destructive patriarchal patterns' (1994: 251). Helen Gremillion goes further, arguing that standard treatments not only replicate but also exacerbate the particular sociocultural conflicts experienced by women with eating disorders: 'when psychiatric discourse mystifies the social shaping of bodies and persons through medical objectification, it also crystallizes certain ideas and practices that are designed to create fit and healthy bodies (and that, ironically, patients can use to support their anorexia)' (2003: 32). The activity of treatment requires a return to the 'docility' of normative femininity.

This is not to say that individual healthcare practitioners – male or female – deliberately invoke these discursive processes, or that they purposefully relegate their patients to a passive state. For, of course, they desire their patients' recoveries and continued wellness. However, as with all social exchanges, their practices occur within the broader sociocultural sedimentations of these power/knowledge apparatuses. A vital distinction must be made between individual practices and institutionalized regimes; complex negotiations of these regimes occur on an everyday level, and individual actions may produce broader unintended significations. Both feminist and medical scholarly critiques of inpatient eating disorder treatment regimes raise concerns over the complexities and difficulties of eating disordered treatment within such cultural frameworks, and against the unfortunate realities of individuals' daily struggles with disordered eating and the fact that no biomedical 'cure' has been found for disordered eating. And, as a result, alternative treatment approaches have been advanced in many fields (e.g. Brown and Jasper 1993; Fallon, Katzman and Wooley 1994; Gremillion 2003; Kinoy 2001; Polivy and Herman 1987; Roberts 1992; Saukko 2000; Vandereycken and Beumont 1998). To be clear, though, this critical perspective does not suggest that individual men or male physicians impose anorexia or other eating disordered practices on women, as both women's – and men's – experiences of disordered eating arise within these same discursive apparatuses, as well as through complex, individually contextualized circumstances. Hence, the activity of treatment has altruistic goals, but its discursive consequences are far more complex, and often troubling.

For instance, the feminized passivity discursively encoded into the 'docility' of treatment is coupled with an active irrationality, a sense of uncontained power and movement which needs to be tamed – quarantined. The viral logic of contagion informs the furor over pro-anorexia and its subsequent labelling as not only diseased but dangerous. Aligning with certain perspectives on media, and even hate speech, the virtual texts of the pro-ana movement are seen to transmit what they address. Borrowing from Abigail Bray's discussion of viral telecommunications, they are a 'form of social and political contagion' (1996: 419). Judith Butler's analysis of linguistic performativity, in relation to hate speech and pornography (1997), pertains to the case of pro-anorexia as well, as a performative and specifically illocutionary logic is applied to pro-anorexic materials: they are understood to 'cause' that of which they speak. Butler details how such speech acts are seen to be imbued with the interpellative power of illocutionary performatives, informed at once by intent and convention, collapsing the speech act into injurious conduct (20-28). In this logic of the illocutionary performative, exposure to pro-anorexic websites produces disordered eating: viewing this material harms. Thus, such speech acts and texts are censored on the basis of their injuriousness.

However, Butler (1997) argues that it is not the text itself that is inflammatory or injurious; its use, context and discursive production are vital considerations, opening space for responses other than censorship. As Butler notes, 'if the text acts once, it can act again, and possibly against its prior act. This raises the possibility of *resignification* as an alternative reading of performativity and politics' (69, emphasis in original). The text itself is not the source of the problematic speech act; therefore, its removal will not rectify the concerns underlying its censorship. Hence, Butler suggests that the politicized resignification of offensive texts remains a viable – if perhaps limited – response available to those who

question the discourses materialized in such texts. In the case of pro-anorexia, as long as their virtual texts are the sole focus of their public condemnation, the underlying discursive manifestations of feminized constraints will not be addressed.

Further, it is not simply that these texts are of concern to those against pro-anorexia, but also that seemingly unsuspecting or uncritical computer users/readers/viewers – who are assumed to be female – will be exposed to their infectious content. Moreover, women are seen as distinctly susceptible to this kind of media transmission, and especially to popular cultural images of ultra-thin models, the waif aesthetic of 'heroin chic', the disappearing bodies of female celebrities. But, this argument relies on essentialized and paternalistic notions of feminized subjectivity, by suggesting that 'women are pathologically susceptible to a collective mentality and a lack of independence or individuality. It points to a space in which femininity can only be controlled or managed by external systems of signification, because when it is in the hands of women it is more susceptible to disorder' (Burke 2006: 325). As Bray (1996) warns in her critique of feminist interpretations of anorexia as a disease brought on by women's consumption of such images, 'if all women are perceived to be preoccupied with their weight, primarily because of their consumption of mass-produced images of idealized thin femininity, then the female audience is framed as neurotically vulnerable to late twentieth-century media representations' (421).

This linkage is problematic on multiple registers as it relies on nebulous assumptions about feminized subjectivity, appetite, audience and spectatorship, as well as the performativity of mediatized texts themselves. For instance, Bray (1996) argues that such interpretations characterize female subjectivity through a rhetoric of irrational, excessive consumption. Constituting anorexia as a 'reading disorder', they assume that 'anorexia is the result of consuming too many ideologically unsound representations of women' (420). Paralleling the nineteenth-century association of female hysteria with women's reading practices, Bray argues that similar interpretations of modern day anorexia infantilize women as inherently uncritical in their engagements with media (419). Late capitalist ideological tensions of (feminized) consumption and (masculinized) constraint further inform this susceptibility, as do the hegemonies of medical epistemology and heteronormativity. As Bray asserts of these interwoven discourses, 'the woman who practises eating/reading disorders is . . . imbricated within the pathologizing discourse of psychiatry. The perverse irrationality of 'anorexic' reading practices, whereby consumption facilitates autophagy,² serves to highlight this critical agenda; the effects of crass materialism are identified with a perverted feminine appetite' (421).

Eliza Burke (2006) elucidates these tensions further and in particular relation to the gaze. Exposing again the irrationality historically consigned to women and the female body, Burke suggests that 'contagion constructs the female gaze as a vulnerable and disorderly space which is not just 'susceptible to media images' (Probyn 1988: 203) but effectively prone to their embodiment' (318). Specifically, 'the excess of the female gaze is aligned with a failure to perceive boundaries between the sick and the healthy, the feminine and the freakish, and results in the embodiment of already represented symptoms . . . contagion can be seen to support conceptions of an hysterical female gaze that is pathologically bound to reproduce the symptoms of other bodies and other femininities' (326). Thus, Burke concludes that 'the overriding effect of the idea of contagion is the characterisation of the field of vision as one which is not only dangerous to women, but in which women are a danger to themselves. . . . it would seem that for a woman to participate *unproblematically* in the consumption of images, she must either look *as* a male, or risk the space of female spectatorship and thus risk anorexia' (327, emphases in original). Returning to the debates over pro-anorexia, pro-anas have then both succumbed to this dangerous field of vision and reproduce such contagious texts. Their censure is thus at once on the grounds of cause *and* effect – of virus and symptom collapsed – both the source of the injurious illuccionary performative and its unknowing victims.

² 'Autophagy' refers to 'feeding upon oneself, sustenance of life during the process of starvation by absorption of the tissues of the body', or 'self-devouring' (see 'autophagous' in the *Oxford English Dictionary Online*, <http://dictionary.oed.com>).

For instance, in the dominant discourse of disordered eating, the pathology of illness and the out-of-control woman merge in the threat of pro-anorexic contagion, reproducing at once the rationale for medical control over women's bodies and justification for censoring the pro-anorexia movement. Contrary to the discursive passification of the anorexic patient, though, pro-anas seem fervently aware of their practices, even if this awareness is fraught with contradictions.³ Though arguably disciplining themselves to socially normative standards, participants in the movement reject the constraint of medical intervention upon their identities and practices. Their public voice also violates the medical authority over their 'disease.' By contrast, medical objectification denies the possibility of a pro-anorexic voice by discursively de-subjectifying its patients: these are ill women needing to be cured; any voice derived from anorexia is a further expression of this illness. While pro-anas turn to the pseudo-public realm of cyberspace to find support, Ruth Bankey notes that 'occupying public spaces and revealing one's abnormality or deviance is considered equally if not more unhealthy' (as cited in Dias 2003: 32). And, this slippage is not lost on pro-anas, as illustrated by images such as 'Toxic Ana: The Secret Virus' (figure 2; Ana's Underground Grotto). Pro-anas are all too aware of their struggles, but discursively and materially resist the hegemonic medical interpretations of their practices: they refuse the passive objectification demanded by socio-medical epistemology.



Figure 2: Image of 'Neon Ana', captioned as 'Toxic Ana: The Secret Virus'

Usurping the Medical Gaze

While this contemporized reiteration of anorexic women as 'dangerous' establishes a discursive framework by which individuals involved with eating disordered practices are repeatedly silenced, anorexia still retrieves its meaning from medicine and pro-anorexic discourse distends this meaning. Pro-anorexia is inextricably caught up with medical logic, and cannot fully escape medical authority as it attempts to resignify its punitive force. Instead, the movement appropriates the terms of medical discourse in order to elude its hegemonic power. Contrary to the perspective that anorexics are not fully cognizant of their practices, pro-anorexia suggests that the dominant medical discourse of anorexia is central to 'Ana' identity. Through the appropriation of medical knowledge, pro-anorexic discourse intervenes in and usurps the traditional authority wielded in the clinic of the doctor's office, establishing a literal, though virtual, clinic that seeks to manipulate the pattern of gaze-diagnosis-treatment in order to teach individuals both how to project and to perform a 'normal' body. In a postmodern elision of space, knowledge and practice, pro-anorexia deliberately displaces the clinical moment, thereby disrupting the non-reciprocal exchange upon which medical intervention is based.

Pro-ana websites de/form this regulatory apparatus by, first, framing their practices in a rhetoric of science, physiology and health. Many sites detail the specific diagnoses of anorexia nervosa, bulimia nervosa and other eating disorders, although this data is often included with little explanation (e.g., Anorexic Nation; Cerulean Butterfly, Ed Info). Following 'diagnosis', pro-anorexic discourse treats its self-imposed symptomology. The 'Medicine Cabinet' at the 'House of Ana', for instance, suggests taking

³ Traditional medical approaches to disordered eating assume that a necessary self-discipline is lacking in the anorexic patient and, consequently, treat this patient as a medicalized object ostensibly unaware of his/her condition. However, many women struggling with disordered eating are intensely aware of their practices and, in fact, actively manipulate the terms of their treatment protocols. Helen Gremillion notes, for instance, the adept skill of anorexic inpatients at maintaining or manipulating their prescribed 'goal weight', deliberately reinterpreting it as an acceptable maximum weight rather than an acceptable minimum weight (2003: 47).

women's multivitamins to replace the minerals and vitamins lost through excessive exercise and lack of food, *Eno* to treat cramping, *Advil Migraine* for the body pain that anorexic practices produce, and aspirin – not for pain, but to speed up the metabolism. A message of evasion is implied: diagnostic data will pre-empt diagnosis; vitamins and 'meds' will mask symptoms.

While some sites address the negative side effects of anorexic practices, others couple self-control and discipline with physiology and health in pursuit of the thin aesthetic, mirroring the contemporary infiltration of this aesthetic by the medical standards of health. For example, 'Victoria's Pro-Ana Journal' (2005) extensively discusses the physiology of fasting, including material on ketosis (the conversion of fat to fuel) and the catabolization of amino acids in muscle tissue. With proper fasting technique, for instance, one will achieve increased energy levels, elevated growth hormones and ketone bodies, improved mental clarity, a more youthful appearance, and overall improvement in health. Despite warning that 'severely restrictive diets are extremely unhealthy, in many cases, even life threatening', 'Victoria' asserts: 'eliminating food (during the fasting period), one of life's greatest pleasures, is not easy for most!' However, those that have the discipline, and determination [will] have tremendous to extreme healthy benefits awaiting them!' And, as the 'House of Ana' states, 'if you're gonna be Anorexic, be as healthy as possible'.

This appropriation of medical knowledge is most exemplified, however, by explicit pro-ana discussions of how to deceive the physician and disrupt the medical gaze. Such discussions assume the prior identification of 'diseased' status or, at least, acknowledge that pro-anorexic practices put an individual 'at risk' – whether at risk of illness or of being discovered is often not clear. For example, under the heading '@ the Doctor's Office', 'Cerulean Butterfly' offers tips for avoiding detection, all of which focus on disguising the physiological symptoms of disordered eating; but, she acknowledges that 'very few things scare me more than my WEEKLY visit to the doctor' (At the Doctor's Office). Paralleling physicians' concerns about anorexic patients 'overloading' before weigh-ins (e.g. Patel, Pratt and Greydanus 2003: 250), some of her tips suggest ways to increase one's weight temporarily: 'drink a lot of water before you go' (although this technique may skew a urinalysis and reveal what you've done); wear heavy clothing; and, put coins in your underwear. Complain of a recent sore throat to disguise the throat irritation left from purging. Dress warmly to increase body temperature temporarily, shave off any lanugo (fine body hair which develops due to severe weight loss) before the appointment, ingest salt to increase blood pressure, and 'practice meditation to control your heartrate'. Finally, if none of this works and your doctor confronts you, 'tell him/her you want this to be kept confidential. This is especially important if you're under 18, since some doctors will go ahead and tell your parents anyway...UNLESS YOU SAY OTHERWISE'. However, these methods of deception are dubious. While Cerulean Butterfly reveals her own regular monitoring by a physician, she also states that her doctor is 'way [too] damn smart to let me get away with any of [the] stuff I'm about to tell you to do. These tips pretty much only work if your doc doesn't know about your eating disorder'. Provided the physician does not 'know', then, the medical gaze may be tricked into seeing a 'normal' body, as signified by the quantifications of weight, temperature, heart rate and urinalysis.

Manipulating this gaze is paramount to the 'space' of the pro-ana clinic. On the one hand, the gaze is the explicit mechanism of pathologization, initiating diagnosis. Thus, diagnosis – and, hence, the medical gaze – is a potential threat to 'Ana' identity. On the other hand, when the legitimized medical gaze of the physician is explicitly manipulated by pro-anas, it becomes a means of evading detection and preserving their identity. Pro-anas first appropriate the gaze to imagine its power. Once imagined, they manipulate the litany of symptoms it is trained to identify. And, once manipulated, they pre-empt its diagnostic power. This appropriation of medical power disrupts the hegemonic medicalized discourse on anorexia, thereby resignifying 'anorexia' through the identity of 'pro-ana'.

Paradoxically, this appropriation enables the potential normalization of pro-anorexia: escaping the medical gaze of the physician pre-empts pathologization via the 'normal' reading of the pro-anorexic body. This slippage demonstrates the intimate connection between individualized discipline and broader

social normalization, discursively functioning together via apparatuses of power/knowledge such as the biopolitical strategies of medical discourse. 'The norm', Foucault states, 'brings with it a principle of both qualification and correction. The norm's function is not to exclude and reject. Rather, it is always linked to a positive technique of intervention and transformation, to a sort of normative project' (2003: 50). The 'norm', in other words, functions to extend the regulatory impulses of the domains in which it is produced (2003: 49-50). Thus, both normalization and pathologization require the continuing intervention of the physician, but with differential outcomes. Regarding pro-anorexia, the absence of pathologization that is performed by pro-anas enables a resignification of their bodies as 'normal' in the clinical exchange, entangling pro-anas again with medical discourse as the source of this normalization. Simultaneously, though, this normalization frees pro-anas from the body-object status of medical epistemology, thereby reasserting their embodied subjectivity.

In turn, this normalization inadvertently reinforces the signification of the thin body as the cultural exemplar of feminized bodily health and beauty, demanding that the thin feminized ideal be read within and against contemporary discourses of the obesity epidemic. On the one hand, the pro-anorexic production of 'normal' bodies separates pro-anas from the 'health crisis' of rising obesity rates: they are disciplining themselves to socially appropriate standards of diet and exercise. On the other hand, this production reveals the social regulatory impulses underpinning this epidemic rhetoric: pro-anas have 'gone too far', but a thin body is still signified as more acceptable than a fat one. And, this contradiction is itself utilized in pro-anorexic discourse. For instance, while pro-anorexic 'thinspiration' materials (intended to promote weight loss) frequently feature 'hardcore bone' images (images of severely emaciated women), 'reverse triggers' (often near-pornographic images of obese women) are employed as warnings against not being disciplined enough. 'Bone' images tend to be uncaptioned – as if these emaciated bodies speak for themselves; but, reverse triggers seem to require additional interpretation with derogatory comments often captioning these particular images. For example, at 'Ana's Underground Grotto',⁴ one reverse trigger image of a reclining, scantily clad obese woman is captioned 'couch surfing like a beached whale'. Mediating this derision slightly, the preface to its 'Reverse Triggers' page states, 'these images represent what we never want to become. If you want to know why . . . just look around you at how these people too often end up being treated. Perhaps you yourself have been guilty of this at times. For the record, this site does not condone bashing fat people. We just choose not to be among their number, is all'. The overriding cultural derision toward fatness, and fat women in particular, is reiterated in such statements, again normalizing the thin feminized ideal. Though pro-anorexia may invoke the affect of disgust, it is still only obesity that signifies the cultural 'grotesque'. The fat girl is called out as freak, whereas the thin girl may be pitied but she is still secretly envied.

And, yet, the disciplinary gaze of other individuals still threatens pro-ana identity – that of parents, friends and teachers who question the changing behaviour and bodies of pro-anas. And, pro-anas also 'hide their friend' from these individuals (Cerulean Butterfly, Hiding Your Eating Disorder). As 'The House of ED' counsels, wake up late (or leave early), so you don't have to face family meals; hide weights in your clothing and offer to weigh yourself in front of those expressing concern; simply say you've already eaten, or aren't hungry, or are a vegan; or, 'just say 'no' (it's easier than you think)'. In fact, medical authority is used in this deception as well: you're just getting over the flu and the 'doctor said to only drink fluids for a while'; a medically prescribed change in medication is 'screwing' with your appetite; and, of course, 'say you're ill, simple but effective'. The irony with this final statement, of course, is that this constructed illness is acceptable where anorexia itself is not. Thwarting the concern of others may temporarily sustain pro-ana identity, but it is still only the legitimized gaze of the medical clinic that holds the authority to diagnose anorexia; and, it is this particular gaze to which other individuals turn for reassurance. If the medical gaze and its punitive impetus are manipulated, the pro-

⁴ See also 'Uglypeople' from which the image to which 'Ana's Underground Grotto' refers was taken.

anorexic body, and individual, will be read as normal, thereby silencing concerns raised elsewhere. Virtual space thus becomes clinical space in which the evasion of multiple disciplinary gazes is enabled.

Yet, this evasion implicitly acknowledges the abnormality of pro-anorexia, again linking it to the dominant discourse of anorexia. While manipulation of medical knowledge outside its usual clinical space produces the conditions by which pro-anas may be able to unseat medical control over their bodies, they do so precisely because of medical authority over their 'disease': pro-anorexic individuals know they are seen as abnormal. Their breach of medical authority, therefore, works only so long as it is not detected. If detected by the medical gaze, they are again brought into the regulatory space of the clinical moment, but with the additional label of deviance added to their diseased state. No longer just the diagnostic standards of weight loss, denial and amenorrhoea, anorexic pathology is then additionally produced through the 'irrationality' of pro-anas, as evidenced by their deception of the physician, their usurpation of the gaze, their appropriation of medical knowledge for other ends. Pro-anorexic discourse thereby instigates the renewed terms of its own pathologization and, in turn, dismissal as 'sick', sick being at once ill and disgusting: disgust at the 'thought' of pro-ana, disgust at the content of the websites, disgust at the anorexic body itself. Its practices thereby reproduce the abjection of the anorexic body that Debra Ferreday suggests is central to the mainstream rejection of the pro-anorexia movement, a rejection itself constituted through the affect of disgust (2003: 288).

Yet, in a final blow to medical logic, pro-anas take this doubled pathologization to its extreme – only death is good enough. With mortality rates higher than for any other psychiatric illness, research suggests that between 5 and 20 percent of anorexic individuals die from their practices (Neumarker, 1997; see also Crisp *et al.*, 1992; Hewitt, Coren and Steel, 2001; Lowe *et al.*, 2001; Millar *et al.*, 2005; Zipfel *et al.*, 2000). This risk, however, is of little consequence to some participants. 'AnOreXic AdDiCt' writes:

A lot of people in the guestbook ask me and other pro-rexies if they realize that they can die from anorexia. i don't know about anyone else, but i do in fact realize that. in fact, i don't really care. if i died tomorrow, so be it. my life doesn't really mean that much to me, so if you want to tell me that I'm stupid because i don't realize that i could possibly die from anorexia, [that's] just fine with me.

No rhetoric of health and wellness, or even self-preservation, intervenes in this single-minded pursuit of thinness.

While a stark statement on the realities of pro-anorexic practices, AnOreXic AdDiCt's words exemplify the limits of medical regulatory power, resisting at once the diagnostic power of the medical gaze in the intimacy of the clinical exchange and the diffused medical surveillance that informs the censure of pro-anorexia in virtual space. The deliberate pro-anorexic disruption of the medical discourse of anorexia, as well as the pro-anorexic usurpation of the medical gaze, suggest that pro-anas are acutely aware of the hegemonic medical authority over disordered eating. Because medical surveillance – as an apparatus of power/knowledge – mediates regulatory authority over not only women's health but anorexia in particular, the legitimized gaze of the physician holds the authority to 'normalize' the pro-anorexic body and, in turn, free pro-anas from medical intervention (if only temporarily). Pro-anorexic manipulations of medical surveillance thus locate pro-anas in a liminal space in which they attempt to resignify not only the cultural significations of anorexia, but also the weight of medical authority over their individual practices, a space signified at once by the virtual and the material, the normal and the pathological, silence and resistance, life and death.

However, this limnality produces an unsettling discursive and material impasse. While – from a critical feminist perspective – the voices and struggles of pro-anas must be acknowledged and taken seriously, their virtual textualizations reveal the depths of their struggles – their all-consuming efforts to eradicate their feminized bodies. But, I am reticent to impose a singular signification onto their practices, or to condemn them along with many mainstream critics. In taking their discourse seriously rather than turning

away in disgust, their words suggest alternative possibilities. Instead of a polarized reading of pro-anorexia as either 'good' or 'bad', I believe pro-anorexia must be read as pro-anas often insist: as a struggle, individually contextualized within and against medical discourse. Where medical discourse too often fails these individuals and pro-anas in turn manipulate this discourse, pro-anas are attempting to mediate their practices (whatever their particularized meanings) in a space of acceptance. Many sites – and many run by formerly anorexic women – offer support in the process of recovery, but recovery when the individual is ready. As sites such as 'Makayla's Healing Place' suggest, they offer a 'safe space' in which the difficulties faced by pro-anorexic individuals are understood, acknowledging the pain and rejection experienced by these individuals. While pro-anorexic discourse reveals a multiplicity of individual significations attached to disordered eating, struggle is an underlying theme, and one not frequently acknowledged in mainstream discourse. As 'Cerulean Butterfly' (2005) states:

Eating disorders are painful, life-destroying creatures that are not worth their cost. They are not cool or glamorous. They are not a quick fix. They are not a diet. They are a living, breathing hell. But once you're in, you're in. You're in until it either kills you or destroys your life so much that you have to break free. So stay out. Stay back. Stay sane. If you do have an eating disorder, you know what a hell it is. You know how sometimes this hell is the only thing that keeps you going. Welcome. Here you will find support and understanding. (To those of you who come here looking to 'become anorexic')

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⁵ Please note that, as most pro-anorexic websites are routinely shut down and often reappear under different webnames and URLs, I cite these references by original URL and date accessed.

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