

A genealogical exploration of the conditions of possibility for re-feeding to emerge as a treatment regimen

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ABSTRACT

Following the genealogical work of Foucault, Rose and others, this thesis aimed to trace the conditions of possibility for re-feeding to emerge and continue as a primary treatment regimen for self-starving individuals. This focus was in relation to the known poor long-term outcomes – an approximately fifty per cent recovery rate - for people who come into contact with services and are diagnosed with anorexia nervosa. Historical and present case narratives, which captured re-feeding practices in 1960s and 2000s, were presented and analysed using the genealogical research strategies of ‘surface of emergence’ and ‘descent’ in relation to five perspectival dimensions, namely strategies, authorities, technologies, subjectivities and problematizations. Re-feeding emerged in relation to neo-hygienic strategies for public health for preventative and individualised medicine, and the reconfigured authority of psychiatry as a ‘mental medicine’, which had new physical technologies such as modified insulin therapy and psychopharmacological treatments, to shape the conduct and bodies of self-starving individuals in accordance with the ‘norms’ of health. Increasingly, re-feeding practices have become imbricated within strategies for the ‘administration of risk’ as self-starving individuals have become problematized in terms of the degree of AN or level of risk they pose. Overtime re-feeding as a life-saving measure, and self-starvation as a ‘mental disorder’, has become ‘black boxed’ in relation to bio-political strategies for administering risk within the context of rights, choice and empowerment, and a culture of blame and sanctions. Implications for research and clinical practice are discussed.

CONTENTS

ABSTRACT	i
CONTENTS	ii
1. INTRODUCTION	1
1.1. Introduction to the study.....	1
1.2. Issues of Definition.....	3
1.3. Researcher’s position	3
1.4. Aims of the Research	5
1.5. Chapter Overview	5
1.6. Defining the Literature.....	5
1.7. Self-starving Women	6
1.8. Re-feeding Starving Women	7
1.9. Self-starving Oneself to Death.....	9
1.10. Re-feeding Self-Starving Women who Refuse to be Re-fed.....	11
1.11. Feminist, Post-structuralist and Social Constructionist Critiques	13
1.12. Locating Re-feeding in Broader Strategies and Practices	14
1.13. Rationale for the Research.....	15
1.14. Theoretical-Analytical Approach	16
1.14.1. <i>Introducing Foucault’s work</i>	16
1.14.2. <i>Governing life</i>	17
1.14.3. <i>Bio-power</i>	19
1.14.4. <i>Summary</i>	20
2. METHODOLOGY	21
2.1. Introduction to Methodology	21

2.2. Epistemology	21
2.3. A Material-discursive Position.....	22
2.4. Reflexivity	23
2.5. Contextualising Genealogy.....	24
2.6. Key Features of Genealogical Research.....	25
2.6.1 <i>Descent and emergence</i>	26
2.6.2 <i>Power-knowledge</i>	28
2.7. Perspectival Dimensions.....	28
2.7.1 <i>Strategies</i>	29
2.7.2 <i>Authorities</i>	29
2.7.3 <i>Technologies</i>	29
2.7.4 <i>Subjectivities</i>	30
2.7.5 <i>Problematizations</i>	30
2.8. Corpus of statements	31
2.9. Method	32
2.9.1 <i>Tools for analysis</i>	33
2.9.2 <i>Questions to help interrogate the data</i>	34
3. ANALYSIS AND DISCUSSION.....	35
3.1. Past and Present Re-feeding Practices.....	35
3.1.1 <i>Past practices</i>	35
3.1.2 <i>Present practices</i>	40
3.2. Surface of Emergence	47

3.2.1. <i>Strategies and apparatus for public health</i>	47
3.2.2. <i>The authority of science</i>	49
3.2.3. <i>Psychiatric Medicine: Strategies, Institutions and Problematized Individuals</i>	49
3.2.4. <i>Neo-hygienic strategies and technologies of medicine</i>	51
3.2.5. <i>Practices and techniques of psychiatric medicine</i>	53
3.2.6. <i>Psychiatric techniques for re-feeding self-starving individuals</i>	56
3.2.7. <i>Authority in relation to techniques of classification</i>	58
3.2.8. <i>The family and technologies of subjectification</i>	60
3.2.9. <i>Making up people through medicine</i>	63
3.2.10. <i>The subjectification of the pathologised female</i>	64
3.3. <i>Descent</i>	67
3.3.1. <i>Contemporary bio-political strategies and apparatus</i>	67
3.3.2. <i>A growth in documentary apparatus and self-starving bodies</i>	68
3.3.3. <i>Technologies of diagnosis</i>	71
3.3.4. <i>Transforming psychiatric techniques</i>	74
3.3.5. <i>From inpatient to community apparatuses</i>	77
3.3.6. <i>Constituting the self-starving body as a risky body</i>	82
3.3.7. <i>Administering life-saving measures</i>	84
4. <i>CONCLUSION</i>	87
4.1. <i>Summary of Research and Aims</i>	87
4.2. <i>Evaluation and Critical Review</i>	89

4.2.1. Assessing quality	89
4.2.2. Reflexivity	91
4.3. Clinical and Research Implications	93
4.3.1. Clinical implications	93
4.3.2. Research implications	94
5. REFERENCES	95
6. APPENDICES	110
Appendix A: Literature Search	110
Appendix B: Narrowed Literature Search	111
Appendix C: Summary of Causes of Deaths	112
Appendix D: Corpus of Statements	114
<i>Appendix D.1: Key papers, chapters and handbooks</i>	114
<i>Appendix D.2: Guidelines regarding the assessment, management and treatment of anorexia nervosa</i>	115
Appendix E: Junior MARSIPAN Risk Assessment Framework	116
Appendix F: Junior MARSIPAN Guidance of Re-feeding Practices	118

LIST OF FIGURES

Figure 3.1.1.a Photographs of patient before and after treatment	38
Figure 3.3.2.a. Search results for anorexia nervosa (1885 - 2013)	69
Figure 3.3.2.b. Registered yearly incidence of AN in mental healthcare in northern Europe in the 20th century	69

1. INTRODUCTION

In this section I introduce the reader to the focus of this study, issues of definitions, my position as a researcher and the aims of this research.

1.1. Introduction to the study

Self-starving individuals who actively refuse to gain weight and come to the attention of mental health services are likely to be diagnosed with ‘anorexia nervosa’¹ [AN], which is said to refer to a psychiatric syndrome (Russell, 1970) characterised by self-induced low body weight, a fear of fatness or weight gain, a distorted body image and amenorrhea (American Psychiatric Association [APA], 2000).

Early accounts assumed that self-starvation was a consequence of a “morbid mental state” and recommended that “patients should be fed at regular intervals” (Gull, 1874, cited in Dally & Sargant, 1960, p. 1770). Aside from the decades in the early-to-mid-twentieth century during which weight loss was conceptualised as a hormonal condition requiring hormonal treatment (discussed in section 3.2), re-feeding, with the objective of weight restoration and return of regular menses, has been a dominant treatment regimen for self-starving individuals, exemplified in the following quotes:

The treatments of patients with anorexia nervosa can be subdivided into two phases:

1. The initial treatment aimed at saving life, restoring nutrition and relieving acute psychiatric disturbance.
2. The long-term treatment where the aims should be the consolidation of the patient’s improvement, and the prevention of relapses which are only too common.

(Russell, 1970, p. 151)

¹ ‘Anorexia nervosa’ and ‘AN’ are used interchangeably with self-starving individuals. For ease of reading inverted commas will not be used after this point but it should be noted that the label is not used uncritically.

Treatment goals in AN include stabilisation of medical and nutritional status (restoration of weight and normal menstrual cycles), re-establishment of healthy patterns of eating (including cessation of restriction and purging), improvement of body image and amelioration of the morbid pre-occupation with weight and shape.

(Claudino, de Lima, Hay, Bacaltchuk, Schmidt & Treasure, 2006, p. 4)

The success of re-feeding practices and concomitant interventions to “cure” AN, however, have been and continue to be limited:

During the first phase, treatment is relatively simple and successful results are easily obtained so long as a few elementary principles are adhered to. It is easy to induce a very considerable weight gain in wasted patients. The long-term treatment is much more difficult and the outcome is often unpredictable.

(Russell, 1970, p. 151)

The treatment of AN is frequently longterm and challenging. Prognostic studies have shown that AN is often a chronic illness, with only half of the patients achieving full recovery in long-term follow-up studies.

(Claudino et al., 2006, p. 4)

Despite an estimated fifty per cent ‘recovery’² rate (Claudino et al., 2006; Steinhausen, 2002), re-feeding continues to be recommended as a primary intervention for people diagnosed with AN (NICE, 2004). As the more recent quote illustrates, patients who do not respond to this treatment have become conceptualised as having a ‘chronic’ and incurable form of anorexia.

Curious about the continued use of re-feeding practices in spite of its limited effectiveness, I decided to explore re-feeding practices from a different theoretical

² In this context, ‘recovery’ or a ‘good outcome’ refers to the ‘normalization’ of weight, menstruation and eating behaviour (Steinhausen, 2002).

framework. The different framework, a Foucauldian genealogical approach, problematizes present practices by employing a theoretical-analytical framework to historicise the present. A Foucauldian genealogical approach historicises the present by examining the conditions that made it possible for practices and subjectivities to emerge and by tracing the complex course of events between the period of emergence and present day that enable particular practices and subjectivities to continue. The aim of this approach is to disturb what was formerly immobile (Foucault, 1977b).

1.2. Issues of Definition

I will briefly deconstruct the title of this thesis; *A genealogical exploration of the conditions of possibility for re-feeding to emerge as a treatment regime*. The first part of the title refers to the use of a theoretical-analytical approach – genealogy – employed by Foucault in works such as *Discipline and Punish* (1977a) and *The History of Sexuality Vol. 1* (1979b). This approach has continued to be used and developed by Rose (1985; 1999), Butler (1990), Ussher (1996; 2011), Malson (1998) and others in relation to critiques of the practices and knowledge of the ‘psy’ disciplines. The verb *emerge* draws attention to the fact that re-feeding as a practice came into being in relation to the *conditions of possibility* – the network of macro and micro social, cultural and political contexts and events (Foucault, 1977b).

In the current study, *re-feeding* refers to practices that focus on weight gain. As described above the individuals who are the target of these practices are those who refuse to maintain a ‘normal’ body weight and who, following assessment within mental health services, are given a diagnosis of AN. Finally, *treatment regimen* draws attention to the legitimacy, or *authority* and *expertise*, of psychological, medical and legal discursive practices in relation to the management and treatment of self-starving individuals.

1.3. Researcher’s position

In this section I explicitly acknowledge “the personal and political values and perspective informing” this thesis (Burr, 2003, p. 157).

As a trainee clinical psychologist, on a course which adopts a critical approach to the training of psychologists and the 'psy' professions (Harper, Patel, Davidson & Byrne, 2007), I have been challenged to look beyond what appear to be givens about people, diagnoses and clinical practice. I have become increasingly interested in "how we know what we know?" and how some constructs and practices continue to be privileged despite vigorous analysis and criticism (e.g., Bentall, 2003; Boyle, 2002; Harper, 1996; Rapley, 2004). A lecture on the assessment and treatment of eating disorders, in my first year of training, included a vignette of a woman who had been admitted to hospital on multiple occasions because her weight was 'dangerously low'. Each time she was admitted her weight was restored to an acceptable level and each time after returning home she lost the gained weight. I wondered whether the 'treatment' might have played a role in her becoming a 'chronic anorexic' and a 'revolving door patient'. I found it difficult, however, in this lecture, and in other lectures, to question knowledge and clinical practice, as though by asking these questions I was questioning the obvious and putting myself in opposition to my discipline and colleagues.

My own experiences have led me to wonder whether there is space to discuss anything other than what is 'known' in relation to re-feeding and other clinical practices. For example, my reading has highlighted that approaches outside of the dominant discourses, such as social constructionist accounts of AN and treatment, have been criticised for being purely academic enterprises (e.g., Holmes, 2001).

I have become increasingly curious as to why some forms of knowledge or discourses, for example, psychological and psychiatric discourses associated with positivist methods of research, which prioritise bio-psycho explanations and interventions, continue to be dominant in clinical practice in spite of their failing "capacity to cure" (Rose, 1996b, p. 3). I have come to identify as a critical feminist psychologist.

1.4. Aims of the Research

The purpose of this research is to problematize the practice of re-feeding as the primary treatment for self-starving individuals. The primary aim of problematizing re-feeding is to de-stabilise taken-for-granted truths about the necessity of this approach, which silences questions or other perspectives, and prevents other approaches or conceptualisations from emerging. The secondary aim is to draw attention to the practice in the context of the 'psy' disciplines and how they are intertwined with power and the ways we have come to know and act on others and ourselves through technologies of power and technologies of the self (Dreyfus & Rabinow, 1982; Tamboukou, 2003).

These aims are based upon the conclusion that only half of the people who come into contact with mental health services and diagnosed with AN make a good or satisfactory recovery (Claudino et al., 2006; Steinhausen, 2002). In problematizing clinical practice, it is hoped that it will open up space for new ways of thinking about how we interact and intervene with self-starving individuals.

In sections 1.1 to 1.4 I have set the scene for this thesis by introducing the focus and aims, my position as a researcher and the methodological approach. A review of the literature follows.

1.5. Chapter Overview

In the following sections I define the literature included, review the micro and macro discourses and discursive practices relating to re-feeding and state the justification for this research.

1.6. Defining the Literature

A search of the literature³ yielded a total of 28,202 results for anorexia nervosa and 2,051 results for re-feeding and anorexia nervosa. Notably, the majority of the literature relating to anorexia (66.1%) and re-feeding and anorexia (71.16%) had been published between 2000 and 2013.

³ See appendix A for the details of the databases searched and search terms employed.

Limiting the search for the current review, I focused on particular practices and knowledges that have been associated with re-feeding. These included recovery, compulsory treatment, mortality rates and chronic anorexia. Appendix B summarises the parameters of the search.

Congruent with a feminist and critical thesis and the theoretical-analytic framework informing this research, I have not limited the review to the above literature, which could in the main be described as being based upon ontological and epistemological assumptions of “empiricist notions of objectivity” (Malson & Ussher, 1997, p. 47). Published research relating to less dominant discourses (e.g. informed by post-structuralist, post-modernist, critical and feminist epistemological frameworks) has also been reviewed.

1.7. Self-starving Women

Self-starving women⁴, the focus of re-feeding practices, have been problematized as ‘having’ anorexia, a ‘mental disorder’⁵, illustrated in the quote below:

Anorexia nervosa is a syndrome in which the individual maintains a low weight as *a result of a pre-occupation with body weight*, construed either as a fear of fatness or pursuit of thinness. (...)

(National Institute for Clinical Excellence [NICE], 2004, p. 13)

Physicians Charles Lasègue and William Gull have been credited with producing the earliest medical descriptions of l’anorexie hystérique and anorexia nervosa in 1873 and 1874, respectively. Both physicians published accounts of severe emaciation and amenorrhea in the absence of known physical causes (Russell, 1995).

Over the last 30 years there has been increasing diversity within the literature in relation to practices of self-starvation; for example, maintaining a low weight in relation to social-cultural practices such as the thin ideal and the dieting industry

⁴ Diagnoses of anorexia nervosa have overwhelmingly been applied to females (Ben-Tovim & Morton, 1990; Gans & Gunn, 2003; Hsu, 1989; Malson, 1998).

⁵ ‘Mental disorders’ is a problematic term but for ease of reading I have not used inverted commas after this point.

(Garner & Garfinkel, 1980; Silverstein, Peterson & Perdue, 1986; Hsu, 1989), a rejection of female roles or the consequence of lack of a positive female identity (Irigaray, 1988, cited in Malson & Ussher, 1997) and AN as an object of discourse and not a reified disease (Hepworth, 1999). Medical or “quasi-medical” frameworks, in which anorexia is conceptualised as a “‘real’ *individualized* clinical” entity, however, continue to dominate (Malson, Finn, Treasure, Clarke & Anderson, 2004, p. 474).

Self-starvation, however, has not always been conceptualised as an individualized clinical entity. Hepworth (1999) and Malson (1998) have highlighted how historical accounts of self-starvation during medieval Europe portrayed fasting as a saintly or religious act, for example, “Cristina the Astonishing (...) gave up food because she had nothing else to give up for Christ” (cited in Malson, 1998, p. 50). The shift from religious to medical explanations for fasting was not clear cut but the “ascendency of the medical profession” marked a discontinuity between theological conceptualisations and ‘scientific’ medical explanations (Malson, 1998, p. 51).

AN has become firmly entrenched, or ‘black boxed’, within Western society and although knowledge of its aetiology is not known and treatment continues to be ineffective for large numbers, the body of research related to anorexia, for example, risk factors for chronicity, physical complications, mortality statistics, has grown exponentially.

In this section I have described dominant conceptualisations of starvation as a mental disorder and in the section below I discuss how this positions re-feeding as the obvious treatment regime.

1.8. Re-feeding Starving Women

Treatment approaches have, inevitably, been shaped by ways in which eating distress, body dissatisfaction and associated body-management practices are understood.

(Malson et al., 2004, p. 474)

Self-starvation conceptualised as a mental disorder marked by symptoms of low body weight, intense fear of weight gain, distorted body image or denial of the seriousness of low body weight and amenorrhea, leads on to treatment regimes that increase body weight, establish healthy patterns of eating, improve perception of the body and restore normal menstrual cycles. The NICE guidelines, while recognising the absence of conclusive evidence to support treatments used for people diagnosed with AN, identified the following three key priorities for intervention:

- Most adults with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders.
- People with anorexia nervosa requiring inpatient treatment should normally be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) and in combination with psychosocial interventions.
- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

(NICE, 2004, p. 60)

Unsurprisingly, all three recommendations centre on physical and psychological symptoms associated with anorexia. For the outpatient accessing psychological therapy, which targets the perceptual distortions and resistance to eating and weight gain, or relational therapies, such as interpersonal therapy, cognitive analytic therapy or family therapy, weight maintenance or weight gain remains the primary goal. Increasing weight loss, which puts the individual at 'high risk', leads to stepped-up care in a day programme or in-patient unit (NICE, 2004; Royal College of Psychiatrists [RCP], 2010).

Following on from the inevitability of clinical conceptualisations of self-starvation shaping clinical responses, in the following section I consider evidence informing the 'high risk' discourse of AN.

1.9. Self-starving Oneself to Death

Within the anorexia literature, mortality is repeatedly highlighted with claims that it is the most lethal of all mental disorders (e.g., Guarda, 2008; Hoek, 2006; Harris & Barraclough, 1988; NICE, 2004; Ramsay, Ward, Treasure & Russell, 1999; Robinson, 2012). The actual number of people who die each year from AN in developed countries, however, is unclear.

A standardised mortality ratio [SMR]⁶ of 5.9, which suggests that people diagnosed with AN have almost a six-fold increase of premature death in comparison to the rest of the population, is frequently cited to illustrate the lethality of AN. This figure of 5.9 was based on a review of published research since the 1950s by Steinhausen (2002). Reported mortality statistics, based on SMRs, however, have ranged from 0.0 (Wentz, Gillberg, Anckarsäter, Gillber & Råstam, 2009) to 23.14 (Agras, Crow, Halmi & Byson, 2009).

The variability in mortality rates have been attributed to differences in research design, diagnostic criteria used (Arcelus, Mitchell, Wales & Nielsen, 2011), method of treatment (Keel et al., 2003) and length of follow-up (Arcelus et al., 2011). It has also been suggested that higher mortality rates could be in relation to the assumption that all premature deaths have resulted from AN (Arcelus et al. 2011).

Papers published between 2000 and 2013, which reported causes of death⁷, included deaths associated with AN (e.g. suicide and physical complications) and deaths unrelated to AN (e.g. passenger in a car accident, homicide, other health conditions) in their estimated mortality ratios. Interestingly the deaths associated with AN did not result from inanition or associated physical complications alone. Fatal outcomes associated with AN were reportedly related to complications of malnutrition and alcohol use (Birmingham, Su, Hlynsky, Goldner & Gao, 2005; Button, Chadalavada & Palmer, 2010; Herzog et al., 2000; Keel et al., 2003;

⁶ Two different calculations have been used to report mortality rates: the crude mortality rate [CMR] and the SMR. The CMR simply refers to the percentage of deaths within the study population (Van Hoeken, Seidell & Hoek, 2003) whereas the SMR involves assumptions about the sample and broader population in order to calculate “the ratio of observed to expected deaths” (Arcelus et al., 2011, p. 725).

⁷ A table listing the papers and causes of death can be found in appendix C.

Rosling, Sparén, Norring & von Knorring, 2011), bingeing and purging behaviours (Herzog et al., 2000; Keel et al., 2003; Löwe et al., 2001; Rosling et al., 2011) and suicide (Birmingham et al., 2005; Button et al., 2010; Crow et al., 2009 ; Herzog et al., 2000; Hjern, Lindberg & Lindblad, 2006; Huas et al., 2011; Keel et al., 2003; Papadopoulos, Ekbo, Brandt & Ekselius, 2009; Rosling et al., 2011).

In contrast to cohort studies, prevalence studies have reported much lower incidences of mortality. For example, an audit of death certificates in England and Wales between 1993 and 1999 identified 140 deaths associated with AN, which equated to less than 20 deaths per year from a population of 52 million people (Muir & Palmer, 2004). A North American study reported an average of 145 deaths per year for the entire US (Hewitt, Coren & Steel, 2001). Similarly, Hjern, Lindberg and Lindbald (2006) reported a point prevalence of 1.51 per 100,000 (0.000151%) among a total population cohort of Swedish females born between 1968 and 1977. Commenting on the disparity between mortality rates in prevalence and cohort studies, Muir and Palmer (2004) suggested that audits of death certificates have probably underreported the number of deaths associated with AN because suicides and physical complications were not reported. They also argued, however, that there was probably “a serious over-reporting” of deaths associated with AN in follow-up research (p. 359).

Despite the methodological limitations and variability of research reporting mortality statistics and the complexity of the relationship between food refusal, self-starvation and other behaviours which might be associated with high levels of distress, mortality rates have been frequently employed “as an indicator of the severity of anorexia” (Hoek, 2006, p. 389). Re-feeding is predicated on the belief that not restoring weight puts the individual’s life at great risk (RCP, 2010).

I have briefly problematized mortality statistics and suggested that they lead on to re-feeding practices in order to save lives. In the next section, I briefly describe how discourses of death and risk are employed as a rationale for the compulsory re-feeding of self-starving individuals.

1.10. Re-feeding Self-Starving Women who Refuse to be Re-fed

Resistance or ambivalence towards re-feeding practices is common among self-starving individuals. It has been suggested that this is because of the 'ego-syntonic' nature of AN (Halmi, 2011).

Even when a patient's health deteriorates to the degree where death is imminent, she may refuse treatment. If she refuses treatment, her treaters and family must decide whether to override her refusal, disrespect her autonomy, and risk the therapeutic alliance even without a guarantee that treatment will be effective, or respect her wish and risk her death. Or, weighing the conditions, they may override her refusal and reverse the effects of starvation, save her life, and launch her on the road to recovery.

(Gans & Gunn, 2003, p. 677).

Gans and Gunn (2003) have acknowledged that the treatment might not be effective but draw on the discourse of risk for re-feeding to be used as a 'life-saving measure'. It is argued that the death rate would "undoubtedly be higher" if compulsory re-feeding was not used for self-starving individuals with a "dangerously low" body weight (Draper, 2000, p. 121). 'Risk of death' enables mental health professionals to use or threaten involuntary treatment under section 3 of the Mental Health Act (MHA) (2007), which authorises the detention and re-feeding of self-starving individuals without consent (RCP, 2010) if their "health is seriously threatened by food refusal" (Care Quality Commission, 2011, p. 6).

Ninety per cent of 686 senior psychiatrists surveyed in the UK agreed that the MHA should be used to enforce compulsory re-feedings. Eighty per cent rated the 'risk of death' as the most important reason for employing the act (Tan, Doll, Fitzpatrick, Stewart & Hope, 2008). Psychiatric patients may acquiesce to treatment and be recorded as 'voluntary' or 'informal' "for social administrative purposes" (Vassilev & Pilgrim, 2007, p. 352). It has been suggested that for self-starving individuals, where figures for compulsory treatment are 'relatively low', this is frequently the case (Tan, Stewart, Fitzpatrick & Hope, 2010).

Compulsory treatment, however, is divisive as some argue that that it is superficially effective while alienating patients as they “eat their way out” (e.g. Bruch, 2001). Others, argued that AN impairs the capacity to make judgments and choices and “that their views often change after they have received care” (e.g. Guarda et al. 2007, p. 109). The clinical effectiveness of compulsory treatment is not known and, it has been suggested, cannot be known because it would be unethical to not intervene (Tan, Hope & Stewart, 2003). Ramsay et al. (1999) compared the outcomes for 82 compulsory patients with 81 voluntary patients. They reported increased mortality among the compulsory group (10 deaths) in comparison to the voluntary group (2 deaths). They stressed, however, that the increased mortality did not reflect on the effectiveness of compulsory treatment but could most probably associated with severity, chronicity and avoidance of treatment leading to the necessity of compulsory re-feeding.

There seems to be agreement that in most cases compulsory treatment is in the best interests of the individual. It has been suggested, however, that the judgement and choices of the self-starving individual should be consulted if they “have been afflicted beyond the natural cycle of the disorder (which is between one and eight years)”, and their quality of life is low and unlikely to improve (Draper, 2000, p. 122). Draper appears to have suggested that only once an individual has been repeatedly subjected to treatment without success should they be consulted about treatment or considered for palliative care.

In this section I have considered professional discourses and practices relating to the use of compulsory treatment for those resisting re-feeding practices (e.g. that the MHA act is an important life-saving tool and that the self-starving individual’s resistance to being re-fed will change following weight gain), the outcomes of compulsory treatment and noted another perspective suggesting that compulsory re-feeding is only superficially effective. Following on from this, I will consider alternative conceptualisations of self-starvation and ‘critical’ research into re-feeding practices.

1.11. Feminist, Post-structuralist and Social Constructionist Critiques

Feminist critiques have long argued that attempts to understand eating symptomatology and personal distress must go beyond individualised accounts of pathology and ideas that social-cultural norms about dieting and weight have been over-internalised (Hardin, 2001; Hepworth, 1999; Malson & Ussher, 1997; Malson, 1999).

Research within feminist and poststructuralist frameworks has highlighted the complexity of practices of self-starvation and problematized the ways in which it has been conceptualised. Hepworth (1999) and Hardin (2003a; 2003b; 2003c), for instance, have argued that anorexia nervosa is an object of discourse and not a reified disease. Malson and Ussher (1997) stated that AN could be construed as a “metaphor for the manifestation of a *multiplicity* of contemporary socio-cultural concerns” (p. 45) after starving oneself and fading away was described as self-destruction associated with “self-hatred, punishment and unhappiness”. It was also described as a means of becoming less visible, which is paradoxical as the starved body becomes more scrutinised, to avoid ‘being me’ and assuming a gendered identity (Malson & Ussher, 1997, p. 51). Hardin (2003a) explicated the ways in which the subject positions available to individuals diagnosed with AN folded back and constructed anorexic individuals. Following this, Malson et al. (2011) described how the construction of an anorexic self makes it difficult for, or prevents, individuals from imagining their own recovery. In contrast, constructing the self as separate from, and more complex, than eating practices and body weight created possibilities for “a future recovered self” (p. 33).

Feminist and post-structuralist research has highlighted the “multiplicity of subjectivities” associated with self-starved bodies (Malson, 1988, p. 192). The research also highlights the paradoxical practices of surveillance in different settings, for example, social-cultural surveillance to engage in body image dissatisfaction and weight loss practices and clinical surveillance to promote weight gain and ‘normal’ eating behaviours (Hepworth, 1999; Malson et al., 2011; Malson, 1998; Malson & Ussher, 1997). It is from within these conflicting practices of surveillance and subjectifying practices, that the self-starving individual must negotiate her “recovery” (Hardin, 2003a).

In this section, I have briefly considered the ways in which the anorexic subject position has been understood as constructing and limiting an individual's identity and potential recovery and summarised meanings associated with practices of self-starvation. Below, I briefly discuss practices of the broader contexts within which re-feeding practices occur.

1.12. Locating Re-feeding in Broader Strategies and Practices

Since the 1970s, the ideology of risk has become increasingly dominant in the administration and treatment of mental health in parallel to the shift from the asylum to community care (Rose, 1998). Prior to this, dangerousness, attributed to internal pathology, was used to refer to particular inhabitants of asylums. In the context of managing patients with mental health diagnoses in the community, discourses of dangerousness were supplanted by discourses of risk (Castle, 1991). Statistical tools were employed by psychiatric professionals to identify populations who posed a risk to others and to themselves and compulsory intervention, under the Mental Health Act, could be used for those considered at high or immediate risk.

Rose (1996b) has argued that, within 'advanced liberal' forms of government, psychiatrists and other mental health professional have become increasingly responsible for developing practices and methods for the 'administration of risk' against "a culture of blame, in which almost any unfortunate event becomes a 'tragedy' which could have been avoided and for which some authority is to be held culpable" (p. 4). Vassilev and Pilgrim (2007) stated that every reform in 'mental health' legislation since the turn of the twentieth century has focused on setting out the conditions to prevent risk.

Harper (2004) has described how the construction of a particular context provides certain possibilities but also certain constraints in the ways that stories are constructed and retold. A context of predicting and minimising 'risk' is likely to support certain ways of constituting discourses and knowledge, such as 'ethical' and 'scientific'/Hippocratic discourses which emphasise the irresponsibility of not re-feeding the 'starving' person. These dominant discourses, however, limit other discourses. For example, Vassilev and Pilgrim (2007) suggest that "it is the

current climate of 'risk', the culture of risk assessment, and the politics of anxiety, that have led to more conservative decision making in politicians" (p. 352). Broader political decisions and practices infiltrate local practices, leading to increasing cultures of risk, anxiety and conservatism among practitioners working within public institutions.

In this section, I have briefly considered the shift to, and increase in, discourses of risk, 'psy' professionals' roles in administering risk and the impact of risk on local practices. For a more thorough discussion on the topic of risk thinking see Castel (1991) and Hacking (1990). In the following section, I set out the rationale for this thesis.

1.13. Rationale for the Research

As explicated in the previous sections, the short-term benefits and the poor long-term outcomes associated with treatment focusing on weight restoration and 'normal' eating are well known. The problems of current constructions of anorexia in relation to negotiating recovery as 'normal' weight have also been highlighted. Academic literature, mental health legislation and national evidence-based guidance, drawing on discourses of risk, however, continue to emphasise re-feeding as a primary intervention.

Researchers have tended to make sense of poor treatment responses by focusing on 'within-patient' explanations (Malson et al., 2011). For example, the published literature has commented on individuals' ambivalence towards, avoidance of, or drop-out from treatment (Boughtwood & Halse, 2008; Guarda, 2008; Nordbø, Espeset, Gulliksen & Skårderud, 2006; Ramsay et al., 1999). I would argue, on the basis of post-structuralist research, that understanding anorexia as an 'illness' with a 'chronic' course and 'slow recovery' works to authenticate the construct of anorexia and the interventions offered and prevents the development of alternative perspectives.

Building on the critical feminist and post-structuralist research in relation to Western conceptualisations of the thin or anorexic body, the current thesis will constitute an alternative account of re-feeding practices for self-starving individuals using a Foucauldian genealogical approach.

Before setting out the methodology chapter, in which I articulate the research strategies and tools guiding this thesis, I will briefly contextualise the theoretical-analytical approach central to this thesis.

1.14. Theoretical-Analytical Approach

In this section, I briefly introduce the reader to Foucault's work⁸ by summarising the context within which Foucault's work emerged, drawing attention to the focus of his analytical work and explicating his theories of governmentality and bio-power, which are central to this thesis. This section is intended to orient the reader to the theoretical-analytical approach explicated in the methodology section.

1.14.1. Introducing Foucault's work⁹

Michel Foucault's (1926-1984) analyses emerged within the context of debates between humanism and Marxism in France during the 1960s. Within these debates, humanism was conceptualised as a product of bourgeois institutions attributing agency to individuals to minimise the effects of social structures, and Marxism was considered to offer a monolithic model of state power in terms of class relations. The work of Foucault, Guattari and Lyotard, among others, emerged in relation to the need for a new critical theory to account for political change (Arribas-Allyon & Walkerdine, 2007).

Foucault's work focused on discourse; not in terms of offering a universal or structuralist account of linguistic systems, which was a dominant approach at the time, nor in terms of hermeneutics, conceptualising discourse as 'meaning systems' to be interpreted. For Foucault, an 'out there reality' or universal laws were not waiting to be interpreted or discovered, rather, behind interpretations and descriptions were further interpretations (Dreyfus & Rabinow, 1982).

⁸ Foucault was a prominent thinker and prolific and controversial writer who published an extensive corpus of work (Rabinow, 1994). This introduction is limited to Foucault's work which is most pertinent to the current thesis.

⁹ This section is descriptive to orient the reader to the present thesis and as such does not critique Foucault's work.

Working '*beyond structuralism and hermeneutics*'¹⁰, Foucault's work focused on discursive practices, which he characterised as:

the demarcation of a field of objects, by the definition of a legitimate perspective for a subject of knowledge, by the setting of norms for elaborating concepts and theories. Hence, each of them presupposes a play of prescriptions that govern exclusions and selections.

(Foucault, 1994, p. 11)

For Foucault, there was a historical dimension between the discursive practices which constitute our reality (Dreyfus & Rabinow, 1982). His objective, therefore, was to map out the history of the multiplicity of ways that persons develop knowledge about themselves within 'games of truth' (Foucault, 1994). Foucault posited four types of technologies that were intertwined with how human beings were known and acted upon:

1. Technologies of production
2. Technologies of sign systems
3. Technologies of power (or domination)
4. Technologies of the self

Foucault's genealogical inquiries (e.g. *Discipline and Punish; History of Sexuality*) centred on analysing specific and local technologies to delineate the ways in which power constituted subjectivities. In the following sections, I outline Foucault's theories of governmentality and bio-power in relation to the latter two technologies: technologies of power and the self.

1.14.2. Governing life

In *Discipline and Punish* (1977a), Foucault analysed the transformation of disciplinary power from the mid-seventeenth century to the twentieth century in Western countries. He delineated the shift from the sovereign's absolute and unconditional power to judicial power, which was conditioned by the defence and

¹⁰ *Michel Foucault: Beyond structuralism and hermeneutics* is the title of Dreyfus and Rabinow's book.

survival of the sovereign. Both of these forms of power had the right to administer death. Increasingly, power was not exercised in relation to the sovereign, but the state and its people. Following this shift, the political power of 'government', by which Foucault was referring to that activity of governing human existence through *state* institutions, became intertwined with the political function of "*administering* life" (Foucault, 1979b, p. 139):

The old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life.

(Foucault, 1979b, pp. 139-140).

Starting in the seventeenth century, the domination of populations became more diffuse and less visible as power came to be exercised through strategies and techniques, distinct from government and judicial apparatus, which were seen to administer life (Foucault, 1977a). The administration of life centred on two, initially separate, 'poles' which emerged during the classical period¹¹. The first pole centred on the "body as a machine" and the second pole, which developed later, was concerned with the "species body" (Foucault, 1979b, p. 139).

The emergence of the concern with 'the body' was in the context of the rise of anatomical and biological technologies, which individualised and specified the human body. In relation to these technologies, the body – as a site of 'micro-power' – became viewed as an object to be broken down into its constituent parts, which could be made divided, reconstituted, manipulated and managed in relation to its parts and totality (Rabinow, 1991). Over time, the dividing and signifying practices that had been applied to the body became increasingly minimised or ignored (Dreyfus & Rabinow, 1982).

Following the anatomo-political human body, various disciplines emerged to administer and manage the 'species body' or population. During this period, disciplinary apparatuses such as universities, secondary schools, barracks and workshops developed alongside the emergence of increasing bio-political

¹¹ Roughly from the middle of the seventeenth century through to the nineteenth century.

concerns relating to birth rates, mortality, life expectancy, public health, housing and migration (Foucault, 1979b).

The “explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” marked “the beginning of the era of the ‘bio-power’” (Foucault, 1979b, p. 140). The inscribed and disciplined individual body and the administered and regulated population were the surfaces upon which power was exercised.

1.14.3. Bio-power

The human body and the metaphorical body – the species body – continued to be distinct disciplinary technologies until the nineteenth century. In the nineteenth and first half of the twentieth century, these two poles of bio-power spread under the banner of improving the fitness of the nation (Dreyfus & Rabinow, 1982; Rose, 2001).

The totalizing and individualizing technologies of bio-power, for instance, the increasingly detailed specifications and associated commentaries which divided up, compared, differentiated and ranked the individual in relation to populations, such as pupils, workers, soldiers, prisoners, patients within particular locales of apparatuses, were “inextricably bound up with the rise of the life sciences, the human sciences, clinical medicine” (Rose, 2001, p. 1). The ‘objective’ human and social sciences emerged, with the goal of establishing regulative controls of the vitality of life and to increase the docility and usefulness of the individual body, and the modern individual become objectified, analysed and fixed (Dreyfus & Rabinow, 1982). The ‘norm’ of the body and a normalising society – technologies of power or domination - emerged within the context of technologies of power that focused on administering life (Foucault, 1979b).

Bio-power conjoined “the production of useful and docile individuals with the production of controlled and efficient populations” (Dreyfus & Rabinow, 1982/1994, p. 193):

Western man was gradually learning what it meant to be a living species in a living world, to have a body, conditions of existence,

probabilities of life, an individual and collective welfare, forces that could be modified, and spaces in which they could be distributed in an optimal manner.

(Foucault, 1979b, p. 142).

1.14.4. Summary

Foucault's work focused on analysing the ways in which the material and social body have become integral to power relations in modern society as life has become central to political strategies (Dreyfus & Rabinow, 1982, p. 112). For Foucault, individuals and populations have become increasingly governed through "technologies of domination", and not acts of repression, in which the human body and species body became objectified, divided and managed and known and acted upon, or subjectified, by the self (Foucault, 1982). The interweaving of technologies to dominate others and the self – governmentality – spread within the context of "administering life":

The 'right' to life, to one's body, to health, to happiness, to the satisfaction of needs, and beyond all oppressions or 'alienations', the 'right to rediscover what one is and all that one can be.

(Foucault, 1979b, p. 145)

Following the work of Foucault, I will attempt to trace the relations in which knowledges about the self and others are intertwined. In the following chapter, I explicate Foucault's genealogical approach to analysis and the research strategies and tools guiding this thesis.

2. METHODOLOGY

2.1. Introduction to Methodology

In this chapter, I articulate the material-discursive epistemological position I have adopted and its relation to a Foucauldian genealogical inquiry. Following this, I position myself within the study. I then locate genealogy within the context of Foucault's work and describe the features of genealogical research, before explicating how I have interpreted and conceptualised the genealogical research strategies to guide this thesis.

2.2. Epistemology

Epistemology determines the theory and analysis underpinning the research investigation (Ussher, 1996). I have found that engaging with the work of Foucault and others who have developed Foucault's genealogical investigations, such as Rose, Tamboukou, Hook and Ussher, has helped me to reflect and find coherence between my own epistemological position, which had been influenced by social constructionism, and a Foucauldian genealogical approach.

Social constructionism refers to related epistemological positions which share the following key assumptions: "a critical stance toward taken-for-granted knowledge", "historical and cultural specificity", "knowledge [...] sustained by social processes" and "knowledge and social action [...] together" (Gergen, 1985, cited in Burr, 2003, pp. 2-5). Burr (2003) has associated Foucault's work and analytics of power, particularly within Foucauldian Discourse Analysis, with *macro social constructionism*. Others whose work has drawn on Foucault's genealogical theory and analysis have criticised the language of social constructionism. They have suggested, for example, that it implies that there is nothing 'real' behind discourse (Ussher, 2011) and that it replaces one form of essentialism, *naturalism*, with another, *discourse* or *social determinism* (Blackman, 2008). It has also been argued that the language of social constructionism reinforces the binaries in the free will and determinism debate (Butler, 1990; Rose, 1999), which Butler suggests separates the natural and the social and, in doing so, reifies the material by positioning it as distinct from, and more real than, discursive practices. Deconstruction, the work often associated

with social constructionism, also implies an end in itself, the production of another truth or 'anti-truth', which Foucault set out to avoid in his archaeological and genealogical work.

Rose has argued that "less insecure scientific domains have long accepted that scientific truth is a matter of construction" (1989/1999, p. 51) and that attempts to "reveal the constructive character of scientific knowledge in order to 'deconstruct' it (...) paradoxically saves empiricism" because "it bases itself on the very territory it seeks to reproach" (Rose, 1999, p. 52). A material-discursive position attempts to move away from the dualism – real world and constructed world – which Rose, Butler and Ussher have suggested social constructionism reinforces.

2.3. A Material-discursive Position

A material-discursive epistemological position implies an inseparable and complex relationship between nature and culture in which human beings are brought into being and made understandable, objectively and subjectively, in relation to discursive practices. Discursive practices refer to more than language; they include, for example, technologies, apparatuses and practices. Foucault, for instance, spoke of the 'technologies of the self' to refer to the processes through which the subjectification of oneself and others – or subjectivities¹² – are created (Kendall & Wickham, 1999). Within this position, I am not denying reality: as Rose puts it "[t]hat which is invented is not an illusion; it constitutes our truth" (p. 3). Blackman, focusing on the body, illustrates the *complex relationality* between the material and the discursive in relation to our *truths*:

We bring particular bodies into being and the production or performance of such bodies is intimately connected to the practices, techniques and artefacts which make different bodies possible. In this approach to corporeality or materiality bodies are real but they are also made, remade and even unmade.

(Blackman, 2008, p. 124)

¹² 'Subjectivities' has been used by Rose (1996, 1999/1989) and critical feminist theorist such as Ussher (1997; 2011), Butler (1990) and Malson (1998) to refer to discourses and discursive practices in which the subject comes to be known and knows and acts on his or herself within the nexus of power-knowledge-self.

Blackman, who has written about material-discursive practices, has drawn on Foucauldian and feminist theoretical-analytical frameworks in her work. Feminist theorists have argued that masculine discourses and discursive practices have been central to the making, remaking and unmaking of reality and in doing so constituting women and femininity as other and negative to men (Butler, 1990; Malson, 1998; Malson & Ussher, 1997; Ussher, 2011). Feminist researchers have also critiqued notions of 'objective' research and highlighted the importance of reflexivity within research practices.

2.4. Reflexivity

Burr (2003) has stated that reflexivity includes recognition that the epistemological judgements and analysis applied to other forms of knowledge also apply to one's own research and associated claims. As briefly discussed in section 1.3, reflexivity¹³ also refers to owning and stating one's own values and positions, in relation to one's political agenda or history, for instance, which informs every stage of the research (Burr, 2003).

For Foucault, truth cannot be *known* independently from the procedures of its production and therefore the task of the genealogist is to "criticise, diagnose and demythologise 'truth phenomena'" (Tamboukou, 1999, p. 202). Commenting on the production of his work, Foucault is aware of the contingent and temporally located status of his own work:

I am fully aware that I have never written anything other than fictions. For all that I would not want to say that they were outside of the truth. It seems plausible to me to make fictions work within truth, to introduce truth effects with a fictional discourse, and in some way to make discourse arouse, 'fabricate' something which does not yet exist, thus to fiction something. One 'fictions' history starting from a political reality which renders it true, one 'fictions' a politics that does not yet exist starting from a historical truth.

(Foucault, 1979a, p. 75)

¹³ Although I continue to use the language of reflexivity, I recognise its limitations and am aware that all that I have 'thought' or experienced has occurred in a multitude of 'intra-actions'.

Similarly, I view this thesis as a “fabrication of something that does not yet exist”, which does not undermine its attempt to trace the heterogeneous processes of production that led to, and sustain, the practice of re-feeding as a primary treatment regimen for self-starving individuals.

In a discussion of the researcher’s relationship to his or her work, Tamboukou (2010) highlighted Haraway’s (1997) critique of the language of reflexivity for implying a search for the “authentic and really real”. Moving away from notions of reflexivity, reflectivity and inter-actions, Tamboukou has connected with the idea of *intra-actions*, used by Barad. Barad, a physicist and feminist theorist, uses the term *intra-actions* to denote “how entities – both human and non-human – occur as relations between components” (cited in Tamboukou, 2010, p. 9). An analysis of knowledge-truth-power *intra-actions*¹⁴ is central to a genealogical approach. *Intra-actions* also refer to “the multifarious entanglements – both material and discursive – between ‘the researcher’, ‘the research object’ and ‘the research context’” (Tamboukou, 2010, p. 12), which illustrates and draws attention to how I am imbricated within the production of this thesis.

2.5. Contextualising Genealogy

Foucault used genealogy as a methodological device for doing *effective histories*¹⁵ or *histories of the present* which were “concerned with the processes, procedures and apparatus by which truth and knowledge are produced” (Tamboukou, 1999, p. 202) and lead to taken-for-granted assumptions about what we know and how we have and can come to know ‘truths’ about things in the world. Foucault’s use of genealogical analysis in *Discipline and Punish* and *The History of Sexuality* marked a methodological shift away from his archaeology projects (Dreyfus & Rabinow, 1982), in which Foucault’s analysis

¹⁴ *Intra-actions* refer to the dynamic and inseparable relations between the focus of the research, the researcher’s methodological approach and researcher’s contexts. The activities and outcomes of *intra-actions* are conceptualised as one system, which is different to ideas of multiple systems, which can be separated out and known (i.e. research focus, methodology, and researcher’s beliefs and background), interacting

¹⁵ “History becomes ‘effective’ to the degree that it introduces discontinuity into our very being – as it divides our emotions, dramatizes our instincts, multiplies our body and sets itself against itself” (Foucault, 1977b, p. 154).

had focused on discourse through the analysis of the *technologies of signs systems* and *technologies of production* (Tamboukou, 1999).

Foucault's genealogical investigations moved away from the dualism of the discursive and non-discursive evident in his archaeological projects towards a topographical approach which attempted "to show how discursive and non-discursive formations coexist in various forms of correlation, opposition or juxtaposition" (Tamboukou, 1999, p. 205). As Sembou (2011) commented, Foucault continued with "Nietzsche's tradition of 'philosophizing with the hammer'" (p. 5), in order to fragment 'truths' which appear to be without history or are thought to correspond to an underlying reality. In *Nietzsche, Genealogy, History*, his most explicit paper about his genealogical work, Foucault examined Nietzsche's *On the Genealogy of Morality* (1913) and considered the objectives of genealogy. Discussing the different vocabulary Nietzsche employed, Foucault distinguished *Ursprung (origins)*, which implies a deeper reality or essence to be revealed, from *Entstehung (emergence)* and *Herkunft (descent)*. Foucault stated that there is "not a timeless and essential secret" behind things but instead "the secret that they have no essence or that their essence was fabricated in a piecemeal fashion of alien forms" (1971, p. 142). Therefore, the task of the genealogist is to analyse the *emergence* and *descent* and capture the discontinuity and dissension within 'the process of production' of the things taken to be 'truths'.

Gordon (1980) stated that in his use and development of archaeological and genealogical methods, Foucault was not intending to repudiate or replace other methodological approaches such as those of "historical sociology and ethnology but to make available to historical analysis a whole additional range of objects and relations" (cited in Tamboukou & Ball, 2003, p.18).

2.6. Key Features of Genealogical Research

In contrast to traditional histories, which focus on a historical period and produce chronological narratives of great men and great discoveries and inventions through time, Foucault's effective histories have been concerned with a problem-based approach to history (Kendall & Wickham, 1999). A problem-based

approach “demythologises” notions of the present as a product of universal laws and sequential development through the *problematization* and examination of the most familiar and everyday truths and practices (Kendall & Wickam, 1999; Tamboukou, 1999). A genealogical analysis examines the discursive practices at play and seeks to disturb the certainties of truth and their history to “produce as awareness of the complexity, contingency, and, fragility of historical forms” (Smart, 1983, p. 76).

In this sense, Foucault’s work has been referred to as anti-ontological, in that it does not seek to provide an alternative or more true truth (Hook, 2007; Kendall & Wickham, 1999) or deconstruct truths to produce an anti-truth (Kendall & Wickham, 1999; Tamboukou, 1999). Rather than denying the truth, reality or utility of an object or event that we have come to know, genealogy attempts to show that the object or event “is best grasped as a *complex of factors*, a poised moment of converging contingencies and intersecting lines of force rather than a self-sustained, autonomous entity” (Hook, 2007, p. 145).

2.6.1 *Descent and emergence*

In exploring *how*, and not *why*, an object or event achieved epistemological coherence, a genealogical inquiry scrutinises the complex and multiple processes surrounding its emergence in order to trace the strategies, technologies and apparatus, which work together to produce truth and knowledge. It does not assume that truths will lead us to liberation but examines the nexus of relations between the object and political objectives (Dreyfus & Rabinow, 1982). According to Tamboukou and Ball (2003), Deleuze (1992) has described this as a process of drawing maps which illustrate the matrix of relations connected to the *problematization*. Concerned with mapping the analysis of descent, as opposed to depth and hidden meaning, the genealogist as a topographer focuses on tracing the working of practices and constructs “a polygon rather than a polyhedron” (Foucault, 1991, p. 77). Foucault has compared the *moment* of genealogy to “an overview, from higher and higher up, which allows the depth to be laid out in front of him in a more and more profound visibility; depth is re-situated as an absolutely superficial secret” (Foucault, 1967b, p. 187).

Genealogy begins with a “diagnosis of the current situation” (Dreyfus & Rabinow, 1982, p. 119); an examination of current discourse and discursive practices. The tracing and analysis of descent examines localised practices “without taking anything for granted” and exploring the “countless historical transformations” of what people do and have done (Tamboukou, 1999, p. 209). The genealogist looks for *meaning* in ‘surface practices’ and not, as already discussed, in terms of essences or origins. This process seeks to capture the complexity of an object’s descent; isolating “the errors, the false appraisals ... the faulty calculations that gave birth to those things that continue to exist and have value for us” (Foucault, 1977, p. 146).

Although Rose (2007b) has stated that making contingencies visible is no longer ‘radical’, it is worth remembering that Foucault was writing and publishing in the 1970s when structuralist theories, founded upon the assumption that there was a “deeper reality underlying the surface features of the world” (Burr, 2003, p. 11), were dominant in history, sociology, linguistics and some areas of psychology, for example, the theories of Freud and Piaget. Foucault’s genealogical research strategies did not suppose or search beneath the surface for governing rules and structures but instead sought to describe the surface of events and practices in terms of their emergence, interrelatedness, disconnectedness, mutations and temporality. In section 2.7, I explicate the *perspectival dimensions*, which inform the genealogical research strategies employed in this thesis, to trace the surface of emergence and descent. This is followed by the analysis and discussion chapter, in which I have attempted to map out and analyse the surface of emergence; capturing the diversity, discontinuity and contingencies of events and practices surrounding the emergence of re-feeding practices, and the tracing of descent; how events and practices have mutated, shifted or stayed the same over time and in relation to what conditions.

Genealogy is interested in the *field of historical action* in which the object or practice is brought in to being. Neither the state nor an individual subject is at the centre of the field of action and, therefore, responsible for the emergence of the object/practice. For Foucault, truth and power are not the result of psychological motivation or ‘will to power’ (Hook, 2007). Psychological motivation is the result

of strategy and not strategists, as Foucault states, “no one is responsible for the emergence; no one can glory in it, since it always occurs in the interstice” (1977b, p. 150).

2.6.2. Power-knowledge

Power is central to Foucault’s genealogical works (Kendall & Wickham, 1999). For Foucault power was positive, diffuse and ubiquitous (McNay, 1994); it was not a substance that acts on things:

Power is employed and exercised through a net-like organisation and not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power.

(Foucault, 1980, p. 98).

Power cannot be analysed independently from knowledge or truth (Rose 1999). In his later work, focusing on the production of *the self*, Foucault conceptualised power, the subject and knowledge as three interdependent axes, which lead to the subjectification of oneself and others (Kendall & Wickham, 1999). It is in its productiveness that Foucault formulated power as positive and following this Butchart (1988), for example, argued “there can be no objects of knowledge in the absence of methods for their production” (p. 184). Kendall and Wickham (1999) have drawn on the metaphor of power as source of energy to illustrate how power is both mundane and productive in maintaining connections. Drawing on Foucault’s *Discipline and Punish*, Kendall and Wickham (1999) have illustrated how power operates as double relation between the visibilities of the object or event and what can be said or known about the object or event; for instance, the visible prison produces statements about criminality and criminality produces forms of visibility which reinforces the prison.

2.7. Perspectival Dimensions

Rose (1999; 1996) has suggested that the following dimensions, which are best described as *perspectival*, can sensitise the genealogical analysis on the nexus

of relations and connections between subject-knowledge-power. In this section, I briefly explicate the five dimensions, namely strategies, authorities, technologies, subjectivities and problematizations, that were central to the analysis in this thesis. These perspectival dimensions alongside a reading of Foucauldian theory have helped me to apply a Foucauldian theoretical-analytical lens to this research.

2.7.1. Strategies

Strategies direct us to the connections between practices and techniques for knowing and shaping human beings and broader moral, social, or political concerns or aspirations, which are connected to ideas about the undesirable and desirable conduct and features within populations (e.g. “prevention of degeneration, eugenic maximisation of the fitness of the race, minimisation of the cost of social maladjustment through mental hygiene...”) (Rose, 1996, p. 28). It includes the relations and distinctions between political and ‘non-political’ authorities and apparatuses involved in governing conduct and human beings. The governance of conduct and shaping of subjectivities is possible within a network of knowledge-subject-power, in which power is exercised through the relations between these five *perspectival* dimensions.

2.7.2. Authorities

This dimension refers to those who have, or claim, authority or expertise “to speak truthfully about humans, their nature and their problems”; the apparatuses which legitimate authorities or expertise (e.g. the courts, universities, politics); the relationship between authority and “a claim to positive knowledge”; the “relation between authorities and those who are subject to them: priest and parishioner, doctor and patient, manager and employee, therapist and client”; the governance of authorities, for example, by “legal codes, by the market, by the protocols of bureaucracy, by professional ethics” (Rose, 1996, p. 27).

2.7.3. Technologies

Technologies refer to the assembly of practices, techniques and apparatuses that have been created to govern the human being and to shape conduct within the

broader moral, political and economic strategies (Rose, 1998, p. 26). These include practices of judgement, division and classification (e.g. examinations and assessments with their associated norms), techniques and programmes focused on intervention or prevention and the apparatuses or institutions within which techniques and programmes are structured and implemented (e.g. the school, hospital, prison). Technologies also refer to the practices, techniques and apparatuses which constitute how we come to know and act upon ourselves as human beings – processes of subjectification, discussed in more detail below.

2.7.4. Subjectivities

Subjectivities direct our attention to the ways in which human beings have come to be known (i.e. their ontological status); how they can be known (e.g. through observation, testing, confessional practices); the type of person they should strive to be; the techniques and practices they can apply to themselves for self-improvement, autonomy and fulfilment (Rose, 1999). Subjectivities emerge in relation to technologies of power and the self, which are imbricated within the broader strategies and which have the authority to impose particular frameworks or conceptualisations of knowing others and ourselves.

2.7.5. Problematizations

Problematizations sensitise us to the ways in which human beings have become understood as problematic, in relation to strategies, authorities, technologies and subjectivities, explicated above. Practices and ways of being, for example, normal, mad, deviant, are rendered problematic in relation to overarching moral, political and economic strategies, within particular apparatuses or institutions and through sanctioned knowledges and practices (Rose, 1999, p. xi).

So far I have discussed five perspectival dimensions which are central to the Foucauldian theoretical framework informing this attempt at a genealogical inquiry. In the following sections I describe my corpus of data and operationalized these five dimensions in relation to my research.

2.8. Corpus of statements

In accordance with a genealogical approach, I will not be seeking to produce an account of coherent narratives and underlying reality. Instead, I will be focusing on interrogating the workings of discursive practices in which knowledge about re-feeding regimes have been constituted (Tamboukou, 1999) and are located within *regimes of truth* (Rose, 1996). My data sources, or *corpus of statements*, will include official publications and published research and commentaries within psychological, psychiatric and medical journals and book chapters, pertaining to re-feeding and weight restoration treatment practices. These sources represent “expert discourses” within psychiatry, psychology and allied disciplines. One potential limitation of drawing *statements* from within the official and academic literature is that it is possible that there will be a lack of counter-discourses and resistances because the acceptance of journals and invitations to participate in the construction of guidelines are associated with adherence to the norms and standards within the *rhetorics of truth* (Rose, 1996a, p. 55).

Foucault (1977b) stated that genealogy “requires patience and a knowledge of details and it depends on a vast accumulation of source materials” (p. 140). Carabine (2001) reported that she spent years immersing herself in the primary, secondary and related data sources for her genealogical investigation of unmarried motherhood. For the current investigation – a professional doctoral thesis – I have a defined time-frame in which to complete the genealogy and, therefore, I needed to define inclusion criteria to delimit my *corpus of statements*, while ensuring that it included temporal variation.

Arribas-Ayllon and Walkerdine (2007) emphasise the importance of the temporal variability of the *corpus of statements* selected in order to analyse the *discontinuities* of practice over time to show how an object or practice has “been spoken about differently in the past and exposed to different forms of regulation ... and reform” (p. 100). They suggest that the internal validity of the statements is through their role in determining the *conditions of possibility* for the object or practice being investigated.

The source materials for the current study comprise a *corpus of statements* taken from official guidance produced by, or in partnership, with professional or governing bodies and key texts which capture the academic and clinical literature. The inclusion criteria for the selection of papers for the past and present case narratives (see section 3.1) were critical time points: the first re-feeding treatment study within the published literature and current treatment practices. Dally and Sargant's (1960; 1966) *new treatment* (see section 3.1.1) was the first treatment study identified in a database search. Current practice guidance for treating 'mental disorders' within the NHS is provided by NICE and the Royal College of Psychiatrists [RCP]. NICE and RCP guidance relating to the treatment of anorexia were, therefore, selected as the basis of current treatment practices. In order to capture temporal variation while limiting the volume of source materials, one key text, which provided multiple perspectives, was included for each decade. A list of the documents that form the corpus of statements and a rationale for the inclusion of each document can be found in appendix E.

2.9. Method

Carabine (2001) stated that genealogy is more about methodology, which she has defined as the philosophical and epistemological assumptions underlying and informing the research process, than it is about method, the techniques for selecting and analysing the data.

In her *Exploration of Foucault's Strategies for Doing Research*, Tamboukou (1999) considered the "theoretical and methodological dimensions" of Foucauldian genealogy and reflected on the challenges of undertaking a genealogical approach because of the absence of a unified theory or methodology (Tamboukou & Ball, 2003, p. 2). Foucault did not articulate a closed theoretical framework (Rose 1999) or follow a set of structured methodological principles (Tamboukou, 1999). The implications of working with an open methodological framework pose challenges for the researcher. My previous research experience prior to this thesis has always been within a closed methodological framework, such as statistical analysis, or qualitative analysis with fairly prescribed procedural steps. As a novice genealogist, I worked to

challenge my need for prescription and certainty and, instead, sought to build a Foucauldian theoretical-analytical lens from which to interrogate the 'corpus of statements'.

Instead of following a prescriptive method, Tamboukou suggested that Foucault's genealogies create a "methodological rhythm of their own and pose questions which invite us to interrogate what we know" (Tamboukou, 1999, p. 215). In undertaking effective or critical histories of the 'sciences of man' Foucault invited researchers to approach his theories "as tools for analysis" (Tamboukou & Ball, 2003, p. 1). Those who have continued with genealogical investigations; for example, Butler, Malson, Rose, Tamboukou and Ussher, have also steered clear of providing a formula for doing genealogy. Formalising the approach would have the potential to take genealogy within positivist knowledges, something Foucault sought to avoid (Rose, 1999). As Tamboukou and Ball (2003) assert, the goal is not to replace one set of epistemological certainties with another but to "introduce a constant instability into our assumptions about 'doing research' and making theory" (p. 10).

2.9.1. Tools for analysis

Consistent with the theoretical assumptions that oppose the definition of a closed genealogical method, in the following section I outline the research strategies or tools for analysis that have directed the current genealogical exploration. The research strategies are centred on my understanding and intra-actions with Rose's (1999/1989; 1996) perspectival dimensions explicated in section 2.7, which were informed by Foucault's theoretical conceptualisation of bio-power discussed in section 1.14.3. In the following chapter, analysis and discussion, I attempt to trace the *surface of emergence* and *descent* (concepts described in section 2.6.1) of re-feeding practices (Arribas-Ayllon & Walkerdine, 2007).

I have devised questions that correspond to the five perspectival dimensions to help me to interrogate my *corpus of statements* within a Foucauldian theoretical-analytical framework. In compiling these questions, which I present below, I draw on the taxonomy of questions provided by Rose (1999; 1996a) and considered

Tamboukou's (1999) reflections on the types of questions that could direct a genealogical inquiry.

2.9.2. Questions to help interrogate the data

Problematizations	Where, how, by whom and for whom have the practices of re-feeding been rendered essential, according to what systems of judgement in relation to what concerns?
Technologies	What are the practices of judgement, division and classification that relate to re-feeding? What techniques and programmes guide re-feeding practices? Within which apparatuses do re-feeding practices take place?
Authorities	How is power exercised within the production and proliferation of discourses relating to these practices? Where is there resistance to re-feeding practices and what is the impact of resistance? How are the knowledge, techniques and sites related to re-feeding practices governed?
Subjectivities	What subjectivities are produced through the practice of re-feeding? What are the subject positions eclipsed by this practice?
Strategies	How is re-feeding linked to practices of normalisation, and to wider social, moral or political objectives about the desirable features of populations?

In this chapter I have articulated my epistemological position, discussed genealogy as a theoretical-analytical approach and outlined the research tools or strategies that have guided the genealogical analysis in this thesis. In chapter 3, I attempt a genealogical exploration of re-feeding through the analysis of emergence and descent.

3. ANALYSIS AND DISCUSSION¹⁶

In this chapter, I provide a rationale for drawing on case narratives as a starting point for my analysis and then describe and contextualise past and present case examples. Following on from this, in section 3.2, I explicate the *surface of emergence* of the historical case narrative and, in section 3.3, I present the analysis of *descent*.

3.1. Past and Present Re-feeding Practices

In the previous chapter, I discussed Foucault's research strategies and outlined a number of strategies and tools for analysis that are central to this thesis. In the following section, following Foucault's way of using narratives to elaborate his concepts¹⁷, I present two exemplary cases that capture the ways that re-feeding has been conceptualised as a problem and a clinical practice for self-starving individuals who come into contact with services. The case studies portray historical and current practices and form the starting point for my attempt to trace the surface of emergence and descent of re-feeding practices while identifying and analysing the five perspectival dimensions which relate to technologies of power and the self. Before presenting each case study, I provide a context and justify its inclusion.

3.1.1. Past practices

In the NICE (2004) clinical guidelines, which have summarised the core interventions in the treatment and management for anorexia nervosa and other eating disorders, the authors briefly discuss past and present treatment practices within the NHS. They begin by stating that, for the first half of the twentieth century, anorexia nervosa was typically managed and treated by general physicians and "[t]reatment consisted of bed rest, often in a side room of a general medical ward" (NICE 2004, p. 30). The authors stated that psychiatry's interest and involvement in working with anorexia nervosa emerged in the middle of the twentieth century. Commenting on the few psychiatrists who initially took an interest in 'the condition', the authors referred to Dr Peter Dally and Dr William

¹⁶ I have combined the analysis and discussion sections in line with a genealogical approach.

¹⁷ I refer here to the two dramatic scenes in *Discipline and Punish*.

Sargant, physicians in psychological medicine at Westminster Hospital and St. Thomas's Hospital, London, who used physical methods¹⁸ of treatment.

According to the authors, Professors Arthur Crisp and Gerald Russell, academic psychiatrists, also began to take an interest in “the condition” (NICE, 2004).

Following on from NICE's reference to psychiatry's initial interest in anorexia, I tried to identify the earliest account of re-feeding practices in the NHS in the UK. I hand searched the reference lists in early papers to find accounts of treatment of AN in the mid-twentieth century¹⁹. My search identified two papers by D. W. K. Kay, a psychiatrist at the Maudsley Hospital, in the 1950s. Kay (1953) and Kay and Leigh (1954) described treatment practices at the time, including bed rest and a high calorie diet, psychoanalysis, leucotomy and electroconvulsive therapy (ECT), but were not treatment studies. Kay and Leigh's (1954) detailed case analysis of 38 patients led them to conclude that heterogeneity among the “psychiatric symptomatology” indicated that anorexia nervosa was not a distinct clinical entity or syndrome (p. 428).

After the work of Kay and Leigh, my search for the earliest study of re-feeding practices in the NHS identified research published by Dally and Sargant in 1960 and 1966. In *A New Treatment of Anorexia Nervosa* (1960) and *Treatment and outcome of anorexia nervosa* (1966), both published in the *British Medical Journal* [BMJ], Dally and Sargant explicated and evaluated their “new treatment” programme which they developed to treat the “syndrome” of AN. Interestingly, perhaps, they do not refer to Kay's work. These two papers have formed the basis of the historical case study presented in detail below.

Dally and Sargant's (1960) “new treatment” combined chlorpromazine²⁰ and insulin within a re-feeding regime and was prescribed to patients who were inpatients in their London hospitals.

¹⁸ The physical methods of psychiatry, during this period, included insulin therapy (an insulin induced coma), psychosurgery, ECT and psychopharmacological treatments.

¹⁹ The mid-twentieth century was chosen as a starting point in relation to the claims in the NICE guidelines about psychiatry's early involvement in AN and because my reading made me aware that diagnoses of Simmonds' disease displaced AN until this time (discussed in section 3.3.3).

²⁰ Chlorpromazine is a neuroleptic drug, often referred to as an antipsychotic, with sedative effects, which was introduced into psychiatric practices in the 1950s (Moncrieff, 2009).

Describing the events surrounding their decision to use chlorpromazine and insulin, Dally and Sargent stated that treatment in AN had not advanced in the seventy-five years since Gull “recognized that the patient’s refusal to eat was due to ‘a morbid mental state’” and that “patients should be fed at regular intervals and surrounded by persons who would have moral control over them”. They commented that despite all kinds of ‘moral’ persuasion, these patients continued to refuse to eat, which was dangerous as evidenced by the death of 15% of patients in “[a] recent study from the Maudsley Hospital”²¹. Dally and Sargent claimed that treatments that had been used on patients diagnosed with anorexia, including thyroid, insulin, and cortisone hormonal treatments, ECT (electro-convulsive therapy) and modified leucotomy, ranged from being ineffective to harmful. They claimed, however, that the physical methods such as ECT and modified leucotomy were preferable to the “much graver risks of allowing states of inanition to continue indefinitely”. Dally and Sargent argued that the failings of treatments in achieving weight gain had led to a resurgence of tube feeding, which they suggested was the best alternative to modified leucotomy but undesirable from a psychological point of view. In this context, Dally and Sargent were offering their *new treatment* (1960, p. 1770).

The patients included in the paper met the “essential criteria” for the “syndrome” of anorexia nervosa. The criteria are reproduced below (Dally & Sargent, 1960, p. 1770):

1. Refusal to eat, whether or not accompanied by anorexia at the start;
2. Severe loss of weight;
3. Absence of evidence of schizophrenia, severe depression, or organic disease;
4. Amenorrhea of at least three months’ duration in female patients.

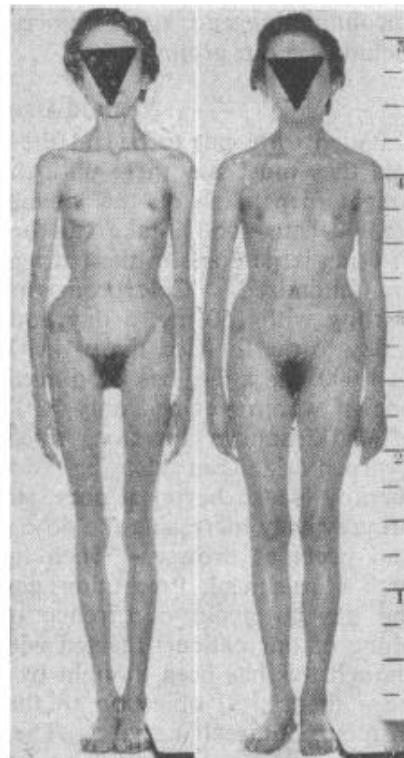
The *new treatment* method prescribed total bed rest until the patient had regained near normal weight. In addition to bed rest and high calorie meals, the patients were heavily sedated with chlorpromazine and modified insulin therapy. Doses of chlorpromazine were commenced with 150mg a day and this dose was increased to 1000mg per day for patients who were considered to be “difficult”.

²¹ This study, which was not referenced, was the study by Kay and Leigh (1954) described above.

In the second paper Dally and Sargent reported that they had increased the dosage of chlorpromazine, administering up to 1600mg per day if necessary, “until the patient’s resistance to eating is overcome” and “she loses her customary sense of panic at the sight of food and usual epigastric discomfort which follows eating”. In parallel to the chlorpromazine, patients were started on modified insulin therapy (MIT), which would have been likely to produce a sub-coma state. The insulin was started at five units and the dose was progressively increased “until the patient sweats and becomes drowsy”. The insulin therapy was interrupted during meal times. Meals were light to begin with and included fortified mild drink and the daily calorie intake was increased from 1,500 to 4,000 calories (Dally & Sargent, 1960, p. 1771).

Dally and Sargent (1960) stated that “[m]ost patients began to gain weight almost at once when treated with the combination of chlorpromazine and insulin”. Fig. 3.1.1.a is a ‘before and after’ photographic presentation in their discussion of the results. The authors claimed that this patient’s “‘belly touched her backbone’ on admission” and that she was “depressed, untruthful, and resisted all attempts to make her eat”. Following five weeks of the *new treatment* this woman was described as “cheerful, co-operative, and almost normal after a gain in weight of 20lb. (9kg).” (p. 1772).

Fig. 3.1.1.a Photographs of patient before and after treatment



The priority of the *new treatment* was weight gain and Dally and Sargent stated that attempts to uncover psychological difficulties were halted until the weight was restored to the normal level. Once weight was restored, medication was reduced or stopped altogether, and the patient was discharged if she continued

to eat satisfactorily one week after the target weight was reached (Dally & Sargant, 1960, p. 1771). Information about how the psychological difficulties were uncovered was not provided in either paper.

In their follow-up article, Dally and Sargant (1966) reported their results for the “48 anorexia patients” who had received the *new treatment* between 1957 and 1962. Reporting on the outcomes they stated that “treatment with chlorpromazine and modified insulin resulted in a large and rapid gain in weight, however resistant initially the patient was to eating”, and that it “seems probable that the important factor in this combined method is chlorpromazine, which lessens the patient’s fear of and resistance to eating” (p. 794).

In addition to its tranquilizing effects, chlorpromazine also led to signs of Parkinsonism in eight patients, which included “dyskentic reactions” (involuntary jerky movements) and “restlessness (akathisia)”. Individuals also complained of drowsiness, blurred vision, and a dry mouth; side effects associated with chlorpromazine. Five patients also had a grand-mal seizure “within the first fortnight of starting treatment”. Dally and Sargant, however, reflected on the success of their treatment in inducing weight gain and stated that even “though initially the patients can be very debilitated”, the treatment programme was “surprisingly free of dangerous complications” (1966, p. 794).

Despite the treatment’s success in the speed and volume of weight gain – patients treated with the *new treatment* gained twice as much weight as individuals treated with bed rest and a high calorie diet – one third of the 30 individuals with a shorter history of anorexia nervosa were readmitted following weight loss within two-years. Outcomes were only provided for the 30 individuals who had been “ill” for less than four years. Dally and Sargant (1966) stated that by the end of three years approximately two thirds of those treated with either the *new treatment* or other means “had made a satisfactory recovery” (p. 795). Less satisfactorily, perhaps, they reported that forty-five per cent of those treated with the *new treatment*, compared to 12% of those treated by other means, no longer resisted food but that they compulsively overate and became overweight.

Of the remaining 18 individuals, who had previously received treatment and been ill for five years or more, they concluded that it was unlikely that restoring weight alone would have much effect and that the “outlook is gloomy” for patients with chronic anorexia (1966, p. 795). For example, eight “chronic anorexics” steadily lost weight after returning home. Three individuals with chronic anorexia, however, “did extremely well following the weight gain; they retained their weight, they resumed menstruation, and one, a married woman, became pregnant” and one person recovered spontaneously after 25 years (Dally & Sargant, p. 795).

Reflecting on the future for patients given a diagnosis of anorexia, Dally and Sargant stated that “[m]ost anorexia nervosa patients are backward in their psychosexual development and consequently have considerable conflicts over their sexual feelings and behaviour. None the less, these girls are able to marry and have children, although in some instances at least they do so in order to ‘be like everyone else’ rather than through a more mature sense of love” (1966, p. 795).

The case narratives presented above will be revisited in tracing the surface of emergence and descent in sections 3.2 and 3.3.

3.1.2. Present practices

In this section the case narratives illustrate how re-feeding practices for self-starving individuals have changed, and how they have stayed the same, since Dally and Sargant’s *new treatment* in the 1960s.

In selecting the material for the present case narrative, I turned to NICE clinical guidance (2004) which provides an introduction to the stepped approach to the treatment of self-starving individuals. In a stepped approach, the intervention is intensified in accordance with the ‘degree’ of AN or ‘risk’ of harm. I have then edited more detailed guidance for the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) published in 2010, which focuses on re-feeding practices within inpatient settings.

The MARSIPAN guidance emerged in the context of the variability of the quality of provision for anorexia and concerns in relation to fatalities in general medical

settings and death from underfeeding syndrome. The treatment guidelines were compiled by the MARSIPAN working group, a collaboration between the Royal College of Psychiatrists and Royal College of Physicians, with the hope that they would prevent unnecessary fatalities. The authors of the MARSIPAN report, however, have claimed that “some fatalities are inevitable” because “[a]norexia nervosa has one of the highest mortalities of any psychiatric condition (RCP, 2010, p. 10).

Current NICE clinical guidance (2004) has stated that most people diagnosed with AN should be treated on an outpatient basis. Inpatient treatment should be reserved for those who have not responded to outpatient treatment and those at substantial risk of suicide or self-harm. When inpatient care is required, it should be offered within services with ‘skilled re-feeding’ and physical monitoring programmes, in combination with psychosocial interventions. The authors of the NICE guidance have stated that they do not recommend pharmacological interventions as a sole or primary treatment for anorexia. They acknowledge, however, that medication continues to be used in the treatment of AN for those with “comorbid conditions” and in order to “reduce high levels of anxiety” (p. 91).

The aim of providing inpatient treatment is “to return body weight to a healthy level” (NICE 2004, p. 82). The authors of the NICE guidance have stated that following re-feeding patients are “vulnerable to subsequent weight loss” and, therefore, “outpatient psychological treatments” should be “offered to prevent this” (p. 85). They have noted that the provision of eating disorder services and models of service delivery within the UK vary and “range from ‘generic’, in which outpatient therapies are provided by community mental health teams, backed up by psychiatric admission, to variable models of specialist eating disorder services” (p. 31). As stated above, this diversity in service provision informed the development of the MARSIPAN guidelines, which were compiled by psychiatrists and physicians who claimed specialist expertise in managing and treating anorexia nervosa.

Two MARSIPAN reports have been published; the original (RCP, 2010), which focused on adults, and more recently a junior MARSIPAN report (RCP, 2012), which focused specifically on children and young people up to the age of 18. The

rationale for the separate reports included the different thresholds for risk and legal frameworks and the central role of paediatric services in the treatment of young people, which was related to the lack of specialist eating disorder units (SEDUs) in child and adolescent mental health services (RCP, 2012).

The MARSIPAN guidance applies to “really sick patients” and the level of sickness is primarily defined in terms of body weight and those regarded to be at the “highest risk” (RCP, 2012, p. 14). In the adult guidance, this refers to those with a BMI of less than 15 and individuals admitted to medical wards or to SEDUs (RCP, 2010). For under 18s, “really sick” refers to those with “less than 70% median BMI for age and gender, for whom hospital admission is likely” (RCP, 2012, p. 14). Both documents have stated that these guidelines may also be applied to those with a BMI above the cut-off, but who have been losing weight rapidly, and those vomiting, using laxatives and/or over-exercising.

Both MARSIPAN reports begin with issues of risk and risk assessment. Discussing the rationale for a comprehensive risk assessment, the adult guidance has stated that:

Patients with anorexia nervosa can seem deceptively well. They may have an extremely powerful drive to exercise which sometimes seems to override their lack of nutritional reserve, so that they may appear very energetic right up to a physical collapse. One patient was seen to be going round a medical ward, cheerily waving to other patients through their windows just a few days before collapsing from fatal hypoglycaemia.

(RCP, 2010, p. 14)

Similarly, the junior guidance emphasises the need to assess risk beyond a diagnostic assessment, because the symptomatology of young people may be different to adults and because they can appear more well than they are:

Young children and pre-pubescent adolescents may present without the typical features (e.g. absent periods or significantly low BMI) found in adults, and the behaviours associated with eating disorders are often covert. The complexities of managing these

patients are compounded by the anxieties of the patient and their family, which also have an impact on the caring team.

(RCP, 2012, p. 16)

A thorough risk assessment including clinical assessments and physical examinations is recommended, and frameworks are provided for assessing the level of risk in both sets of guidelines. The adult guidance has included a “basic list of observations to be made to assess risk [and whether inpatient care is required]” (RCP, 2010, p. 14), which I have reproduced in box 3.1.2.a below. In contrast, the junior guidance has compiled a comprehensive risk assessment framework which “can be used to highlight areas useful to assess and grade concern, but is not a substitute for an overall experienced clinical assessment” (RCP, 2012, p. 16). Due to limitations of space in this thesis this framework is reproduced in appendix F.

Box 3.1.2.a. Risk assessment in anorexia nervosa²²

1. Body mass index: weight (kg)/height² (m²)
 - anorexia <17.5
 - medium risk 13–15
 - high risk <13
2. Physical examination
 - low pulse, blood pressure and core temperature
 - muscle power reduced
 - Sit up–Squat–Stand (SUSS) test
3. Blood tests
 - sodium low: suspect water loading (<125 mmol/l high risk)
 - potassium low: vomiting or laxative abuse (<3 mmol/l high risk)
Note: low sodium and potassium can occur in malnutrition with or without water loading or purging
 - raised transaminases
 - hypoglycaemia: blood glucose <3 mmol/l (if present, suspect occult infection, especially with low albumin or raised c-reactive protein)
4. ECG
 - bradycardia
 - raised QTc (>450 ms)
 - non-specific T-wave changes
 - hypokalaemic changes

²² Reproduced from the adult MARSIPAN guidance (RCP, 2010, p. 15).

The authors of the junior guidelines have cautioned against prioritising clinical and physical assessments, which can help to rule out underlying pathology, at the expense of commencing re-feeding because, they have stated, this increases risk. They have suggested that in “situations of diagnostic uncertainty, introducing calories will predictably elicit calorie-avoiding behaviour in those with a drive for thinness and fear of weight gain” (RCP, 2012, p. 17).

When inpatient care is required, the adult MARSIPAN guidelines recommend that it should be provided in SEDU where possible. For children and young people, the site of inpatient treatment will depend on the local services and could include a paediatric unit, a generic CAMHS inpatient unit or a SEDU for children and adolescents²³. Admissions can be voluntary for those who accept re-feeding treatment and compulsory for those who refuse although both guidelines stated that compulsory treatment should be a last resort. For adults, “feeding is recognised as treatment for anorexia nervosa and can be done against the will of the patient as a life-saving measure” (RCP, 2010, p. 17) under Section 3 of the Mental Health Act (2007). The junior guidelines have stated that children and young people under the age of 16 can be treated against their will if one parent consents to the treatment. If the parents and child or young person refuse re-feeding treatment, they have recommended that safeguarding procedures are followed and stated that the Children Act (2004) can be applied to those up to the age of 18. In addition, the Mental Health Act (2007) can also be invoked for those aged between 16 and 18.

The guidelines have stated that the preferred method of feeding for children and adults is oral. However, if oral feeding fails to result in weight gain or the patient resists weight gain, then “nasogastric intubation and feeding may be necessary”, particularly “if poor nutritional intake is life threatening” (RCP, 2010, pp. 22-23).

The authors of the first MARSIPAN guidance considered and debated the practices of re-feeding because of different concerns in relation to the individual’s health; some physicians, for example, advocated beginning re-feeding slowly in

²³ The authors have stated that there are only two SEDUs in the NHS and that the majority are in the private sector (RCP, 2012).

order to avoid re-feeding syndrome²⁴, whereas primary concern for the psychiatrists was “to avoid further weight loss in a very underweight patient” (pp. 23-24). Following their discussions, the authors reached an agreement about the guidance in the management of weight gain and prevention of physical complications. The recommended guidance is reproduced in box 3.1.2.b below. The management of re-feeding for children and young people is almost identical to the adult guidance (again due to limitations of space the junior guidance is included in appendix G).

Box 3.1.2.b. Management of re-feeding²⁵

1. In eating disorder settings, a starting calorie intake of 20 kcal/kg/day appears to be safe. However, electrolytes and clinical state need careful monitoring and transfer to a medical unit may be required if, for example, phosphate falls to <0.4 mmol/l.
2. In medical in-patient settings it is sometimes prudent to use lower starting intakes (e.g. 5–10 kcal/kg/day), especially in the presence of severity indicators (Appendix 5).
3. If low initial calorie levels (5–15 kcal/kg/day) are used, clinical and biochemical review should be carried out twice daily, with calories increased in steps to 20 kcal/kg/day within 2 days unless there is a contraindication.
4. The decision to initiate low-calorie feeding should be made in consultation with an expert physician in clinical nutrition and a nutrition support team. Minor or even moderate abnormalities of liver function (e.g. alanine transaminase up to four times the upper limit of the normal range) should not delay increased feeding.

Alongside the nutritional guidance, which emphasised the importance of regularly monitoring and managing physical complications, the reports have stated that bed rest may be indicated for individuals who are “severely unwell” (RCP, 2012, p. 48). The adult report recommended 24 hour bed rest for those with a BMI less than 13 and stated that bed rest may be introduced for those with a BMI of less than 15. The junior guidelines have noted that “[e]nforced bed rest is extremely distressing for young people with anorexia nervosa unless they are robustly supported” and that it is, therefore, essential that some gentle activity, such as

²⁴ Re-feeding syndrome refers to a range of electrolyte disturbances that can occur during re-feeding. In some cases “it can cause cardiac and respiratory failure, delirium and fits” (NICE 2004, p. 101)

²⁵ Reproduced from the adult MARSIPAN guidelines (RCP, 2010, p. 24).

watching TV with others, reading a book, or doing some crafts, is available (RCP, 2012, p. 49).

Finally, the guidelines highlighted the behavioural challenges to re-feeding practices and the authors of the adult guidelines likened the “extreme compulsion to pursue thinness” to “addiction to heroin”. They have stated that this leads patients to “take terrible risks” and that the persistence of these “behaviours may contribute to deterioration” and even “death” (p. 25). They listed the risks and deceptive behaviours and recommended vigilance by professionals. The risks and behaviours included individuals drinking water before weighing; wearing weights or other items; gripping the weighing machine with their toes to appear heavier; engaging in “obsessive exercise”; wearing “very little clothing in order to shiver”; disposing of food; and vomiting (p. 25).

The present case narrative, based on NICE and MARSIPAN guidelines, described above captures current guidance for the management of re-feeding practices for self-starving individuals diagnosed with anorexia nervosa. In comparison to the historical case narrative, Dally and Sargant’s (1960; 1966) *new treatment*, current assessment and treatment practices related to re-feeding self-starving individuals appear more technical and specialist. Current guidance seems increasingly concerned with risk with different recommendations for treating those most and least at risk. These and other transformations in practices will be explored further in the analysis of descent. In addition to changes in practice, the case narratives also illustrate continuities, for example, the primary focus on weight gain and the use of bed rest.

In section 3.3, the tracing of the descent of re-feeding practices, I will attempt to delineate the continuities, discontinuities and transformations in relation to Foucault’s conceptualisations of the technologies of the self and technologies of power using Rose’s five *perspectival dimensions*. In the following section, the surface of emergence, I focus on mapping the diverse events and relations which made it possible for re-feeding to emerge as treatment for self-starving individuals.

3.2. Surface of Emergence

In this section, I attempt to trace the conditions in which Dally and Sargant's (1960; 1966) *new treatment* within a re-feeding regimen emerged in relation to the perspectival dimensions explicated in section 2.7. I begin the analysis by delineating the broader governmental strategies and problematizations, which created the conditions of possibility for psychiatry to emerge and mutate as a discipline. Following this, I narrow the focus to map out the events and practices in which the *new treatment* emerged.

3.2.1. Strategies and apparatus for public health

As discussed in section 1.14.2 and appendix D.2 governmental strategies, by which I refer to the wider social, moral and political objectives and concerns about the desirable and undesirable conduct and features of the population in Western Europe, including the UK, have been imbricated in the way that individuals and populations are known and acted upon (Rose, 1996a). In the late nineteenth and early twentieth century, the governmental strategies for improving the health, longevity and economic fitness of the nation's citizens were focused on strategies for regulating hygiene and welfare and the strategy for eugenics (Rose, 1985; 2001). Strategies for hygiene and welfare focused on the external conditions of health including clean water, a sufficient diet, satisfactory housing and domestic sanitation (Rose, 1985). Eugenic programmes focused on classifying, identifying and constraining, or even eliminating, individuals in accordance with the goal of increasing the fitness of the nation (Rose, 2001).

These strategies were intertwined with the continued shift away from visible and hierarchical forms of power to less visible strategies of exercising power that appeared separate from the state or sovereign (Foucault, 1977a). Technologies of power, bodies of *authority* and *expertise*, emerged in the openings of space between governmental strategies of hygiene, welfare and eugenics and the changes in the way populations and individuals were governed. Disciplinary authority and expertise became intertwined within networks of relations in which power-knowledge could be exercised in particular institutions and sites, which required the management and efficiency of citizens. These sites and institutions

(for example, the factory, the school, the army, the prison), which were ostensibly distant from governmental strategies, created space for techniques and practices, such as observation, classification, reports and examinations, to emerge. They created space for “the most mundane activities and thoughts” to be scrupulously recorded in order to create increasingly voluminous and detailed dossiers, which facilitated the comparison, differentiation and ranking of individuals (Dreyfus & Rabinow, 1982, p. 159).

The expertise and authority accorded to professional disciplines compiling detailed dossiers, such as public health, demography, epidemiology, statistics, specialist medicine, psychiatry and psychology among others, emerged in relation to their effectiveness in developing *dividing practices* that could distinguish the healthy from the pathological, the normal from the abnormal and the mad from bad, for instance, in accordance with governmental strategies (Rose 1999; 2001). Their authority and expertise were also intertwined with claims to particular types of knowledge (Foucault, 1977a). Accordingly, dividing practices (for example, the examination and techniques of surveillance), underpinned by assumptions of homogeneity, resulted in the detailed “scientific” specification of individuals and the compilations of norms. Dreyfus and Rabinow (1982) have argued that the “sciences of man” emerged in relation to the growing and increasingly detailed specification and norms about individuals and populations, and conceptualised the modern individual as a fixed figure that could be objectified and analysed.

Within the array of sites and institutions and in relation to the particular normalising techniques and dividing practices enacted by emergent professional disciplines, the individual and the collective body had become knowable. The knowable individual and population had become governable in relation to concerns about hygiene, welfare and the fitness of the population. These discursive practices, or techniques of objectification, marked an essential shift and growth of power. Power, for instance, no longer visibly enacted by the sovereign or state, was exercised within its relation to knowledge and the individual (Foucault, 1977a).

3.2.2. The authority of science

Problems in the nineteenth and twentieth century were located in the language of science (Rose, 1996a) and, therefore, required a scientific solution. As already described, disciplines that claimed the status of science acquired the authority to judge, classify, problematize and manage individuals through techniques including surveillance, examination and normalising judgments. Over time claims to science made it increasingly difficult to question norms and discourses; Dreyfus and Rabinow (1982) have suggested that in Western society 'scientific' norms and discourses have become "almost sacred" and beyond questioning.

Scientific practices associated with positivist or hypothetico-deductive philosophies assume that there is a natural and objective reality to be known, and are founded on the "empiricist assumption that 'true' knowledge must be grounded in experience and observation" (Malson, 1998, p. 35). Positivist approaches, predicated on the assumption that the researched can be known independently of the researcher, lead to the adherence to particular research procedures, including measurement, quantification and statistical analysis alongside an emphasis on objectivity, reliability and replicability (Malson, 1998; Ussher, 2011). Critiques of positivism, for example, by Popper and Kuhn have led to the emergence of post-positivist philosophies and approaches such as Kuhn's paradigmatic view of the validity of science (Dreyfus & Rabinow, 1982). Within the context of post-positivism, the philosophy and sociology of scientific activity and knowledge within the natural sciences has become increasingly examined and contested (Rose, 1999). However, positivism continues to be dominant within the 'psy' disciplines; psychiatry, psychology and allied professions (Malson, 1998; Ussher, 2011), which has shaped and continues to delimit what can be authoritatively known about individuals and groups.

3.2.3. Psychiatric Medicine: Strategies, Institutions and Problematized Individuals

In the eighteenth century, pre-dating the governmental strategies for hygiene, welfare and eugenics, demography and associated disciplines emerged in the context of knowing, managing and caring for shifting populations that were

becoming condensed in urban areas due to industrialisation (Foucault, 1977a). The disciplinary technologies of demography and town planning, for example, were constituted in relation to, and constituted, notions of normal populations. The prison, the asylum and work houses among others emerged as sites for the non-normal or deviant (Foucault, 1977a). During the eighteenth and nineteenth century, Vagrancy Laws were introduced and these laws gave local magistrates the authority to legitimately incarcerate the “furiously mad and dangerous” within asylums (Moncrieff, 2003, p. 8).

The site of the asylum created possibilities for the mad and immoral to be made visible and the visible asylum made it possible for bodies or statements or discourses to be produced about its incarcerated inhabitants – it enabled power to operate as a double relation constituting knowledge and the subject (Kendall & Wickham, 1999). Initially administrated and managed by “alienists”, who were held in lowly regard (Porter, 1987), the asylum, and the strategies of hygiene and eugenics of the late nineteenth and early twentieth century, presented possibilities for the discipline of psychiatry to develop in relation to the need for techniques to manage the inmates of asylums (Porter, 2002). The asylum and psychiatry, therefore, created spaces for disciplinary technologies to emerge. These disciplinary technologies were embedded within the network of broader strategies for managing the non-normal and deviant through techniques and practices that could produce docile citizens or docile bodies by identifying and administering the ‘the mad’, paupers and other ‘social deviants’ and removing them from society. Psychiatry, as a disciplinary technology, grew into an authoritative and expert discipline in relation to legislative changes which required two medical certificates to detain people (Porter, 2002), the problematization of particular conduct, and through increasingly specified practices of classification and diagnosis, informed by a framework of positivist science (Rose, 1996a).

The failure of psychiatry to cure or produce morally responsible self-governing, or docile, citizens, the growing public awareness about the conditions within asylums, and the strategic shift to the neo-hygienic strategies for public health, in the early to mid-twentieth century, created new possibilities for the discipline of psychiatry. For example, the management of the “insane” extended beyond state

controlled practices of incarcerating those with mental disorders within asylums (Moncrieff, 2003) to programmes associated with the neo-hygienic strategies of health (Rose, 1985).

The broadening out of the governmental strategies of physical hygiene, welfare and eugenics, which had focused on external programmes of knowledge and administration to include neo-hygienic strategies for public health, marked a shift from technologies of power to technologies of the self. The neo-hygienic strategies for public health were embedded within changes to state intervention and social welfare and the increasing coordination between preventative and individualised medicine and autonomous individuals (Moncrieff, 2003; Rose, 1985; 1996b). Within this network of relations, programmes of mental hygiene emerged in the UK, and the US and France, in the 1920s and 1930s, with the intention of inventing “a more positive and social vocation for psychiatry” (Rose, 1996a, p. 9). This new vocation, within the context of preventative and individualised medicine, indicated a more active role for psychiatry in the detection and management of milder and potentially curable mental disorders (Rose, 1985).

3.2.4. Neo-hygienic strategies and technologies of medicine

According to Rose (1985) “[t]he key move in the new strategy of mental hygiene was to establish the continuity of disorders of mind and body and hence extend to the former the new preventative and therapeutic techniques which had worked well for the latter” (p. 160). The stigma of lunacy and infringements of liberty associated with compulsory and long-term internment, barriers to the new preventative and therapeutic techniques, which encouraged help seeking by those with milder or neurotic problems, were targeted through revised policy and legislation (Rose, 1985) and mutations in psychiatric practices and institutions of medicine and “mental medicine” during the early-to-mid-twentieth century.

In the late 1920s in the UK, the Macmillan Commission was formed to review the detention of people who were of “unsound mind” and “treatment without certification for people without a mental disorder” (Coppock & Dunn, 2010, p. 31). The Macmillan Commission endorsed the medical model of mental disorder,

stating that '[t]here is no clear line of demarcation between mental and physical illness' (Royal Commission, 1926, cited by Moncrieff, 2003, p. 8), and shaped changes in legislation. In 1930, following the Macmillan Commission's recommendation, the 1930 Mental Treatment Act (MTA) replaced the Lunacy Act 1890. The terminology in the MTA was revised: "mental illness" replaced "lunacy"; "mental hospital" or "hospital" replaced "asylum", and two new categories of treatment and patients: "voluntary" and "out-patient", were introduced (Coppock & Dunn, 2010; Turner, Deahl & Salter, 1999).

The strategy of mental hygiene also related to the shift towards general hospitals as sites for the new "mental medicine" because they could reach "patients, ex-patients and potential patients" (Rose, 1985, p. 161).

The Mental Health Act (MHA) 1959 marked further shifts in terms of sanctioning medical approaches to mental illness (Ramsay & Holloway, 2007). Compulsory detention and treatment moved away from legal practices and became "an essentially medical decision" (Turner, Deahl & Salter, 1999, p. 578). The authority for detention became based on the judgement of two registered medical practitioners (Ramsay & Holloway, 2007) that the person was "suffering from mental disorder" and that it was "necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should be so detained" (MHA, 1959, p. 16).

In addition to legal and policy changes in relation to mental disorders, broader strategies for state intervention and social welfare led to the formation of the National Health Service (NHS) in 1948. Its objective was to provide "universal, comprehensive and free health care" and ultimate responsibility for the provision and quality of the care resided "in the minister appointed by the governing party" (Gorsky, 2008, p. 438). For some the formation of NHS was "an incarnation of social solidarity and distributional justice" and for others it represented "inflexible bureaucracy and paternalism" (Gorsky, 2008, p. 438). Within the neo-hygienic strategies of public health, the NHS became a key apparatus for disciplinary technologies of others and the subjectification of oneself; for example, through medical professionals' expertise in relation to health and illness, inculcating the self through preventative practices for maintaining health and preventing disease,

and social responsibility to others in terms of making National Insurance contributions through one's working wage. The political and physical institution of the NHS also created space for psychiatry and other 'psy' disciplines to authenticate their authority and expertise, while creating a medium through which practices and sites of medicine could become increasingly governed.

3.2.5. Practices and techniques of psychiatric medicine

The legislative and policy shifts increased the distance and invisibility of governmental power, and power was increasingly exercised through strategies for extending the practices and techniques of medicine, to govern the minds and bodies of the unwell and the well. Psychiatry's status and authority as a medical discipline, and its new social vocation to cure and not just administer those diagnosed with mental illnesses, created a context for new physical treatments to emerge (Rose, 1985).

In the 1930s, biological psychiatry's repertoire of technologies in the asylums mutated from the classification and management of the mad to include physical therapies such as psychosurgery (leucotomy, later known as lobotomy), ECT and insulin coma therapy (Moncrieff, 2009; Roche, 2010). Sedatives were also widely used, but their role was seen primarily as a "chemical restraint", not as aid to treatment or a cure (Moncrieff, 2009, p. 2). It has been claimed that the popularity of physical practices was associated with the "demonstrable improvements in patients, after a period of falling recovery rates in asylums" (Roche, 2010, pp. 71-72). In contrast, Whitaker (2010) has argued that it was well known by those practising psychosurgery that it led to profound changes in people who became more "lethargic, disinterested and childlike", rather than cured (p. 49). Physical treatments, however, helped to shore up psychiatry's expertise and authority within the network of governmental strategies.

William Sargant's career in psychiatry began in the mid-1930s at the time when physical therapies were emerging and psychiatry's authority and reach was growing. Sargant reportedly stated that the mentally disordered "could not benefit from psychotherapy and that physical therapies were first required to restore normal brain" (Roche, 2010, p. 72). Sargant's view was shared within

and outside of psychiatry, in the UK and overseas, perhaps demonstrated by the Nobel Prize in Medicine in 1949 being awarded to the Portuguese neurologist, Egas Moniz, had who introduced the practice of leucotomy (Whitaker, 2010, p. 49). Although psychosurgery and other physical interventions failed to cure madness, they extended the disciplinary techniques of psychiatry beyond classification and administration to expert management and treatment, which produced more docile patients.

Although sedatives were already in use in asylums and mental hospital (Moncrieff, 2009), in the middle of the twentieth century, drugs with psychoactive effects became known as new techniques within psychiatry's repertoire. Psychiatry's drug treatments emerged in the context of the search for medicines that could treat infectious diseases following the development of medicinal doses of penicillin during the Second World War (Whitaker, 2010). The calming effects of some compounds on the mental and physical states of surgical patients led to the use of drugs in psychiatric contexts. In 1952, two prominent French psychiatrists published articles describing the effects of chlorpromazine on "psychotic patients":

"Seated or lying down, the patient is motionless in bed, often pale and with lowered eyelids. (...) If questioned, he responds after a delay, slowly, in an indifferent monotone, expressing himself with few words and quickly becoming mute. (...)"

(Delay and Deniker, cited in Whitaker, 2010, p. 50).

Chlorpromazine, a major tranquiliser, worked by decreasing activity of the central nervous system leading to the inhibition of mental and physical activity (Moncrieff, 2009). It was marketed as a great discovery and was enthusiastically received within biological psychiatry (Moncrieff, 2009), which had become increasingly popular in relation to psychiatry's strategic alignment with medicine. In North America, where many psychiatrists continued to be psychoanalytically oriented, Smith Kline and French, the manufacturers, marketed chlorpromazine more cautiously:

“there is no thought that chlorpromazine is a cure for mental illness, but it can have great value if it relaxes patients and makes them accessible to treatment”

(Time Magazine, 1954, cited in Whitaker, 2010, pp. 59-60)

Chlorpromazine and other drugs emerged during a period when psychiatry was failing to cure madness in the asylums, asylums were being viewed as expensive institutions (Moncrieff, 2009), asylums and physical treatments were increasingly criticised (Rose, 1985), policies were encouraging voluntary and outpatient treatment (Coppock & Dunn, 2010), and when broader strategies for public health were targeting prevention and intervention at the level of the autonomous individual (Rose, 1985; 1996a). It has been argued that psychiatry was transformed by the success of the new drugs to relieve symptoms of mental illness, which led to the increasing use of psychopharmacological medication (Roche, 2010). Psychiatry was perhaps transformed because its new technologies could shape conduct and be administered to large numbers while being cost-effective. It provided a method of governing at a distance, in accordance with the overarching political strategies, under the auspice of medicine.

Initially chlorpromazine was mainly administered to patients diagnosed with schizophrenia. Psychiatry claimed that, like physical medicine, it had drugs that could be prescribed for their patients and treat ‘diseases’ (Whitaker, 2010), however, chlorpromazine and other drugs did not treat ‘underlying pathology’ (Moncrieff, 2009). In addition to sedating patients, chlorpromazine produced numerous unpleasant and even deleterious effects, particularly at higher doses. These effects, commonly referred to as side-effects, included rigidity of muscles (acute dystonic reaction), a state of restlessness (akathisia), irregular heartbeat or arrhythmias, metabolic disruption causing weight gain, hormonal changes and dry mouth, blurred vision and constipation (Moncrieff, 2009). These effects were initially considered to be “signs that the drugs were working, and hence markers of a therapeutic reaction” (Rose, 2003, pp. 49).

3.2.6. Psychiatric techniques for re-feeding self-starving individuals

Increasingly, physical methods became marketed as treating the underlying disorder (Moncrieff, 2009; Whitaker, 2010). Dally and Sargant's (1960; 1966) use of modified insulin therapy (MIT) and chlorpromazine in relation to re-feeding practices, however, were not explained as acting on underlying pathology but described as methods to overcome the individual's resistance to eating and fear of gaining weight.

The use of physical methods in Dally and Sargant's (1960) *new treatment* emerged in relation to the concerns about deaths among patients treated for AN reported in a recent study, increasing pessimism about the long-term outcome of current treatments, and claims that tube feeding (a technique associated with the general physician) was "undesirable from a psychological point of view" (p. 1770). The use of the techniques for 'treating' self-starving individuals also emerged in relation to increasingly dominant discourses within biological psychiatry that mental disorders were brain disorders and the view that AN was caused by "a morbid mental state", which meant that "the inclinations of the patient must be in no way consulted" (Gull, 1874, cited in Dally & Sargant, 1960, p. 1770). These discourses, intertwined with practices that prioritised psychiatric conceptualisations, silenced the individual or other perspectives and marginalised the role of psychotherapy.

In contrast to the increasing pessimism and critique of general medicine's use of tube feeding, MIT (also known as sub-coma therapy) and chlorpromazine (psychopharmacology) induced rapid weight gain and shifted expertise and authority in relation to self-starving individuals from the domain of the general physician to biological psychiatry. The rapid weight gain, however, was not a result of reversing the brain disorder but a consequence of the fact that heavily sedated and docile patients could be compliantly re-fed. MIT, for instance, resulted in "physiological – essentially vegetative – changes" and produced a sub-coma state (Tyndel, 1956, p. 565) and chlorpromazine was a major tranquilizer which inhibited anxiety in relation to eating.

The achievement of the physical techniques to induce eating behaviours and weight gain in emaciated individuals signalled psychiatry's expertise at saving lives and restoring normal appearance (Russell, 2006) or, in other words, psychiatry's ability to shape conduct. The unpleasant and even harmful effects of the physical treatments, for example, signs of Parkinsonism and grand mal seizures associated with high doses of chlorpromazine, or ECT and modified leucotomy, were silenced in the face of discourses about the risk of prolonged inanition. The practices of re-feeding were authorised by their life saving function – within the strategies of bio-power everyone has the “right to life” (Foucault, 1979b). For the self-starving person who had lost sight of her vital norms, the psychiatrist could authoritatively intervene through legal powers for compulsory treatment under the MHA 1959.

Weight loss following treatment (i.e. failure to apply the techniques of subjectification to oneself after being discharged) resulted in patients being readmitted and retreated with chlorpromazine and insulin. Weight gain and the associated physical normalcy were central to the techniques of physical treatments. The longer-term effects of these physical treatments were less impressive and, it could be argued, positioned as less important.

Roche (2010) has stated that, in general, Dally and Sargant's (1960; 1966) papers were well received and, according to Russell (2006), they indicated that the treatment of AN could be handled predominately by psychiatry (Russell, 2006). In 1966, the year Dally and Sargant's follow-up paper was published, Kidd and Wood, in the BMJ's *Postgraduate Medical Journal*, stated that Dally and Sargant's chlorpromazine and modified insulin therapy was a widely used treatment for anorexia.

It is worth noting that in the 1960s, the period when Dally and Sargant reported on their *new treatment* in the BMJ, the anti-psychiatry movement was emerging (Roche, 2010). The anti-psychiatry movement was a high profile social and political movement which contested psychiatric diagnoses and criticised the asylum and practices of leucotomy and ECT on ethical, moral and political grounds in the 1960 and 1970s (Porter, 2002). It was associated with

psychiatrists such as Laing and Szasz²⁶ and philosophers and social critics, such as Foucault, Deleuze and Guattari. Within the anti-psychiatry movement, there was general agreement that psychiatry's authority was unfounded and unethical but the work of Laing (1960), Szasz (1960) and Foucault (1967a), for example, approached the discipline of psychiatry and dominant conceptualisations of madness in different ways.

3.2.7. Authority in relation to techniques of classification

As discussed above, the authority of psychiatry, as a discipline to administer and manage individuals, emerged within the context of strategies for governing and creating self-governing subjects at a distance. Psychiatry's alignment with physical medicine in relation to neo-hygienic strategies, and its attempts to emulate the practices of science, created a space for formal classificatory systems.

The less technical dividing practices of identifying and segregating the normal from abnormal, the mad from the bad, or the psychotic from the neurotic, became more technical and elaborate through practices of classification to produce taxonomies of madness. During the nineteenth century, increasing numbers of classificatory systems were compiled and employed by psychiatrists in Europe and North America (Zilboorg & Henry, 1941). Emile Kraepelin, for example, published the *Compendium*, which grouped together mental illnesses considered to have a poor outcome in the latter part of the nineteenth century. Psychiatrists such as Kraepelin worked within a natural view of madness, which led to the assumption that a finite number of categories of mental disorders with distinct psychopathology, aetiology, course and outcome would eventually be discovered (Bentall, 2003; 2010; Boyle, 2002).

It was during the middle of the twentieth century that the competing and multiple systems were displaced by an accepted taxonomical system produced by an organisation of psychiatrists in North America, the American Psychiatric Association (APA), which was positioned as the authoritative account that provided a more rigorous and reliable tool for diagnosing mental disorders. The

²⁶ It should be noted that neither Laing nor Szasz referred to themselves as anti-psychiatrists.

authoritative classificatory system also emerged in the context of private health systems, which required diagnoses for treatment practices to be financed (Kirk & Kutchins, 1999). The first edition of the Diagnostic and Statistical Manual of Mental Diseases (DSM)²⁷ (APA, 1952), or “psychiatric bible”, contained a detailed description and symptom checklist for 94 categories of “mental disorder” (Kirk & Kutchins, 1999). Anorexia Nervosa was not among the 94 categories.

At the time of Dally and Sargant’s publication of their *new treatment* in 1960, therefore, anorexia nervosa, as a dividing practice, was not within the web of authority and expertise of psychiatry. Sixteen years later, when the second edition of the DSM was published, and eight years after their first paper was published, AN was still not included within the authoritative nosology of mental disorders. Its absence perhaps reflected the differing opinions about its status as a mental disorder, and ideas that the symptoms were merely features of another psychiatric disorder. Kay and Leigh (1954), for example, (see section 3.1.1), had suggested that anorexia nervosa was not a distinct syndrome and that the symptoms were associated with other disorders, such as “depressive mood”:

The psychiatric symptomatology is diverse. There is no neurosis specific to anorexia nervosa, and no specific anorexia nervosa. We are not convinced that we have been dealing with a psychiatric entity.

Kay and Leigh (1954, p. 411)

Noticably Kay and Leigh’s research was not openly²⁸ referred to in Dally and Sargant’s (1960; 1966) publications. Nor was there reference to the period when the diagnosis of AN fell into disuse (see section 3.3.3). Dally and Sargant (1960) presented AN as a specific “syndrome” with a long history, evidenced in their reference to Gull first describing in 1874 AN and “recognising” that the refusal to eat was due to the individual’s “morbid mental state” (p. 1770). Dally and Sargant’s articles were published in the

²⁷ The DSM became an international system and was used broadly in psychiatric research. It also influenced the criteria for mental disorders in the International Classification of Diseases published by the World Health Organisation [WHO].

²⁸ In section 3.1.1 I have noted that they refer to some of their research findings without referencing the paper, which would mean they were aware of their view.

British Medical Journal which, along with the *Lancet*, was a well-established medical journal in the UK.

The authority of syndrome and nosological systems, however, was central to the psychiatrist's work and Dally and Sargant's account of the diagnostic criteria for AN emerged within this context. Drawing on Gull's description and referring to detailed "psychiatric and endocrinology studies", Dally and Sargant (1960) set out the "essential criteria" used to diagnose anorexia nervosa in their study. The four criteria were refusal to eat, severe weight loss, amenorrhea and the absence of another serious condition (p. 1770).

In overlooking the discontinuities in the history of the diagnosis of anorexia nervosa, for example, excluding Kay and Leigh's (1954) research and ignoring AN's recent re-emergence after a long absence, Dally and Sargant constructed a discourse of continuity in relation to AN as a mental disorder (p. 1770). The publication of their account within an esteemed journal, which had the potential to reach a broad base of general physicians and psychiatrists, and the dominance of authoritative systems to administer mental disorders, provided a network to validate Dally and Sargant's expertise and authority in relation to diagnosing and managing self-starving individuals with the technical practices available within psychiatry. The diagnosed self-starving individual, who had failed to appear and act in accordance with norms of weight and diet, became imbricated within the technologies of power and technologies of the self of the thoroughly medical – physical and psychiatric – individual.

3.2.8. *The family and technologies of subjectification*

As described in section 3.2.3, the neo-hygienist strategies in the inter-war period of early to mid-twentieth century led to increasing coordination between preventative and individualised medicine, which marked shift from a dependence on external practices of health and hygiene to the inclusion of strategies for inculcating self-governing autonomous, and morally responsible, individuals (Rose, 1985). Individuals became liberated to the extent "that they had taken the obligations of moral, prudent and self-responsible conduct into themselves" (Rose, 1996a, p. 7), or that they were a docile body. The obligations of the

autonomous individual were in the context of their relations and commitments to the family and community (Rose, 1985; 1996b).

The family, as an extension of the state, emerged as an important apparatus for shaping the health and well-being of its citizens. In addition to maximising conditions of physical health and hygiene, the family became a site for constituting socially and morally responsible children and adults. The family was also a locale for creating psychologically healthy individuals as “[p]ersonal happiness and social adjustment” became constructed as “two sides of the same coin” (Rose, 1985, p. 186). An autonomous liberated individual was concomitantly a happy individual, and the “natural family” became the obvious apparatus “for the child’s normal and healthy development” (Rose, 1985, p. 176).

Within this context, malfunctioning families became implicated, alongside physical illness and organic mental illness, as aetiological explanations of “troubled children”, social inefficiency, and adult mental disorders, for example the double-bind theory (Bateson, Jackson, Hayley, & Weakland, 1956). The family, an increasingly important apparatus in relation to constituting subjectivities, became a site for preventative intervention.

Child Guidance Clinics (CGC)²⁹ emerged as apparatus for administering expertise and authority in relation to the family, childhood and associated problems (Rose, 1985). It was within the context of working with families at the CGC – the relay between broader moral, social and political rationalities and the role of the family – that psychological theories of development emerged in the middle of the twentieth century. These psychological theories stressed the importance of early object relations between the primary care giver and child in relation to the child’s physical and mental well-being (Rose, 1985). Within the family, the mother-child relationship became a particularly important site for administering and managing strategies for health and hygiene.

Rose (1985) has argued that these theories about familial relationships affecting the subjectivities of its members emerged within the network of relations between the strategies and authoritative knowledges and practices about the individual,

²⁹ The first demonstration CGC in UK opened in Islington in 1928 (Rose, 1985, p. 209).

the family and the community. They did not just emerge to legitimate the re-domestication of women following the Second World War.

As described above, the family had become an apparatus for subjectifying practices in terms of how to conduct oneself as a parent and family member and for instilling physical and psychological health and socially productive habits. The family was not an independent site of power but intertwined with local and more distant technologies in relation to child rearing, which were exercised through CGC, parenting manuals, and discourses about raising healthy children (Rose, 1985). The shaping of the private self had been distanced from state practices, while political strategies were imbricated in their daily lives. If individuals failed to manage themselves accordingly, the family and professionals in the community could intervene.

Self-starving individuals, through psychiatric technologies, have been conceptualised as problematic in relation to healthy and socially productive habits. The self-starving individual, however, does not typically conceptualise their food practices and physical appearance as problematic – it is normally concerned family members or friends who bring the person to the attention of a doctor (Garfinkel & Garner, 1982). Although the family has not succeeded in instilling the desired habits, its relation to discourses of physical and mental health enabled the family to assess the self-starving family member in accordance with normative standards and bring her³⁰ into contact with expert and authoritative technicians.

The family had also become a site of health or dysfunction in relation to the child's current and future mental health; this was not a new idea, in 1888 Charcot had argued:

In order to properly treat a hysterical girl, one must not leave her with her father and mother; she needs to be placed in a mental hospital.

(cited in Foucault, 1979b, p. 112).

³⁰ A female pronoun has been used because diagnoses of anorexia nervosa have overwhelmingly been applied to females (see section 1.17). In *The Madness of Women*, Ussher (2007) argued – more generally – that for centuries women outnumbered men in “diagnoses of madness” (p. 1).

In Dally and Sargant's (1960; 1966) *new treatment*, self-starving individuals were hospitalised and separated from their families; typical practice among psychiatrists and general physicians administering re-feeding treatments (Kay & Leigh, 1954; Goren & Feldman-Toledano, 1966). Although Dally and Sargant (1960) quoted Gull (1874) as saying that "patients should be fed at regular intervals and surrounded by people who would have moral control over them; relatives and friends being generally the worst attendants" (p. 1770), they did not discuss the family as a site of dysfunction. In contrast, in an article in the *British Journal of Psychiatry*, Goren and Feldman-Toledano (1966), a head physician and head nurse, explicitly drew on discourses of family dysfunction in their conceptualisation of anorexia nervosa and approach to treatment. They argued that food-refusing patients were "love deprived" and, therefore, re-feeding should take place within the context of acting as "substitute parents" to address the "love deficiency" (p. 673), alongside a programme of educating parents and not discharging patients directly to their family homes after they had gained weight.

The family was, thus, both implicated in the dysfunction, according to psychological theories, and pivotal to intervening on the self-starving individual by bringing them into contact with professionals for assessment and management.

3.2.9. Making up people through medicine

Medicine, ranging from clinical medicine to health promotion, was imbricated with the new strategies for governing populations and individuals (Rose, 2007). Rose (1994; 2007) has suggested that in developed countries, since at least the eighteenth century, medicine, which was perhaps the first positivist knowledge to take the form of expertise, "has played a constitutive part in 'making up people'" (Rose, 2007a, p. 700). Its authority to make up and act upon people stemmed from its claims to scientificity. Since the eighteenth century, medical expertise and authority, in terms of separating and dividing the person in relation to his or her vitality within a framework of positive knowledge, became intertwined in our experiences and understanding of being human and defining health and pathology (Rose, 1994).

According to Canguilhem (1943), Foucault's PhD supervisor and mentor, knowledge of 'vital norms' within medicine were constituted in relation to the normativity of the body:

It is life itself, and not medical judgement, which makes the biological normal a concept of value and not a concept of statistical reality (...) Health lies in the silence of the organs.

(cited in Rose, 1985, p. 226)

In *The Birth of the Clinic*, however, Foucault (1973) drew attention to the temporality and contingency in the ways in which disease and illness had been configured and localised on the body:

“For us, the human body defines, by natural right, the space of origin and of distribution of disease: a space whose lines, volumes, surfaces and routes are laid down, in accordance with a now familiar geometry, by the anatomical atlas. But this order of the solid, visible body is only one way – in all likelihood neither the first, nor the most fundamental – in which one spatializes disease. There have been, and will be, other distributions”

(Foucault, 1973, p. 3).

Rose (1996) has suggested that it would be an oversimplification or “an epistemological shortcut” to say that vital norms in medical discourse and practices solely derive from the biological normal. For example, certain conditions have made it possible for normative ideas about health and disease to emerge and “some people are more medically made up than others — women more than men, the wealthy differently from the poor, children more than adults, and, of course, differently in different countries and regions of the world” (Rose, 2007a, p. 700).

3.2.10. *The subjectification of the pathologised female*

Feminists such as Ussher (1991; 2011) and Liebert (2010) have analysed the more medically made up female body and argued that vital norms, and other

medical discourses and practices, are gendered. Constituting the molar body, for example, in terms of the male body, others and pathologises the female body. Norms relating to the female body centre on its reproductive function.

The hormonal discourse constructs women as biologically and innately inferior, if not dangerous (...) In this way it naturalizes patriarchal authority, and the institutions (such as heterosexual marriage, heteronormativity, house-wifery and protectionist sex 'education') that bring this into being (Liebert, 2010, p. 278).

The hormonal body is a concern in Dally and Sargent's (1960; 1966) research with amenorrhea included as a primary symptom for diagnosing AN. The vital norms of the self-starving individual's body were associated with a return to a reproductive body: "they retained their weight" and "they resumed menstruation" (Dally & Sargent, 1966, p. 6). Marrying and becoming pregnant, which Liebert has suggested are roles defined by patriarchal institutions, were also associated with doing "extremely well following the weight gain" (Dally & Sargent, 1966, p. 6). In addition, in discussing the long-term outcomes for the individuals diagnosed with AN, Dally and Sargent (1966) have suggested that the majority "are backward in the psychosexual development" but that they "are able to marry and have children" (p. 795). Heterosexual marriage, heteronormativity and house-wifery are constituted as important goals in assessing the "recovery" or return to roles within the broader strategies of the family, community and society.

Self-starving women who consult physicians tend to come "because of amenorrhea or infertility" and others may "present to sexual dysfunction clinics with vaginismus and frigidity" (Garfinkel & Garner, 1982, pp. 15-16). The above quote suggests that self-starving females who seek professional help do so because they have come to understand and act upon themselves as thoroughly medicalised and dysfunctional bodies in relation to their responsibilities to bear healthy children and safeguard the family institution and society (Foucault, 1979b).

In this chapter, I have delineated a number of the conditions in which Dally and Sargent's *new treatment* aimed at re-feeding the self-starving body emerged. In

the following chapter, comparing historical and current practices, I consider the ways in which strategies, apparatus and techniques, for instance, have mutated or stayed the same in the last fifty years.

3.3. Descent

In this section, I analyse the practices of re-feeding, as set out in the present case narrative, and contrast it with Dally and Sargant's *new treatment*. I explicate the *perspectival dimensions* through an exploration of different 'events' implicated in current re-feeding practices to delineate the continuities, discontinuities and mutations between 1960 and the present. I produced a map of descent - a 'dispositif' - to highlight the heterogeneous network of relations and events in which re-feeding practices for self-starving individuals are possible (appendix H). Within the constraints of this professional doctorate thesis, a limited number of events are examined, namely, contemporary bio-political strategies, documentary apparatus, technologies of diagnosis, psychiatric techniques, impatient and community apparatuses and the administration of life saving measures. I could equally have focused on any of the other events mapped within the dispositif.

3.3.1. *Contemporary bio-political strategies and apparatus*

In Britain, following the Second World War, there was an expansion of state apparatus and strategies associated with maximising social welfare in order to secure economic well-being (Rose, 1996a; 1999). Rose (1996a; 2001) argued that towards the latter half of the twentieth century, 'advanced liberal'³¹ forms of government emerged, supplanting strategies of social welfare, in a "market constituted largely by private enterprises" (Rose, 1996a, p. 337). In addition to the earlier neo-hygienic strategies of health and well-being, which sought prudent and self-responsible bodies through medicine, education and domesticity to secure the fitness of the population, new strategies centred on techniques in which individual anxieties and aspirations for health and well-being were interwoven (Rose, 2001). In accordance with advanced liberal strategies of government and bio-political contexts of administering life (see section 1.15.3), individuals and families became inculcated to conceptualise themselves as the key players in shaping their biological lives and hopes for the future (Rose, 2007b).

³¹ "Perhaps one could say that the general strategic field of all of those programs of government that regard themselves as liberal has been defined by the problem of how free individuals can be governed such that they enact their freedom appropriately" (Rose, 1996a, p. 29).

While the state continues to be responsible for securing external conditions of health, it has worked to distance itself from some of its responsibilities in relation to illness and accidents. The health of the nation is reconfigured in moral, ethical and economic terms in relation to the conduct of autonomous free individuals and an enabling and facilitating state (Rose, 2001)

Within these contexts, the subjectivity of the self-starving individual has been problematized with increasing specificity and in different ways. In the following sections I examine the shifts, continuities and discontinuities in relation to the administration and management of re-feeding practices.

3.3.2. A growth in documentary apparatus and self-starving bodies

Since the re-assertion of psychiatry as the authority and expertise for administering and managing self-starving bodies in the 1950s and 1960s, the period of Dally and Sargent's papers, there has been an explosion in the documentary apparatus, or commentaries, relating to the self-starved body and AN populations. As figure 3.3.2a illustrates, publications relating to AN³² doubled in the decade that followed the re-emergence of anorexia (see section 3.3.3). Between the 1970s and the 1980s, the volume of published literature quintupled – it is worth noting that *The International Journal of Eating Disorders* was launched in 1981 – and appears to have continued to grow exponentially since then.

Concomitantly, it has been argued that the incidence of diagnosing AN has increased dramatically in Western cultures (Bruch, 1973; Hsu, 1989). Russell (1977) suggested that the increasing number of publications could perhaps be attributed to anorexia becoming more recognised in recent years or an actual increase in its incidence. Whether the incidence of anorexia has mirrored the growth of the documentary apparatus, however, has been debated. Conglomerating different European studies, which had used different methodologies, Hoek argued that there had been “an upward trend” in the incidence of diagnoses of AN until the 1970s, after which incidence rates

³² Using the same databases as the literature search (see appendix A)

remained stable (Hoek, 2006; van Hoeken, Seidell & Hoek, 2003). Hoek's summary of analysis is reproduced in figure 3.3.2.b.

Figure 3.3.2.a. Search results for anorexia nervosa (1885 - 2013)

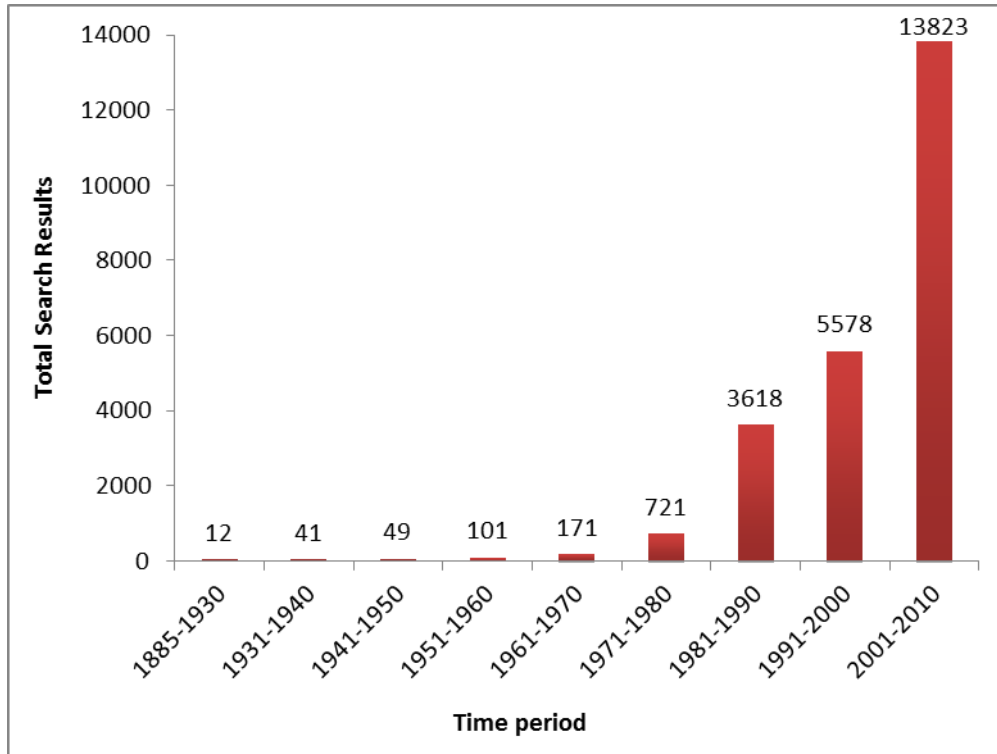
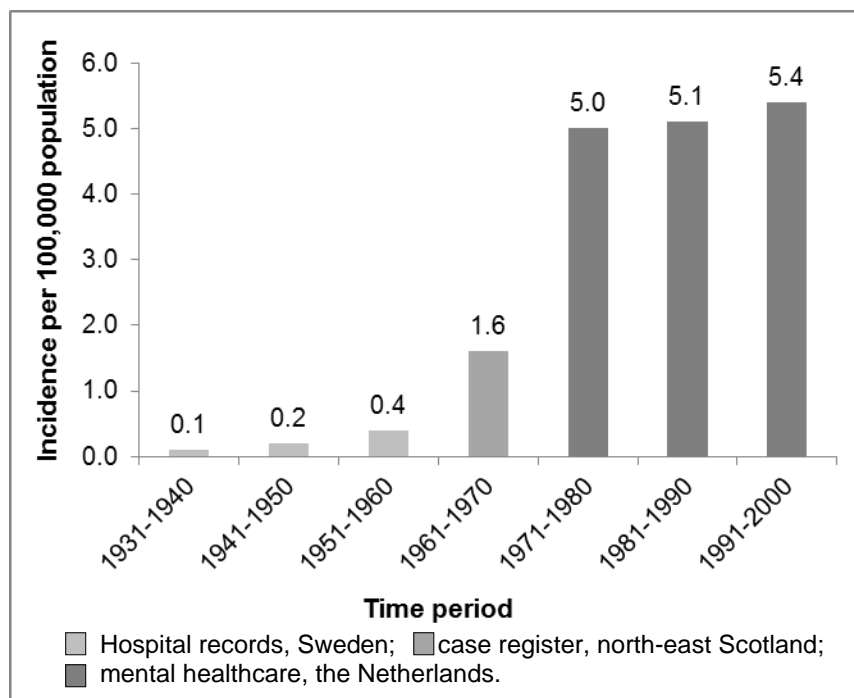


Figure 3.3.2.b. Registered yearly incidence of AN in mental healthcare in northern Europe in the 20th century



Increasing volumes and more detailed documentary apparatuses are within the network of relations that 'black box' the problematization of self-starvation as AN. For example, epidemiology statistics have been criticised for 'merely "counting what psychiatric agencies do"' (Smith, 1990, p. 117), and, in the process, shoring up the 'truth' status of anorexia and strengthening the authority and expertise of psychiatric technologies, despite the lack of progress in relation to 'cure' or 'recovery'.

In the 1970s and 1980s, in contrast to the psycho-medical problematization of self-starvation, critical feminists, commenting on the emergence of anorexia into the public consciousness, argued that 'the anorexic boom' coincided with increasing feminist activism, which perhaps suggested that self-starvation was related to the context and lives of middle class women in Western countries, rather than a psychiatric illness (MacSween, 1993). In addition to the growth of academic and clinical literature relating to AN since the 1980s, there has been an increase in commentaries critiquing psychiatric conceptualizations of self-starvation for de-politicising, de-contextualising and mis-labelling women's distress (e.g. Bordo, 1993; Chernin, 1986; Hepworth, 1999; Orbach, 1986; Ussher, 1991). Critical and postmodern analyses, which have offered alternative frameworks for conceptualising self-starvation, however, appear to have been limited in the extent to which they have infiltrated broader understandings of clinical practice. This could perhaps be understood within the network of relations that work to authenticate medico-psychiatric problematizations and delimit what can be said and what counts as knowledge. For example, reviews of *The Social Construction of Anorexia* (Hepworth, 1999), suggested that the book "is likely to be viewed ... as an idle intellectual excursion offering little of practical value, especially when ... faced with self-starving people who are likely to die without significant interventions" (Holmes, 2001, p. 210) or for professionals who "seek a critical perspective on their own practices" (Toon, 2001, p. 147). These responses perhaps demonstrate how alternative frameworks have been marginalised in relation to the strategies and techniques of 'administering life'.

3.3.3. Technologies of diagnosis

As demonstrated in the present case narrative, presented in section 3.1.2, re-feeding practices, although increasingly problematized in relation to ‘risk’ and the ‘degree’ of AN (see section 3.3.7), are founded upon the unquestioned problematization of AN as an individualized clinical entity (Malson et al., 2004). In 1960, Dally and Sargant referred to AN as specific syndrome, with a long established history, that could be diagnosed according to ‘essential criteria’. Forty years later, the authoritative and essential criteria stated that a refusal to maintain a normal body weight, an intense fear of weight gain, a distorted body image and/or the denial of the seriousness of low body weight, and amenorrhea (or reduced sex drive in males) constituted AN (APA, 2000). Proposed revisions to DSM-5, due for publication in summer 2013, include the removal of amenorrhea and percentage of normal weight from the diagnostic criteria (APA, 2012).

In his 1969 monograph, Dally worked to present a narrative of continuity by retrospectively diagnosing Richard Morton’s descriptions from 1694 of ‘nervous atrophy’ as cases of anorexia. Other authors have also retrospectively diagnosed incidences of fasting in the Middle Ages as AN (Halimi, 1983; Selvini-Palazolli, 1974/1963). Applying diagnoses retrospectively works to authenticate the ‘syndrome’ as a “transhistorical” entity, with essential features, that was waiting to be discovered (Malson, 1998, p. 50).

Following Foucault, who worked against ‘presentism’³³, and Malson (1988), who in her genealogy of AN, delineated the discontinuities and contingencies in relation to temporal conceptualisations of self-starvation in the context of the discursive practices of gender, femininity, subjectivity and embodiment, I will briefly examine the expertise and authority of defining self-starvation as AN during the twentieth century.

As outlined in section 3.1.1, during the 1950s there were disagreements about whether AN constituted a psychiatric syndrome, for example, Kay and Russell (1953) concluded that the diverse symptomatology indicated that anorexia was

³³ Constructing a history of the past in terms of the present.

not a distinct clinical entity. However, this was not the first time that the status of anorexia as a psychiatric disorder had been questioned. In 1914, medical autopsies reported the destruction of the anterior lobe of the pituitary in fatal cases of cachexia. This observation led to Simmonds' disease displacing AN as the dominant problematization of emaciation for over two decades (Garfinkel & Garner, 1982; Russell, 1970). Despite weight loss as a pituitary disorder dominating conceptualisations of emaciation, there were spaces in which Simmonds' disease as a medical understanding for all weight loss was resisted and contested, for instance, by Sheldon (1939) and Ryle (1936).

Simmonds' disease emerged within the technologies and authority of physical medicine and science – before psychiatry was interwoven as an extension of physical medicine (see section 3.2.4) – and offered a physical cure: hormonal therapies. In contrast, anorexia was within the domain of mental disorders, which were considered to be highly stigmatising (Rose, 1985) and lacked effective treatments (Russell, 1970).

As would be expected with scientific research (see Boyle 2002), the failure of hormonal treatments to cure cachexia led to a revision of the signs and symptoms used to diagnose Simmonds' disease in the late 1940s (Russell, 1970, p. 8). This opened space for the “rediscovery” of AN (Garfinkel & Garner, 1982) and although some cases of cachexia continued to be diagnosed as Simmonds', the remainder returned to the domain of psychiatry. In this context, Dally and Sargant (1960) and other psychiatrists reassumed authority in managing emaciated clients and administering their expertise in relation to the physical techniques of leucotomy, ECT and major tranquilizers.

Historical accounts of anorexia have tended to overlook queries regarding its status as a distinct psychiatric disorder and construct narratives of continuity, which position AN as a longstanding and transhistorical syndrome. Dally and Sargant (1960), for example, presented AN as a well-established clinical disorder with essential diagnostic criteria, which they linked to Gull's account of anorexia nervosa from 1874. Others (e.g. Russell, 1970; Selvini-Palazzoli, 1974/1963; Garner & Garfinkel, 1982) have acknowledged the discontinuity within AN's history and attributed the period in which AN was marginalised to non-objective

and anti-scientific practices, in which the hypothesis of Simmonds' disease was doggedly maintained despite its falsification, or to the misdiagnosis of AN as Simmonds' disease.

Similarly to Dally and Sargant, in the second volume of *Modern Trends in Psychological Medicine*, Russell (1970) argued that AN was an illness or syndrome with a constellation of symptoms and signs which permitted a reliable diagnosis to be made. According to Russell, its status as a clinical syndrome could be inferred from research that demonstrated the course of the illness "breeds true" (p. 135). That is to say the course of anorexia – disturbances of appetite, irregular or an absence of menses and low, or fluctuations in, weight – remained the same in over fifty per cent of patients who experienced relapse or chronicity (Russell, 1970). It is worth briefly noting that the fear of gaining weight or fear of fatness was not put forward as a symptom of anorexia until the 1970s (Morgan & Russell, 1975; Russell, 1970).

Formal diagnostic criteria for AN were first published in the 'Feigner criteria', a nosology of disorders compiled for research purposes, in 1972 (Feighner, Robins, Guze, Woodruff, Winokur & Munoz, 1972). The Feigner criteria informed the development of the third edition of the DSM, which became the authoritative taxonomy of mental disorders (Kendler, Muñoz & Murphy, 2010), and in 1980, AN was included in DSM-III (APA, 1980). Not everyone agreed with the criteria set out by Feigner and his colleagues and, subsequently, DSM-III because of the amount of weight loss – 25% – required a diagnosis and general disagreement about the "clinical features necessary for a diagnosis" (Garfinkel & Garner, 1982, p. 26). The inclusion of AN in the DSM, however, also marked its standing as a recognised mental disorder, which was particularly important in the US, where private medical insurance required billable disorders (Kirk & Kutchins, 1999). Since the 1980s, however, psychiatric problematizations of self-starvation have become increasingly 'black boxed' (Latour, 1987), as later revisions to the diagnostic criteria were based on the assumption that AN had a long history with "essential features" (Walsh, 1997, p. 335).

Notably, since the 1950s, when self-starvation was re-problematized as a mental disorder, the ability of psychiatric methods to cure AN has not improved, yet it

continues to 'delimit the sayable' by dominating conceptualisations of, and responses to, self-starvation and marginalising critical or alternative discourses. It also delimits the 'doable', that is to say it shapes 'appropriate' and 'necessary' responses to self-starvation within the bio-political strategies for administering life and risk.

3.3.4. Transforming psychiatric techniques

As discussed in section 3.2, Dally and Sargant's (1960; 1966) use of chlorpromazine and insulin in re-feeding emerged in relation to psychiatry's 'successful new' physical treatments and the reconfiguration of psychiatry as 'mental medicine', an extension of physical medicine.

Dally and Sargant justified the use of chlorpromazine in relation to concerns about deaths among self-starving individuals because it achieved rapid weight gain. Discussing Dally and Sargant's *new treatment*, Russell (1970) stated, however, that "this heroic treatment is not without risk" (p. 153), for instance, from the risk of a hypoglycaemic coma from insulin, or hypothermia from chlorpromazine. Russell also commented on the use of ECT and modified leucotomy, advocated in some cases by Dally and Sargant, and argued that ECT had "very limited value for patients showing a severe degree of depression" and that the outcome of leucotomy was unpredictable and, therefore, should be "undertaken very seldom and only as a last resort" (1970, pp. 153-155). At the start of the 1970s, Russell, marking a move away from psychiatry's reliance on physical treatments, placed much greater emphasis on skilled nursing and dietary treatment on inpatient wards, in relation to restoring weight and "breaking the entrenched habits which have led to the loss of weight" (1970, p. 152). Restoring weight was no longer a sufficient outcome; changing conduct in relation to fears of gaining weight had also emerged as central to re-feeding practices. In addition to concerns about the risk of chlorpromazine, this shift in relation to aims and practices also emerged in the context of the high profile anti-psychiatry movement (see section 3.2.6) and resurgence of feminism.

Reflecting on the practice of administering chlorpromazine in re-feeding regimens, Garfinkel and Garner (1982) noted that while it reduced anxiety and

resistance to eating and weight gain and sedated the individual, which made bedrest more tolerable, its negative effects outweighed the benefits. The negatives included its exacerbation of physical consequences of self-starvation, such as lowering an already low blood pressure and reducing body temperature. Chlorpromazine had also led to the development of bulimia – a new category of eating disorder proposed by Russell in 1979 – in 45% of Dally and Sargent's treated patients.

Over a decade later, Wakeling (1995) commented that the use of phenothiazines, such as chlorpromazine, had spread to the rest of Europe and America. He stated, however, that in the UK their use had declined on the basis of their known harmful effects in malnourished patients, the view that rapid weight gain was no longer constituted as a good measure of outcome, and that psychological approaches were effective in achieving weight restoration. Wakeling criticised the use of phenothiazines in patients diagnosed with AN and distanced himself from those psychiatrists who “inappropriately” used pharmacological interventions.

In the 2003 handbook of eating disorders, Bruna and Fogtelloo continued to express the view that weight restoration was not a sufficient measure for a ‘complete recovery’. In their chapter, which was organized around research evidence, they stated that there had not been any trials of neuroleptics in the treatment of AN since the 1980s, when a study concluded that neuroleptics provided no additional benefit to general inpatient treatment. Bruna and Fogtelloo also referred to a systematic review which had found no evidence that pharmacotherapy improved outcomes. Despite drawing on the research evidence and noting the potentially harmful effects of neuroleptics and tricyclic antidepressants – for instance, they could increase the prolonged QT interval, which has been associated with palpitations, syncope and sudden death – they argued that there was still a role for pharmacotherapy in the management of AN.

Interestingly, despite highlighting the problems and risks associated with chlorpromazine, and other neuroleptics, and arguing that skilled nursing and nutritional management (which address eating behaviours and nutritional restoration) were more effective and desirable, all of the above authors stated

that neuroleptics continue to have a role in the management of AN if other methods fail. As illustrated below, it seems that Garner and Garfinkel, Wakeling and Bruna and Fogteloo recommend the use of major tranquilisers for those who cannot be governed or self-govern, by which I mean those who fail or refuse to comply with the re-feeding practices and the goal of weight restoration.

Garfinkel and Garner (1982) stated that they continued to use the drug, typically not exceeding a daily dose of 300mg, in order to relieve tension, “for the minority of patients who show marked anxiety to foods and inability to eat after the general supportive measures have been attempted” (p. 244). Following his condemnation of phenothiazines with self-starving patients, Wakeling, also suggested that they continued to have a role in treatment:

Given the recognised dangers of major tranquiliser, particularly in malnourished subjects, it is surprising that such drugs are used at all in anorexia nervosa. There is also a complete absence of any research evidence for their efficacy in terms of outcome. Nevertheless, these drugs may have a small and limited role in treatment used in a pragmatic way. Use is generally confined to those patients who continue to show marked anxiety and agitation and inability to eat in a general and supportive treatment setting ... [and] in older patients with chronic and seemingly intractable illnesses who continue to resist refeeding.

(Wakeling, 1995, p. 354).

Similarly, Bruna and Fogteloo (2003) argued that “the benefits do not outweigh the harms”. They advocated, however, the use of pharmacotherapy in cases where “comorbidity interferes with the development of therapeutic process” and “in cases of treatment resistance and perhaps in cases in which relapse is likely” (p. 313). It could be argued that when conduct cannot be shaped with psychological methods alone, despite their risks of harm and potential for iatrogenic effects, major tranquilizers are considered appropriate and necessary life administering techniques in the management of self-starving individuals.

While major tranquilisers continue to be reviewed and advocated, the use of minor tranquilizers – anxiolytics such as benzodiazepines – has become increasingly marginalised. In the 1980s and 1990s, Garner and Garfinkel and Wakeling reviewed the use of anxiolytics and stated that although anxiolytics were more effective at reducing anxiety concerning eating, without the harmful or undesirable effects of neuroleptics, psychiatrists were reluctant to prescribe them because of the potential for dependence and misuse. In the second edition of the *Handbook of Eating Disorders* (2003), there was no reference to anxiolytics in the chapter on drug treatments. In contrast to neuroleptics and tricyclic antidepressants, which produce unpleasant effects, benzodiazepines “cause a sensation of pleasure or euphoria as well as sedation” and prolonged use, over three weeks, typically leads to withdrawal symptoms which are less severe if their use is reduced more slowly (Moncrieff, 2009, p. 96). Challenging concerns about their dependence, Moncrieff (2009) stated that in one study GPs reported that most patients prescribed benzodiazepines did not have difficulty stopping them. Minor tranquilizers were widely prescribed in the 1960s and 1970s – by the 1970s one in five American women were prescribed them (Porter, 2002). Curiously, perhaps, their widespread use, which with all pharmacological interventions was not unproblematic, did not broadly infiltrate re-feeding programmes.

It would appear that attitudes towards the use of psychiatry’s physical techniques have shifted during the last fifty years, with, in some cases, condemnation of their use with malnourished patients. Pharmacological interventions, although not recommended as a ‘primary’ treatment for anorexia in the UK (NICE, 2004), continue to be advocated and used in less covert ways in order to induce desired conduct and ‘normal’ bodies. The newer anti-depressants are also advocated for ‘comorbid conditions’ (NICE, 2003), although their effectiveness is limited in malnourished states (Wakeling, 1995; Treasure & Schmidt, 2002).

3.3.5. From inpatient to community apparatuses

In the 1950s and 1960s, the NHS provided a context of comprehensive and preventative health for the population intertwined with the strategy of maximising public health and the economic fitness of the UK (Rose, 1998). As explicated in

section 3.2.4, the repositioning of psychiatry, through legal and policy changes, extended the authority and expertise of psychiatry to administer and manage individuals with milder or neurotic disturbances. Within these contexts, a shift to community apparatuses for administering 'mental medicine' occurred. More generally, community programmes in the UK, France and the US were developed with the objectives of "covering the maximum amount of ground, reaching the maximum number of people, through the deployment of a unified apparatus linked to the machinery of the state" (Castel, 1991, cited in Rose, 1996b, p. 4).

Within the community, bio-medicine, including psychiatry and allied disciplines, reconfigured its patients in accordance with strategies of social citizenship. Programmes of education, social housing and public broadcasting constituted the individual as a social citizen in a network of societal relations (Rose, 1996a). Those diagnosed with mental disorders, no longer passive recipients of 'care', were reconfigured as individual social citizens. The subjectivities of social citizens were imbricated within networks of moral and ethical responsibilities to their family and community and their own health.

Community programmes for individuals diagnosed with AN, however, lagged behind other areas of psychiatric medicine; the first day programmes for people diagnosed with anorexia were not introduced until 1989 (Zipfel et al., 2002). Prior to, and since 1989, the hospital has continued to be a central site for problematizing and administering self-starving individuals. More recently, however, the hospital has been conceptualised within a staged approach to care in the UK (NICE, 2003) and there has been a move to the development of SEDUs, specialist apparatus for administering eating disorders (RCP, 2010).

Dally and Sargant's treatment was administered within a hospital. Although they did not explicitly discuss the site of treatment, they quoted Gull's assertion that patients should be "surrounded by people who would have moral control over them; relatives and friends being generally the worst attendants" (1960, p. 1770). In the early seventies, Russell stated that inpatient admission was usually necessary in cases of "considerable weight loss" (1970, p. 151) and Bruch (1973) argued that hospitalisation was, in some cases, a necessary 'life-saving' measure.

In place of major tranquilizers, Russell (1970) suggested that skilled and experienced nurses could administer re-feeding regimens in inpatient settings and create “surroundings favourable to breaking the entrenched habits which have led to the loss of weight” (Russell, 1970, p. 152). This suggests that the family continued to be problematized as ‘unfavourable surroundings’. The hospital, however, was also positioned as an essential apparatus for the application of life-administering techniques.

Not everyone during this period agreed that psychiatric or medical inpatient treatment was a useful intervention. Selvini-Palazzoli (1974/1963), for instance, argued that in the interests of the “patient’s psychological health, it is advisable to avoid hospitalization if there is any alternative” because “patients see all hospitals as places of torture, humiliation and oppression” (p. 116). According to Garner and Garfinkel, Browning and Miller (1968) also suggested that inpatient admission did little to help the course of AN. Beck and Brøchner-Mortensen (1954) stated that when hospitalisation was used, individuals had better outcomes in general rather than mental hospitals (cited in Russell, 1970). Russell (1970) argued that the better outcomes in general hospitals could not be interpreted as a measure of success because the patient groups in general and mental hospitals were incomparable; those treated in mental hospitals presented with “a more florid psychopathology” (1970, p. 151). The lack of success, therefore, was not attributable to the psychiatric apparatus but to internal individual factors.

Back in 1936, however, the period when anorexia was largely displaced by Simmonds’ disease, case series research published by Ryle in the *Lancet*, indicated that self-starving people could ‘recover’ or ‘improve’ without being admitted to hospital. Table 3.3.5a below summarises the results of the 36³⁴ individuals whom Ryle had treated and traced, and illustrates the number of ‘recoveries’ that occurred at home.

³⁴ Ryle stated that he had traced 37 patients and that 6 were not improved but I could only count 5 improved or relapsed patients in his reported data.

Table 3.3.5.a. Outcomes and treatment method

	Home treatment	Home & institutional treatment	Institutional treatment	Other (Christian Science)
Complete recovery	17	2	1	1
Improved	5	1		
Improved but relapsed			1	
Not improved	3	1		
Died		4		
Total cases	25	8	2	1

Ryle stated, perhaps in anticipation of critiques of his findings, that his experience of managing anorexia was in the context of “consulting and hospital practice” and that “the disease was well established” in most cases (1936, p. 897). Similarly to Dally and Sargant, Ryle recommended bed rest until a stone of weight or more had been gained. In contrast, however, he concluded that positive outcomes could be achieved at home. He also argued that in situations where the home environment was not suitable, treatment should be provided in a nursing-home rather than a hospital ward, which was an “unsuitable place for treatment” (1936, p. 898). In contrast to the notion that ‘recovery’ was contingent upon the expertise of the physician or psychiatrist to administer the self-starved body, Ryle commented on an individual’s natural propensity to recover within the context of her life:

The natural resilience of youth, a happy change in circumstance, a new interest and time contribute to many recoveries independently of the physician’s endeavours.

(Ryle, 1936, p. 897)

It is worth noting that Ryle was a physician by training and a Professor of Physic [medicine] at the University of Cambridge. In 1943 he was appointed Professor of Social Medicine, which reflected his views that syndromes and diseases were not simply to be found in a person’s body, but in relation to their environment and social-cultural lives (Ryle, 1943).

Noteworthy, Garfinkel and Garner (1982) refer to Ryle’s 1936 paper in their discussion of researchers who reconnected with Gull’s work during the

displacement of anorexia in the 1930s. They also cited Ryle's paper in their discussion of death in anorexia and the importance of a supportive environment. Ryle's view that hospitalisation is undesirable and unnecessary, however, was excluded from the accounts by Garfinkel and Garner, Kay (1953), Dally and Sargant (1960; 1960) and Russell (1970; 1977).

Eventually, as Treasure, Todd and Szmukler (1995) noted, the apparatuses for administering and managing AN followed the rest of medicine and shifted towards community care. As discussed in section 3.1.2, current NICE guidance recommends a stepped approach to care; that most people diagnosed with AN should be treated on an outpatient basis, while inpatient care should be reserved for the most 'unwell' or 'at risk' self-starving individuals (NICE, 2004; RCP, 2010; 2012). Day treatments, another stepped up treatment in the community for anorexia, have also emerged. Robinson (2003) argued that day treatments are preferable where possible because inpatient settings, which are typically hierarchical, tend to replicate the "anorexic pseudo-conflict" (p. 335) of the family and use coercive methods of treatment, perhaps implying that coercive techniques do not occur within daypatient settings. He also argued that day treatments are preferred to inpatient treatments, evidenced by the termination of a study in Edinburgh that sought to compare inpatient and day patient treatment because referrals were predominantly for day treatments.

Treatment, whether in hospital or in the community, continues to centre on re-feeding and restoring weight to normal levels in order to reduce physical risk, normalise endocrine processes and alleviate the psychological and cognitive disturbances assumed to be associated with starvation. In other words, to employ techniques and apparatus to induce a 'normal' body that has the 'right to life'. Increasingly, it has become assumed that this can only occur with the intervention of psychiatric professionals, whether in the context of inpatient, daypatient or outpatient sites. Theander (1995), similarly to Ryle (1936), stated that "[n]owadays we are more aware there is an inherent tendency in the eating disorders towards spontaneous healing" (p. 22). This awareness, however, has not appeared to infiltrate problematizations of starvation, which have become increasingly entangled within the matrix of psychotherapy, inpatient and

outpatient units, multi-disciplinary teams and integrative approaches to administer and manage re-feeding practices. Psychiatric problematizations, which are claimed to have developed according to positivist practices, unsurprisingly, call for specialist psychiatric technologies, and in the process marginalise spaces for other perspectives or understandings.

3.3.6. *Constituting the self-starving body as a risky body*

In his review of the identity and treatment of AN, Russell (1970) stated that malnutrition was probably responsible for the majority of the physical complications (with the exception of amenorrhea) and fatalities (with the exception of suicide). He called for more specialist knowledge regarding the self-starved body because of the potentially dangerous physical complications, and perhaps psychological affects, of malnutrition.

In 1982, Garner and Garfinkel devoted a chapter to reviewing the growing literature on the physical complications of starvation. The emergent literature relating to the starving body drew on the Minnesota studies, which were conducted with 'conscientious objectors' towards the end of the Second World War to learn more about the "psychobiological effects of starvation" (Keys, Brozek & Henschel, 1950). As demonstrated in Garner and Garfinkel's chapter, the self-starving body was reconfigured as pathological in relation to techniques that constituted and measured 'vital norms' relating to cardiovascular and respiratory changes, renal changes, electrolytes, oedema, haematological changes, gastrointestinal complications, neurological complications, dental changes and skeletal maturation. The self-starving – anorexic – body was reconstituted as a "physico-chemical body" (Sheets-Johnstone, 1992, p. 135). The self-starving physico-chemical body was configured in relation to its deviation from 'normal' physico-chemical health, in relation to growing clinical and research literature. Ussher (2011) has argued that emphasis on the 'material' body and biomedical treatments is inevitable within a 'positivist/realist paradigm' (p. 52).

The morbid self-starving body has continued to be an important site for specialist knowledge and techniques. Treasure and Szmuckler (1995) located their review of physical complications in relation to concerns about the higher than normal

mortality rates among self-starving bodies diagnosed with AN. They stated that the mortality rate was six times that of the population, a figure that continues to be cited today (Steinhausen, 2002), which was comparable to other psychiatric conditions five years following inpatient treatment. They also commented that suicide, and not starvation, was the commonest cause of reported deaths.

Reviewing the physical complications, Treasure and Szmuckler (1995) focused on those that had been “the subject of recent interest” and which were “of clinical significance” (p. 197). They problematized the self-starved body in relation to growth and development, osteoporosis, fertility and pregnancy, the central nervous system and weight cycling. They argued that many, although not all, of the changes were reversible following weight restoration, highlighting the importance of re-feeding techniques. They also suggested that the physical complications perpetuated anorexia physically, emotionally and psychologically. Moving beyond a mere discussion of the complications and ‘threats to life’, Treasure and Szmuckler also compiled a table of recommended investigations for administering different phases of treatment: the initial assessment, during re-feeding and in severe chronic anorexia. The table of investigations provided a standardised and detailed technique for the administration of life and risk in relation to self-starving bodies across different sites. The physico-chemical body was morphing into a physically risky body that could be assessed and managed during re-feeding practices.

In addition to the risks to the self-starving body in the present, reviews began to describe the potential risks for permanent or future ill-health (NICE, 2004; Zipfel, Löwe & Herzog, 2003). The self-starving body became knowable in relation to risks of pathology or abnormality in the future.

Young women with anorexia nervosa are at increased risk of bone fractures later in life (Lucas *et al.*, 1999). The effects on the endocrine system have their impact on target organs, causing infertility, a risk of polycystic ovaries and loss of bone mineralisation. Where pubertal development has not been completed, incomplete development of secondary sexual

characteristics may occur (Goldbloom & Kennedy, 1995) and permanent stunting of growth is common.

(NICE CG9, 2004, p.15)

Increasingly, the self-starving body became constituted as “physically dangerous, often in ways that are not apparent”, as deviations from ‘vital norms’ were not detected on simple exams such as the electrocardiogram or blood tests (Mickley, 1999, p. 16). The adult MARSIPAN guidance recommended specialist administration and management because self-starving individuals “can seem deceptively well” and “may appear very energetic right up to a physical collapse” (RCP, 2010, p. 14). Canguilhem’s notion of health lying in the silence of the organs was reconfigured to health in relation to the lowest risk of permanent or future complications and premature death.

Despite the growth in knowledge and techniques, fatalities were reported during re-feeding – life-administering – interventions. Rose argued (1996) that failures create spaces for more elaborate techniques. In this case, fatalities in the context of re-feeding regimens led to the creation of the MARSIPAN guidelines (2010; 2012) to assist in the standardised management of ‘severe’ and ‘risky’ AN.

3.3.7. Administering life-saving measures

Rose (2001) argued that risk has been prevalent in bio-politics for over 150 years, evidenced in the early strategies of hygiene, which reformed the external sewage and water conditions in order to reduce the frequency and probability of ill-health or morbidity across populations. In the second half of the twentieth century, in the context of advanced liberal strategies of government and the right to life, the focus shifted to the minimisation of current and potential risks to health.

Rose (2007) argued that the administration of risk transformed the professional subjectivity of psychiatrists, with risk emerging as the primary framework for dividing techniques and criterion for intervention. Discourses of ‘high risk’ and ‘low risk’, for instance, divided “the prudent self from the imprudent self, the self able to manage itself from the self who must be managed by others” (Rose, 1996b, p. 14).

Dally and Sargant spoke of the “much graver risks of allowing states of inanition to continue indefinitely” to justify the unpleasant and harmful effects of their treatment (1960, p. 1770). It could be argued that they were implying that without intervention continued self-starvation would inevitably lead to death. In 1970, Russell stated that the first stage of treatment was aimed at “saving life” (p. 151). The administration of life in relation to self-starving bodies through weight restoration became an increasing priority, reinforcing the primary role of re-feeding practices. Not everyone prioritised weight restoration in their work on self-starving bodies, however, and the negative consequences of this were highlighted:

Not paying attention to the low weight, as is sometimes done in psychoanalytic treatment ... results in a chronic anorexic state.

(Bruch, 1978/2001, p. 103).

Bruch’s comment is noteworthy, considering the chronic state that was deemed inevitable to a large proportion of cohorts diagnosed with AN (Dally, 1969; Russell, 1970).

As stated by Russell in 1970, the first stage of managing the self-starving individual was achieving physical normality and saving life, ideally with the consent and cooperation of the individual – a shift from Dally and Sargant’s treatment. The second stage involved psychological techniques³⁵ to address individual and/or family psychopathology that had caused or was perpetuating the disorder. Fundamentally, the starving body was the primary target for restoring health as discussed in section 3.3.6.

Although the primary goal continues to be “to return body weight to a healthy level” (NICE, 2004, p. 82), saving life has gradually morphed into discourses of administering risk as demonstrated in the MARSIPAN guidance. The guidance provided criteria for identifying “really sick patients” and self-starving bodies at “the highest risk” (RCP, 2012, p. 14). Standardised weight criteria divide the risky and really sick from the moderately sick. The authors also noted that higher

³⁵ A genealogical exploration of psychological techniques is beyond the scope of this professional doctorate thesis.

weights can also be risky if accompanied by purging behaviours or over-exercising. Techniques were provided for monitoring and minimising risks through risk assessment practices, which centre on the physico-chemical body, and specialist guidance to manage re-feeding. A detailed list of the types of 'risky' and deceptive behaviours to remain vigilant for, particularly in relation to those who appear outwardly compliant with the re-feeding treatment but fail to gain weight, was also provided. In addition to constant assessment, or surveillance, of the body and the individual's conduct, the re-feeding regimen for 'high risk' or 'severely' low weight bodies recommended 24 hour bed rest (RCP, 2010; 2012). In section 3.3.4, I also described how pharmacological interventions continue to be advocated for self-starving bodies unable to eat in "a general and supportive treatment setting" and with those "who continue to resist re-feeding" (Wakeling, 1995, p. 354).

In this chapter I have traced a number of the events within the network of relations that continue to position re-feeding as a primary treatment regimen for the self-starving body. I also highlighted some of the techniques and knowledges that have tended to be overlooked, excluded or disqualified. On the basis of the analysis of descent, I would suggest that self-starving bodies have become increasingly specified and subjectified in relation to technologies of power and technologies of the self. In spite of the expanding specificity, practices of surveillance and new dividing techniques for those 'at highest risk', however, re-feeding practices have not changed remarkably over the last 50 years.

4. CONCLUSION

In this section, I revisit and discuss the aims of this thesis in the context of the genealogical exploration. I then consider criteria for evaluating this thesis and reflect on the process of undertaking a genealogical approach to re-feeding before discussing the potential implications for clinical practice and research.

4.1. Summary of Research and Aims

The purpose of this research was to problematize the practice of re-feeding as the primary treatment for self-starving individuals. Firstly, with the aim of destabilising taken-for-granted truths about the approach, which silence questions and prevents other approaches from emerging, to show that practices which appear necessary, inevitable or beneficial can be understood as contingent and contestable. Secondly, with the intention of highlighting the reciprocal relations between the 'psy' disciplines and technologies of power and the self in relation to re-feeding practices. These aims were based upon conclusions in the research literature that only half of the people who are diagnosed with anorexia make a good or satisfactory recovery (Claudino et al., 2006; Steinhausen, 2002),

The research aims were addressed through the employment of past and current case narratives, followed by mapping the surface of emergence for the past case history and tracing the descent between the current and past case histories. The practical considerations of a professional doctorate thesis, in terms of time and word count, restricted the focus to a small number of events from the 'field of action'. Arguably, I could have, and would have liked to, explored more events mapped within the dispositif, for instance, the family, the female body, the psychology of the self-starved body.

In the surface of emergence chapter, I traced the network of relations in which psychiatry became configured as a mental medicine within the bio-political strategies of individualised and preventative medicine. These bio-political strategies prioritised and extended the processes of physical illness to 'mental illness'. Techniques from surgical medicine, drugs which were seen to have calming effects, were employed in psychiatric contexts and, in the process, shored up psychiatry's expertise and authority in relation to administering and

managing mental disorders; pharmacological techniques produced docile and compliant subjectivities, as evidenced in Dally and Sargent's (1960) *new treatment*. The compliant, heavily sedated, starved bodies were rapidly reconstituted as 'normal' bodies, in appearance and reproductive potential, at least in the short-term. In the longer-term, without surveillance and psychiatry's techniques, the success of the *new treatment* was more difficult to determine. Nearly half of the 48 treated individuals developed deviant conduct in relation to food, they started bingeing on food, and self-starving subjectivities persisted for nearly half of the treated bodies. Although the techniques created numerous unpleasant and harmful effects and were only effective in the short-term, they positioned psychiatry as an authoritative apparatus for administering and managing the conduct and interpersonal and physical subjectivities of self-starving bodies. Dally and Sargent's research and treatment, which reached Europe and America, also assertively constituted self-starving bodies as 'anorexic' bodies. These anorexic bodies, which required specialist techniques, were constituted as symptomatic in relation to psychological – or family – pathology and deviation from physical – or hormonal – health.

In tracing the analysis of descent, I examined the rise in the documentary apparatus and number of anorexic bodies. The self-starved bodies were firmly constituted within the authority of psychiatry following the inclusion of anorexia nervosa in the DSM in 1980. In the context of community or hospital apparatuses, the physico-chemical body became the key site for subjectification in order to restore 'vital norms'. The self-starved body became re-reconfigured and acted upon in relation to the growth of specialist knowledge and the rising number of bodies to administer. In parallel, the subjectivities of psychiatrists and allied professionals became increasingly constituted as administrators of risk. In the context of the free and autonomous individuals, the self-starving body was divided and subjectified in relation to its riskiness. For the most risky, life administering measures in the form of standardised and constant techniques of assessment and management were recommended. And for those who could not or would not subjectify themselves in accordance with the re-feeding treatment regimen, pharmacological techniques, at smaller doses than advocated by Dally and Sargent, have been recommended within the context of administering life.

4.2. Evaluation and Critical Review

In this section, I consider issues of evaluation in relation to genealogical approaches and this thesis before reflecting on the process of undertaking a Foucauldian genealogy. I finish the chapter reflecting on the usefulness of the current genealogical approach within the context of clinical practice and research.

4.2.1. Assessing quality

Harper (2013), commenting on rise of qualitative methods in clinical psychology theses, highlighted that qualitative methods depend on the “researcher’s knowledge and skill” rather than their ability to simply apply a collection of techniques “off the shelf” (p. 21). He argued that in order to approach the analysis in a theoretically consistent way, the researcher needs to become immersed in the theoretical and empirical literature. Firstly, in the process of undertaking this thesis, I have made efforts to become familiar with the work of Foucault and Rose, among others, in order to develop a Foucauldian lens or framework to bring to my corpus of statements. Such an undertaking was ambitious and, in many ways, I feel my reading and engagement with their work is just commencing. Secondly, undertaking a genealogical analysis within a conceptual framework which required an acceptance of “epistemological uncertainty” (Tamboukou & Ball, 2003), and a move away from the majority of my psychological knowledge and training, I eagerly sought a thesis supervisor who had used and commented on Foucauldian scholarship and genealogical analysis in her work.

A particular challenge with adopting a genealogical approach was that genealogists such as Foucault, Rose, Tamboukou and Butler have purposively avoided producing closed methodologies, which could be used ‘off the shelf’ and lead to genealogical research being assimilated within a positivist framework. As an alternative to a closed methodological framework, I tried to explicate Foucault’s theories of bio-power and governmentality, which were central to this thesis, and summarise commentaries of genealogical investigations to set the scene for the current exploration. Stopping short of a closed methodology, I explicated the research strategies and tools guiding this social and historical

investigation of the discursive practices which have worked to constitute re-feeding practices. Finally, in undertaking a genealogical exploration I have “created my own rhythms, made selections and decided on inclusions and exclusions” (Tamboukou, 2010, p. 7), shaped by the strategies and inclusion criteria set out in the methodology chapter.

Genealogy as a theoretical-analytical approach without a formal methodology poses challenges in terms of an evaluative framework. Willig (2001) has argued that methods of evaluation need to be congruent with the epistemological framework employed. Although Willig did not comment directly on genealogical research strategies, she stated that a discursive research approach

...needs to be evaluated in its own terms – that is as a discursive construction in its own right, on the basis of its internal coherence, theoretical sophistication and persuasiveness.

(Willig, 2001, p. 148).

She suggested the following questions to assess the quality of narrative accounts:

1. Does it tell a good story?
2. Does it tell a story which is clear, internally coherent and sufficiently differentiated?
3. Does it generate new insights for readers?
4. Is it convincing?

As discussed in section 2.7, in order to address the aims I employed the five perspectival dimensions explicated by Rose (1999; 1996a). My intention was to trace the surface of emergence and descent to make visible the reciprocal knowledge-power-self relations and reconstitute notions of depth, that is to say, the view that present practices are a “culmination of everything that is ‘progressive’ in that which preceded it” (Rose, 1994, p. 70), as a ‘superficial secret’. It was hoped that by highlighting the multiple discursive practices and avoiding ‘presentism’ it would make the contingencies of present subjectivities and practices in relation to re-feeding visible and destabilise the unquestioned

belief that current practices are the only way of knowing and acting upon self-starving bodies. I have attempted to give re-feeding practices “a genealogical history, without claiming to capture what the past really was” (Dreyfus & Rabinow, 1982, p. 204). It is also worth briefly highlighting that my intention was not to create an Aristotelean story within a framework of beginning-middle-end (Tamboukou, 2011). Rather, to delineate or tell the story of events and relations in order to “reveal the meanings of what otherwise would remain the unbearable sequence of sheer happening” (Arendt, 1995, p. 104). It is for the reader to decide whether my account stands up to the questions proposed by Willig.

4.2.2. Reflexivity³⁶

Hook (2007) commented that a genealogical analysis of a practice within one’s own discipline can create tension, as the critical history of an object or event requires a critical history of the discipline in which it is located. Rose (1999; 2007b) suggested that his work has not sought to critique the ‘psy’ disciplines but to make visible the reciprocal relations between the ways we understand and work on ourselves. Following Rose, I have tried to point out the ‘reciprocal relations’ between power, knowledges and re-feeding practices which subjectify the self-starving individual and those who administer and manage her.

In the process of undertaking a genealogical analysis of re-feeding practices, I have encountered dilemmas in relation to distancing myself from the skills and knowledge acquired from studying and training within the discipline of psychology³⁷ and working with a different conceptual framework, which seeks to demonstrate the contingent, temporal and contestable nature of knowledge and practices. For example, becoming immersed in the anorexia literature led to moments, when I reverted to habitual tendencies of reviewing the literature from within a positivist frame, where I accepted the inevitability of, or became convinced by, the psychological, medical or legal literature regarding self-starving individuals and re-feeding practices. At these times, when I departed from the task of genealogy, I was reminded of the importance of engaging with both the

³⁶ As noted in section 2.4 the language of reflexivity is problematic within a material-discursive-epistemological framework.

³⁷ My decision to pursue clinical psychology was not accidental but informed by my interest in the theory and belief in the utility of the discipline.

theoretical (e.g. the work of Foucault and Rose) and empirical literature (corpus of statements).

I experienced tension in relation to undertaking research with the goal of undermining the certainty and inevitability surrounding current practices without suggesting alternatives³⁸. I tussled with the idea that by not suggesting alternatives to re-feeding, I was suggesting we do nothing. I pondered whether by interrogating current practices, which have become inextricably tied to discourses of risk and saving lives, I was, therefore, advocating death. Momentarily captured by the dichotomy of 'to act' (according to current understandings) or 'do nothing', I was acting and thinking within the technologies of self – my own professional subjectivity – that I was trying to step back from and interrogate. These experiences reminded me of the extent to which re-feeding, anorexia and specialist treatments have become common sense and powerful discourses within an advanced liberal society, which is increasingly preoccupied with risk (Rose, 1998; 2001).

On the other hand, I became increasingly aware that the prioritisation of re-feeding practices emerged in relation to heterogeneous events and technologies. For example, the multiplicity of factors positioning psychiatry as the authority in relation to self-starving individuals and the diverse ways in which bodies became subjectified in relation to medicine, gender, families and risk. The literature over time also reminded me of the short-term effectiveness of re-feeding practices for many, the resilience of individuals to recovery outwith psychiatric contexts and the impact of the increasing emphasis on predicting and minimising risk. At times, I wondered what would happen if we were to trust the resilience of youth, recognise that we cannot remove death – “some fatalities are inevitable” (RCP; 2010, p. 10; see section 3.1.2) – and respond in less technical and risk adverse ways. If these ideas infiltrated our thinking, we might, perhaps, start to develop different understandings or practices attuned to each person, find that our anxieties within services do not govern our actions and thinking, and learn that

³⁸ A frequent criticism of Foucault's approach is that it does not – and intentionally so – offer an alternative or more true truth (Kendall & Wickham, 1999).

people can recover in contexts that are not dominated by psychiatric professionals. However, these ideas appear incompatible with a culture of blame, dominant understandings of individuals who self-starve and protocols and universal theories relating to individuals who self-starve.

While engaging with the dilemmas delineated above, I have also been reminded of the expectation that this thesis will offer recommendations in relation to clinical practice and future research. In the following section, I work with the dilemma of generating recommendations in relation to Foucauldian genealogical approaches and the current genealogical investigation.

4.3. Clinical and Research Implications

I tentatively suggest that this thesis has attempted to make a unique contribution to the literature of re-feeding through the construction of a narrative that destabilises the certainties and makes visible the web of relations that delimit the 'sayable' and 'doable' in relation to self-starving bodies.

Moving beyond the aims of the research to highlight the contingency and complexity of re-feeding practices and associated practices, I consider possible avenues this genealogy could enable us to explore in clinical practice and research³⁹. I acknowledge that my recommendations will be located within psychosocial, medical and legal frameworks – the context of the work – which Foucault has problematized. For example, in *Discipline and Punish*, Foucault (1977a) commented that central to different and competing models of disciplinary punishments in the early nineteenth century was the objective of incarceration. Similarly, in compiling a response for alternatives to re-feeding practices, the objective would be to support self-starving individuals to recover and engage with life giving practices where possible.

4.3.1. Clinical implications

The emphasis on the self-governing body appears to fail in the longer term for many self-starving individuals. In contrast to current practices, which, focus on

³⁹ It should be noted that Foucault's genealogical work was never primarily intended to have implications for change either in 'practice' or 'research'; its primary focus (i.e. to destabilise the status quo of understanding) might be to achieve change in cognition.

short-term weight gain as a goal, a broader definition of recovery could support self-starving individuals to take up different positions of recovery in relation to their body. For example, moving away from a focus on achieving the menstruating body, the weight restored body and the 'normal' body. Shifting the focus away from the body could also create opportunities for individuals to live their life, in spite of the self-starvation, outside of psychiatric inpatient wards and other clinical settings. Working with risk in a supported risk taking, rather than risk avoidant, way could also re-create opportunities for an individual's natural resilience to promote their recovery.

4.3.2. Research implications

Building on the marginalised research reported by Ryle (1936), positivist and post-structuralist research could be undertaken to explore incidences, or people's experiences, of 'spontaneous recovery' (i.e. with no professional input) or living active or fulfilling lives with a BMI considered to be in the low or unhealthy range. Researching populations whose lives are not governed by psychiatric practices might challenge the dominant understanding of self-starvation as a sign of physical and mental ill-health, and open up potential understandings and practices that prevent very low weights from developing in the first place.

The suggestions above should be read as the tentative ideas of one person who has attempted to problematize the practice of re-feeding in order to open up new ways to understand. It is hoped that, as Arendt (2005) suggested, if we to keep trying to understand then perhaps we can find new ways to deal with problems, ourselves and the world around us:

Understanding, as distinguished from having correct information and scientific knowledge, is a complicated process which never produces unequivocal results. It is an unending activity by which, in constant change and variation, we come to terms with and reconcile ourselves to reality, that is, try to be at home in the world.

(Arendt, 2005, pp. 307-308)

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6. APPENDICES

Appendix A: Literature Search

I initially ran a search on the Academic Search Complete, CINAHL Plus, Education Research Complete, PsycARTICLES, PsycINFO, relevant databases within EBSCO, an international online research database.

The following search terms were used for anorexia nervosa:

- "anorexia"
- "anorexia nervosa"
- "self starvation".

The following terms were used to search for papers relating to re-feeding:

- "nutritional rehabilitation"
- refeeding
- "re-feeding"
- "inpatient treatment"
- "in-patient treatment"
- "nutritional therapy"
- "feeding programme"
- "feeding program"
- "hospitalization"
- "hospitalisation"
- "artificial alimentation"

Appendix B: Narrowed Literature Search

As with the previous search, I ran the searches on the Academic Search Complete, CINAHL Plus, Education Research Complete, PsycARTICLES, PsycINFO, relevant databases within EBSCO, an international online research database

The time period 2000 to 2013 was applied to the search and the Boolean/Phrase search terms for the filtered knowledges and practices are listed below:

- AN: "anorexia" OR "anorexia nervosa" OR "self starvation".

AND

- Recovery :“long-term outcome” OR “long-term effectiveness” OR “long-term follow-up”
- Compulsory treatment: “compulsory admission” OR “compulsory treatment” OR “involuntary admission” OR “involuntary treatment”
- Mortality rates: “crude mortality rate” OR “standardized mortality rate” OR “death rate” OR “mortality rate”

The abstracts of all papers returned were scanned and the complete journal articles that were in English and related directly to search area were accessed. In addition to this, I sourced and read relevant contemporary and historical articles and books referred to in the papers accessed.

Reported Causes and Conditions at Time of Death

Study (Country)	Total deaths	Unnatural causes (suicides, homicides, accidents) (N)	Recorded death cause AN (N)	Natural causes (possible attributable to malnutrition/binging/purging/ alcohol use) (N)	Other causes (N)
Birmingham Chadalavada & Palmer, 2005 ^a	17	Suicide (7)		Pneumonia (2) Hypoglycemia (2)	Subdural hemorrhage (1) Cancer (2) Liver disease (2) Alcohol poisoning (1)
Button et al. 2010 ^a	10	Hanging (2) Cerebral hypoxia/anoxia, ligature compression neck (1)	Heart failure (1) Cardiac asystole/inanition (1) Complications of AN (1)	Pneumonia/ chronic malnutrition/alcoholic liver disease (1) Bleeding esophageal varices, chronic alcoholic liver disease (1) Alcohol poisoning (1)	Diabetic ketoacidosis (1)
Crow et al., 2009 ^a	7	Suicide (1)			Trauma (1) Medical (4) Substance use related (1)
Herzog et al. 2000 ^b	7	Suicide (3)		Fungal pneumonia (1) Cardiac arrhythmia and seizure disorder (1) Alcohol intoxication (1) Cardiorespiratory failure, hepatic failure and cirrhosis (1)	
Hjern, Lindberg & Lindblad, 2006 ^a	9	Suicide (2) Passenger in car crash (2)	Underlying cause of death AN (2) Degenerative heart failure (1)		Cancer of the uterus (1) Drug overdose (1)
Huas et al., 2011	40	Suicide (7)	Anorexia nervosa (2) Cardiac arrests (7) Cachexia (3) Infection (1)		Unknown (10) Unclear (10)
Keel et al., 2003 ^b	10	Suicide (4)		Heart and liver failure (1) Fungal pneumonia (1) Cardiac dysrhythmias (1)	Diabetes mellitus (1) Amyotrophic lateral sclerosis (1)

Study (Country)	Total deaths	Unnatural causes (suicides, homicides, accidents) (N)	Recorded death cause AN (N)	Natural causes (possible attributable to malnutrition/binging/purging/ alcohol use) (N)	Alcohol poisoning (1) Other causes (N)
Löwe et al., 2001 ^c	14	Suicide (2)	7	3	Asthmatic attack (n=1) Rectal carcinoma (n=1)
Millar et al., 2005 ^a	23	Carbon monoxide poisoning-car exhaust (1) Ligature strangulation (1) Opiate intoxication (1)	Myocardial infarction (2) Bronchopneumonia(1) Cardiac arrhythmia(1) Respiratory arrest (1) Acute respiratory distress syndrome (1) Septicaemia shock (1) Anorexia nervosa (1)	Pneumonia (1)	Degos syndrome (1) Adenocarcinoma (1) Esophageal cancer (1) Diabetic ketoacidosis (1) Hypoglycaemia (1) Opiate intoxication (1) Unknown/unclear (6)
Papadopoulos et al., 2009 ^a	256	Suicide (84) Homicide (4) Traffic accidents (7) Undefined (19) Other (12)	Anorexia nervosa (39)	Nervous system (4) Cardiovascular (11) Respiratory (14) Endocrine (9) Haematopoietic (1) Gastrointestinal (6) Urogenital (2) Autoimmune (3)	Cancer (29) Psychoactive substance use (13) Other psychiatric disorder (2) Other (6)
Rosling et al., 2011 ^a	21	Suicide (7)	AN cause of death/ BMI<13 (6)	Pulmonary edema, hepatic failure, alcoholism (1) Subdural bleeding, alcoholism (1) Hepatic failure, alcoholism (1)	Alcohol intoxication, alcoholism (1) Bronco-pneumonia, benzodiazepine abuse (1) Multiple organ failure, personality disorder (1) Homicide, alcoholism (1) Breast cancer, alcoholism (1)

Appendix D: Corpus of Statements

Appendix D.1: Key papers, chapters and handbooks

Peter Dally and William Sargant's <i>A New Treatment of Anorexia Nervosa</i> , published in 1960, and their follow-up paper in 1966, <i>Treatment and outcome of anorexia nervosa</i> .	The earliest papers identified describing a re-feeding treatment study within the NHS. I have elaborated on the rationale for their inclusion and compiled an historical case narrative based on these two papers in section 3.1.1.
<i>Anorexia Nervosa</i> a short book published by Dally in 1969.	This monograph captures Dally's developing conceptualisations of AN and re-feeding practices alongside the role of psychological treatments.
<i>Anorexia nervosa: Its identity as an illness and its treatment</i> , a chapter written by Gerald Russell, published in 1970.	Russell was one of the earliest British psychiatrists interested in anorexia. In this chapter, appearing in the second volume of <i>Modern Trends in Psychological Medicine</i> , Russell presented a summary of ideas and research relating to AN.
A handbook compiled by Garfinkel and Garner (1982), Canadian psychiatrists, titled <i>Anorexia Nervosa: a Multidimensional Perspective</i> .	This book provided a summary of research up until its publication and described a range of perspectives relating to the symptoms, theories of aetiology and treatment of AN.
<i>Handbook of eating disorders: Theory, treatment and research</i> edited by George Szukler, Christopher Dare and Janet Treasure and published in (1995)	This handbook was edited by psychiatrists who had worked closely with Russell and the handbook“ aimed to provide an up-to-date review of the most “powerful ideas, hypotheses, or models which have dominated the field” of eating disorders (p. xvii)
The second edition of the <i>Handbook of Eating Disorders</i> edited by Janet Treasure, Ulrike Schmidt and Eric van Furth and published in 2003.	In this updated edition, the editors stated that this edition represented a shift to a European perspective on eating disorders.

Appendix D.2: Guidelines regarding the assessment, management and treatment of anorexia nervosa

The revised fourth edition of *Diagnostic and Statistical Manual of Mental Disorders [DSM]* published by the American Psychiatric Association in 2000.

An authoritative nosology of 'mental disorders', which has guided research since the publication of the first edition in 1952. A revised fifth edition is due for publication imminently

Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders published by NICE in 2004.

The National Institute of Clinical Excellence compiled this evidence-based practice guideline in collaboration with the Royal College of Psychiatrists and the British Psychological Society. .

MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa published by the Royal College of Psychiatrists and Royal College of Physicians in October 2010, and *Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa* published by the Royal College of Psychiatrists in 2012

These guidelines were developed to reduce the variability in the quality of treatment practices of AN and in relation to concerns about unnecessary fatalities in general medical settings from tentative re-feeding practices. I have provided a more detailed rationale for their inclusion and information about the guidelines in the case narrative of current practice in section 3.1.2.

Appendix E: Junior MARSIPAN Risk Assessment Framework

Guidance 1 Risk assessment framework for young people with eating disorders⁴⁰

	Red (high risk)	Amber (alert to high concern)	Green (moderate risk)	Blue (low risk)
BMI and weight	Percentage median BMI <70% (approx. below 0.4th BMI centile) Recent loss of weight of 1 kg or more/week for 2 consecutive weeks	Percentage median BMI 70–80% (approx. between 2nd and 0.4th BMI centile) Recent loss of weight of 500–999 g/week for 2 consecutive weeks	Percentage median BMI 80–85% (approx. 9th–2nd BMI centile) Recent weight loss of up to 500 g/week for 2 consecutive weeks	Percentage median BMI >85% (approx. above 9th BMI centile) No weight loss over past 2 weeks
Cardiovascular health	Heart rate (awake) <40 bpm _a History of recurrent syncope; marked orthostatic changes (fall in systolic blood pressure of 20 mmHg or more, or below 0.4th–2nd centiles for age, or increase in heart rate of >30 bpm) Irregular heart rhythm (does not include sinus arrhythmia)	Heart rate (awake) 40–50 bpm Sitting blood pressure: systolic <0.4th centile (84–98 mmHg depending on age and gender _a); diastolic <0.4th centile (35–40 mmHg depending on age and gender _a) Occasional syncope; moderate orthostatic cardiovascular changes (fall in systolic blood pressure of 15 mmHg or more, or diastolic blood pressure fall of 10 mmHg or more within 3 min standing, or increase in heart rate of up to 30 bpm)	Heart rate (awake) 50–60 bpm Sitting blood pressure: systolic <2nd centile (98–105 mmHg depending on age and gender _a); diastolic <2nd centile (40–45 mmHg depending on age and gender _a) Pre-syncope symptoms but normal orthostatic cardiovascular changes Cool peripheries; prolonged peripheral capillary refill time (normal central capillary refill time)	Heart rate (awake) >60 bpm Normal sitting blood pressure for age and gender with reference to centile charts _a Normal orthostatic cardiovascular changes Normal heart rhythm
ECG abnormalities	QTc >460 ms (girls) or 400 ms (boys) with evidence of bradyarrhythmia or tachyarrhythmia (excludes sinus bradycardia and sinus arrhythmia); ECG evidence of biochemical abnormality	QTc >460 ms (girls) or 400 ms (boys)	QTc <460 ms (girls) or 400 ms (boys) and taking medication known to prolong QTc interval, family history of prolonged QTc or sensorineural deafness	QTc <460 ms (girls) or 400 ms (boys)
Hydration status	Fluid refusal Severe dehydration (10%): reduced urine	Severe fluid restriction Moderate dehydration (5–10%): reduced	Fluid restriction Mild dehydration (<5%): may have dry mouth	Not clinically dehydrated

⁴⁰Reproduced from the Junior MARSIPAN guidelines (RCP, 2012, pp. 17-19).

	Red (high risk)	Amber (alert to high concern)	Green (moderate risk)	Blue (low risk)
Hydration status cont.	output, dry mouth, decreased skin turgor, sunken eyes, tachypnoea, tachycardia ^c	urine output, dry mouth, normal skin turgor, some tachypnoea, some tachycardia, ^c peripheral oedema	or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance	
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C		
Biochemical abnormalities	Hypophosphataemia, hypokalaemia, hypoalbuminaemia, hypoglycaemia, hyponatraemia, hypocalcaemia	Hypophosphataemia, hypokalaemia, hyponatraemia, hypocalcaemia		
Disordered eating behaviours	Acute food refusal or estimated calorie intake 400–600 kcal per day	Severe restriction (less than 50% of required intake), vomiting, purging with laxatives	Moderate restriction, bingeing	
Engagement with management plan	Violent when parents try to limit behaviour or encourage food/fluid intake, parental violence in relation to feeding (hitting, force feeding)	Poor insight into eating problems, lacks motivation to tackle eating problems, resistance to changes required to gain weight, parents unable to implement meal plan advice given by healthcare providers	Some insight into eating problems, some motivation to tackle eating problems, ambivalent towards changes required to gain weight but not actively resisting	Some insight into eating problems, motivated to tackle eating problems, ambivalence towards changes required to gain weight not apparent in behaviour
Activity and exercise	High levels of uncontrolled exercise in the context of malnutrition (>2 h/day)	Moderate levels of uncontrolled exercise in the context of malnutrition (>1 h/day)	Mild levels of uncontrolled exercise in the context of malnutrition (<1 h/day)	No uncontrolled exercise
Self-harm and suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		
Other mental health diagnoses		Other major psychiatric codiagnosis, e.g. OCD, psychosis, depression		
Muscular weakness – SUSS Test				
Sit up from lying flat	Unable to sit up at all from lying flat (score 0)	Unable to sit up without using upper limbs (score 1)	Unable to sit up without noticeable difficulty (score 2)	Sits up from lying flat without any difficulty (score 3)
Stand up from squat	Unable to get up at all from squatting (score 0)	Unable to get up without using upper limbs (score 1)	Unable to get up without noticeable difficulty (score 2)	Stands up from squat without any difficulty (score 3)
Other	Confusion and delirium, acute pancreatitis, gastric or oesophageal rupture	Mallory–Weiss tear, gastrooesophageal reflux or gastritis, pressure sores	Poor attention and concentration	

BMI, body mass index; bpm, beats per minute; ECG, electrocardiogram; OCD, obsessive–compulsive disorder; SUSS, Sit Up, Squat–Stand.

a. Patients with inappropriately high heart rate for degree of underweight are at even higher risk (hypovolaemia). Heart rate

may also be increased purposefully through the consumption of excess caffeine in coffee or other drinks.

b. Jackson *et al*, 2007.

c. Or inappropriate normal heart rate in an underweight young person.

Appendix F: Junior MARSIPAN Guidance of Re-feeding Practices

*Management of re-feeding*⁴¹

- Starting intake should not be lower than intake before admission. For most young people starting at 20 kcal/kg/day or higher, such as 1000 kcal per day or quarter/half portions, appears to be safe. However, electrolytes and clinical state need careful monitoring and transfer to a paediatric unit may be required if, for example, phosphate falls to <0.4 mmol/l.
- In the individuals who are at highest risk, and usually in paediatric rather than psychiatric settings, it may be necessary to use lower starting intakes (e.g. 5–10 kcal/kg/day), especially in the presence of severity indicators such as ECG abnormalities or evidence of cardiac failure, electrolyte abnormalities before re-feeding starts, active comorbidities (such as diabetes or infections), or very low initial weight.
- If low initial calorie levels are used (5–10 kcal/kg/day), clinical and biochemical review should be carried out twice daily at first, with calories increasing in steps unless there is a contraindication, and continuing to increase until weight gain is achieved. Low-calorie feeding should be discussed with an expert in clinical nutrition and a nutrition support team. Minor or even moderate abnormalities of liver function should not delay increased feeding.
- Re-feeding syndrome is most likely to occur in the first few days of re-feeding but may occur up to 2 weeks after. Biochemical monitoring should continue for a fortnight or until electrolyte parameters are stable.

ECG, electrocardiam

⁴¹ Reproduced from the Junior MARSIPAN guidelines (RCP, 2012, p. 47).