Embodiment, Lived Experience and Anorexia: The Contribution of Phenomenology to a Critical Therapeutic Approach

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Resumen

En este articulo nos proponemos recuperar el trabajo de Merlau-Ponty como un instrumento válido para la elaboración de una psicología crítica ya sea en como referente teórico o en sus aplicaciones prácticas. En concreto, nos vamos a centrar en los conceptos de *percepción* y *corporalidad* y como Merleau-Ponty los define de forma radicalmente distinta a la psicología convencional. Complementariamente, reflejamos el carácter crítico de las perspectivas fenomenológicas mediante la aplicación de los conceptos de percepción y corporalidad a la concepción clínico-teórica de la anorexia nerviosa. Este artículo constituye un punto de partida que nos permita repensar la naturaleza encarnada de la anorexia nerviosa, tanto a partir de una crítica fenomenológica al concepto de corporalidad en la concepción de los desórdenes alimentarios de la psicología clínico-conductual como la ausencia de la noción de cuerpo encarnado en algunas perspectivas feministas.

Palabras clave: Fenomenología; Psicología Crítica; Anorexia; Feminismo; Embodiment; Introcepción; Modelos clínicos

Abstract

In this piece we will consider the work of Maurice Merleau-Ponty as it relates to critical psychology and also discuss the possibility of its use as a theoretical framework for empirical studies. We will focus specifically on Merleau-Ponty's concepts of perception and embodiment and ask what these may add to perspectives within critical psychology. In terms of these concepts, Merleau-Ponty offers a radically different view of perception from that which is common in mainstream psychology, along with a radically different view of human embodiment. Given this, we believe that many of his ideas are important for critical psychology and could give it an alternative direction. Phenomenological perspectives are also of use in critical, empirical studies, and here we use the concepts of perception and embodiment to reassess the literature on anorexia nervosa. It is our contention that these concepts allow us to rethink the embodied nature of anorexia, particularly in terms of the way that the body is conceptualised in the clinical literature, but also the absence of a notion of the lived body from some feminist accounts.

Keywords: Phenomenology, Critical Psychology, Anorexia, Feminism, Embodiment, Introception, Clinical Models

Merleau-Ponty's Phenomenology and Critical Psychology

The most obvious contribution Merleau-Ponty (1962; 1964a) made to psychology was that he developed a radically different concept of perception in the writings of the middle period of his career. His was not the same concept of perception that appears in mainstream psychology. In most texts in psychology we find that perception is viewed primarily as a phenomenon located in the individual, in the brain or the mind. In this view, perception is a capacity given to humans by their innate ability to process sensory information drawn from the world through the structures of cognitive processes. Either that or sensory data is itself already partly ordered before it reaches self-consciousness through the structure of the central nervous system and brain.

Unlike traditional mainstream psychology, for Merleau-Ponty, perception is reducible neither to the mind or to the brain of the individual. Also, his concept of perception and perceptive truth is not to be confused with the empiricist belief that the direct observation of phenomena can either verify or falsify our hypotheses about reality. Indeed, Merleau-Ponty is highly critical of both these positions. In their place, he offers a theory of the phenomenal primacy of perception in which perception and its truth is located neither in the individual or in the environment around him or her. Rather, the perceptual faith in the solid existence of an objective world is something that exists **inbetween** persons and the world. That is to say, perceptual truth is only established in the relation between people and the world, by the way in which they relate to one another and interact. In this process, it is not the experience of the individual human being that is primary as each individual is located in a definite environment or field which guides their perceptive formation of the world. Although each individual is present at a different location in this world and sees, hears and touches from their own perspective, their perception of the totality of the field or topography of the world is enough to guarantee that each will have a universally similar perception of the perceptual field. Along with this, each person is also part of a social world and the joint human understanding of the field will also infuse the perception of each person, ensuring a reasonably common perceptual faith in reality.

Before going any further here it is worth making a further note on the distinction between Merleau-Ponty's view of perception and that of empiricists. When Merleau-Ponty talks of perceptual faith and the perception of truth, of the way things really are, he is not speaking of a type of perception that can support scientific truth. This is not an experience of the world that can act independently of scientific theory, verifying or falsifying such theory. Instead, the perceptual faith is the very stuff that we begin with in all scientific inquiry, including of course the social sciences. It is the fundamental belief that the things of the world about which we speak really exist, and that this belief is prior to the beginning of any investigation, or to the questioning of something or the debating of a specific point. The view that we construct from that point onwards, whether in scientific theory and hypothesis, or simply in everyday knowledge and understanding, is just one of many constructions of the world that is possible through reflective consciousness. However, it is not possible for the seed of this consciousness to act as guarantor of the truth of the fruit. That is, the perceptual faith supports many different accounts and perspectives on the world, as both everyday experience and historical records testify, and cannot be the guarantor of just one. It is like the soil that our knowledge and consciousness is planted in rather than being the arbiter of hypotheses.

This points up an interesting contrast with the branch of critical psychology known as social constructionism. In his phenomenology, Merleau-Ponty is clearly lending credence to the view that all knowledge is a construct, a particular spin on the world woven out of human discourse in history. What

we know of the given world is clearly a construct of sciences and everyday beliefs as they exist at this moment in history, informing, as they do, our perception of the world around us. However, Merleau-Ponty does **not** say that reality itself is only a by-product or construct of knowledge or of reflexive and discursive consciousness. The perceptual faith we have in our world is prior to any constructions at the level of discursive and reflexive consciousness. Indeed, we can only have such knowledge of the world and debates about its nature providing we have a prior sense of the existence of things. Only in that way can we begin to construct different views and ideas about the nature of our world and the composition of the things in it. Even to deny that there is any objective reality at all, as the old solipsists did, is to begin from the premise that we all hold with certainty such a naïve primary view of the existence of things. What Merleau-Ponty's work challenges in social constructionism, then, is what Gergen (1996) once referred to as its 'ontological scepticism'. That is, its belief that nothing meaningful can be said about the world or about the existence of things independently of our socially and historically constructed knowledge about them.

Merleau-Ponty's phenomenology would challenge this on two counts. Firstly, Merleau-Ponty clearly believes that although there can be no direct reflection of the world or of being in socially constructed knowledge, nevertheless aspects of the world and of being do come through in language and knowledge. When we speak and begin to construct sciences it is in an attempt to capture the perceptual faith, to accurately describe the world of people and things in which we are constantly located. The fact that this can never be done successfully in any complete or final way is not in itself a denial of the perceptual faith, of our continual awareness of our embodied location in the world and in the universe. It simply means that the field in which we exist can never be exhausted or described in its entirety by language and thus internalised in human reflexive consciousness. Instead, the things themselves only appear in partial and refracted ways in language and reflexive consciousness. When we engage in discourse, then, at whatever level that may be, such as scientific debate or everyday conversation, we are constantly talking about an experience that is not itself fundamentally linguistic. For Merleau-Ponty (1968), paraphrasing Lacan, embodied perceptual experience – in particular vision – is structured like a language and therefore is open to being translated into language: however, it is not itself composed of language. As a child develops into adult life, language will deepen and extend its understanding of reality, adding to it entirely new dimensions, but language does not constitute the entirety of perceptual faith or of experience. The perceptual field in which we are located contributes as much to perception as does the constructive human activity – both practical and linguistic – that takes place in that field.

The second difference with social constructionism is that what is essential in the constitution of perceptual faith is our embodied being in the world. Perception takes form in the fundamental relation between embodied human persons and the perceptual field in which they are embedded. It therefore emerges from the constitution of our bodies and by the way they relate to the world in which they exist. We can become aware of the world and certain of its existence as an objective and stable reality only because we ourselves are partly objects in the world. However, for Merleau-Ponty, we differ from these other objects in that we are what he called the 'sensible sentients', in that our bodies have the capacity for 'doubling back' on themselves. We become aware of other people and things because we too are a material presence in the same way that they are. However, we are also sensible of our presence in the world in the way that inanimate objects are not: as humans, we can feel ourselves touching other people or things and are also aware of touching ourselves. It is in that moment that we are revealed as the sensible sentients, in the split second between the awareness of one of our hands touching the other hand and then the awareness in that hand of being touched by the other. In the

movement of that one split second into the next we reveal ourselves as aware of our continual existence as both object and subect; as present to the touch of self and other, yet also sensible of being touched and of touching others. We are aware of our existence as sensible sentients woven into the whole fabric of being, in which we and other people or things share of the same flesh. This is why Merleau-Ponty referred to 'the flesh' as being 'elemental': that is to say, the flesh is not composed of the brute physical fact of the embodiment of people and things. The flesh of the world is the relation of all the people and things in the world to one another and the mutual effects of these people and things upon one another. It is of this flesh that perception is made.

What we initially perceive, and what we carry as perceptual faith throughout the rest of our lives at some fundamental level of our being, is the **relation** between our embodied selves and the world. It is this relation that orders and forms perceptive awareness rather than any ingrained structures of the brain or mind, or, in contrast, any prior structure and organisation of the environment which imposes itself on the form of perception. Perception is therefore neither a subjective nor an objective phenomenon and, instead, is prior to the reflexively constructed human ideas of an objective and subjective world.

However, what this means is that perception and the perceptual faith is not something that is fixed and given for all time. The perception we have of reality is multidimensional and exists at different levels of our being. In one of its many dimensions, perception contains an element of universality as all human beings belong to a world composed of similar fields with similar horizons, shapes and contours, illuminated by ambient light and enlivened by sound. In another dimension, the perceptual field of particular groups may be composed of different details or specific elements special to that field. Viewed from an individual dimension, each person within the social group is located in a different relation to the perceptual field from all the others, so that each one of us perceives from a different point of view. Because of the other dimensions of the field, and because we are mobile and see from continually changing perspectives, we all have some idea of the totality of the common perceptual field, of the existence of things not immediately in the range of our visual, aural or tactile perception. Presence and absence are therefore constant partners in the perception of the world. However, particular events are always seen in the immediate moment, from our own point of view, so that our perception always has in it an element of our **individually situated** relation to the world. The perceiver and the perceived (or two perceivers for that matter) are always united by a situated relation and therefore perception is always, by its very nature, partial.

Yet this is supplemented once more by another dimension, which is the views and perspectives of others. As humans we live in a social world and do not have a purely individual relation to the world. As sensible sentients we are aware of the fact that other human beings are the same as us and are therefore able to listen to other points of view and to see from other perspectives. Indeed, Merleau-Ponty's (1968) definition of vision is to be distinguished from his (infrequent) use of the term sight. To have sight is simply the physical fact of being able to see, but to have vision is to have a sense of the perceptual field in which we ourselves are located as a sensible sentient amongst others. To have vision is to be able to see ourselves as an object amongst others situated in the world of other things and also sensible sentient things. Having vision is predicated on the fact that we are aware of others seeing us as we can see them, and thus we are able to see ourselves as others see us. Perception, then, is intricately bound up in our belonging to both a perceptual field and to a social world, so that these elements are themselves enveloped in one another as different dimensions of the world.

In turn this leads us into another dimension, that of culture and history. For Merleau-Ponty, perception is always swathed in the aura of culture and history. Not only are we located in a social world on an everyday level, but our understanding of the world is formed through socially constructed, historically situated, knowledge. Of course, knowledge and understanding are not exactly the same thing as perception and Merleu-Ponty would argue that we never lose the perceptual faith in a basic reality in which we are enmeshed as human beings. However, socially constructed knowledge and understanding does alter perception at a certain level: while it may not change perceptual faith, it does colour and add another dimension to our perception of the world. For example, through science and technology we have an understanding of the sub-atomic level of all things. We know they are made up of strings of particles that we can only see and perceive with the aid of scientific instruments. We therefore know that at a certain level the things in our world are not as stable and solid as they may seem to unaided human perception. And yet in everyday activity that does not alter our perceptual faith in the reality of our world: it does not stop us placing our books or resting the weight of our bodies on our desk, sure in the knowledge that it will support us and other things. Perceptual faith still exists and is one of the main orientations for everyday action.

Merleau-Ponty's ideas, then, do not contradict some of the main elements of social constructionism, which has been so important in shaping aspects of critical psychology. However, through an understanding of perception, phenomenology can add an extra dimension to critical psychology by reintroducing the notion of embodied perception that is not reducible either to physiology or to a material world that is given prior to sensuous human activity. However, in his later work, Merleau-Ponty (1968) offers another possibility for critical psychology, that it might be able to develop an ontology. Such an ontology is to be found not only in Merleau-Ponty's work on perception and activity, but in his developing notion of Being and of how this is composed of elements and dimensions. This would be an ontology that, as we have already seen, contains both universal and variable, relative elements. Much more work would need to be done on developing this ontology within critical psychology.

The question we want to address now is how the phenomenological approach would change research methodology in critical psychology. To bring forth its potential as a tool for research, we have chosen the study of anorexia nervosa as an illustration of how phenomenology might add some extra dimensions to the investigation of a particular social/psychological/physiological dilemma. First, though, we begin by looking at how the dilemma has already been dealt with and constructed by different protagonists in the debate.

The Study of Anorexia Nervosa in Clinical/Medical Models

In the clinical literature on 'eating disorders', the notion that they are a pathology of the individual person has been the motor for a wide scope of research. However, anorexia and bulimia are appearing more commonly in diverse populations of women, making the possibility of describing a common profile for these cases less and less likely. As each proposed model is destabilised by the actual diversity of the phenomena, more and more effort is made by clinicians to create a 'multidimensional model' for the explanation of 'eating disorders'. However, the multidimensional model proposed by clinicians tends to leave out the crucial dimension of culture. The one unifying factor that clearly exists in cases of anorexia and bulimia is the construction of gender, as most cases are among women (Bordo, 1992). However, in clinical models the role of gender is merely a

contributory or facilitating factor. The prevailing understanding is that culture provokes and gives a distinctive form to an already existing underlying pathological condition, which is medical in its origin.

Against this clinical perspective, feminists argue that culture is not merely a contributory factor in conditions like anorexia. Culture cannot be a modulator when the vast majority of cases of 'eating disorders' are among women (Bordo, 1993). Furthermore, it is argued that most cases can be culturally and historically situated in the advanced industrial societies within the last one hundred years, so they cannot be primarily physiological in their causation or else there would be an even occurrence of 'eating disorders' throughout history.

Yet many medical practitioners would not accept the feminist position. While many would accept that cultural pressures, from advertising and from the beauty and fashion industries, may make women especially vulnerable to 'eating disorders' it is nevertheless pointed out that not all women exposed to these pressures develop anorexia or bulimia. Therefore, other 'non-sociocultural' factors like perceptual disturbances or deficits in autonomy are then considered to be primary in the determination of the 'disorders' (Fairburn, 1993). For example, the Body Image Distortion Syndrome test (BIDS), often used in the diagnostic criteria of anorexia nervosa, has functioned to emphasise the discontinuity between the anorectic and 'normal' perception of body image and body weight. In the clinical literature, the initial theorising of BIDS as a visual misperception clearly placed anorexia within the medical, mechanistic model of illness. The anorectic, then, is constructed as a person with an 'inner defect' that prevents them from forming a realistic image of their body.

In the next stage of development, the medical view of anorexia was modified so that the distortion of the body image was understood as caused by an affective/cognitive coloration rather than a defect in the perceptual mechanisms. According to the affective/cognitive theory, it is not that women actually see themselves as fat, rather they evaluate what they see according to extremely self-critical standards (for example, because of a so called lack of self-esteem) (Szmuckler, 1995). According to the cognitive view, it is not perception that is the problem, rather it is 'disordered cognitions' that lie at the root of the problem of anorexia. The elements of this faulty thinking include:

- Magical thoughts or superstitious thinking
- Selective abstraction of thinness as the sole frame of reference for inferring self-worth
- Dichotomous reasoning concerning food, eating and weight
- Personalisation and egocentric interpretations of impersonal events

However, from our perspective, what must be questioned in this model is the conceptualisation of anorexia as the product of the invalid logic, faulty reasoning or flawed perception of individuals. These constructions portray the anorectic and bulimic as incorrectly processing data from an external reality whose actual features are very different from the perceptions and cognitions of the anorectic. From the phenomenological perspective, clinicians are making two enormous mistakes in their conception of anorexia. Firstly, they are treating the body as a mechanism that either functions normally or pathologically: either way, the body is simply a machine that processes information from an external environment. The body is clearly not understood as a being - as a living person who actively participates in and constructs their world. Clinicians are not only failing to take account of culture in the way that a condition like anorexia is lived, they are failing to understand how culture is lived in an embodied and situated way in the experience of an individual. Secondly, clinicians are taking for

granted that they, as medical scientists, have access to an unquestionable truth about the nature of a stable and unchanging external reality. They are failing to understand that while there is an embodied perception of the world, this is lived from a situated perspective that is both individual (the person's relation to the world and their experience of important life events) and socio-historical. So while they are trying to build multidimensional models, these do not include the dimensions of the lived body, nor do they take account of the fact that the body lives in culture. Because of this, as in most empirical models, the perspective of the scientist is taken to be universal and a-historical, a God's eye view of the world which can comment on the true nature of a patient's reality and then, given that the patient's perception of reality is different, can classify that perception as not according with the true reality. The patient's perception thereby becomes classified as 'distorted'.

From the phenomenological perspective, it could **not** be said that the anorectic's perception is 'distorted'. It could be noted that there is a difference between the perspective of the anorectic and of those who are in contact with her, such as family, friends or doctors. However, if the anorectic's perception of her body is of a fat body, then that is her perception; it is not changed or disqualified by the differing perceptions of those who surround her. It is her lived perception, the way she feels living in her body, and this is not changed by others trying to convince her that their differing perceptions are correct, then becoming frustrated or resorting to medical explanation when she fails to 'see [the other's] reason'. Instead, phenomenology would inquire into the anorectic's perception of reality: what are the elements that make up her lived, embodied perception of reality?

Feminist Approaches and Phenomenology

The feminist approach has recently challenged the clinical paradigm and the practice of clinical therapy in the treatment of anorexia. The feminist paradigm has (1) cast into doubt the designation of anorexia and bulimia as 'diseases', instead emphasising the learned, addictive aspect of eating disorders; (2) reconstructed the role of culture and especially gender as primary and productive in the emergence of anorexia, rather than as a merely contributing factor; and (3) re-conceptualised the factors in anorexia usually viewed by the medical model as pertaining to individual pathology as instead belonging at the level of social pathology.

The feminist perspective on eating disorders has, in general, been distinguished both by a commitment to taking the perceptions of women seriously and by recognising the necessity of a socio-cultural analysis of the phenomenon. When a woman insists that the only way to succeed in our culture is to be thin, then she would be described by clinicians as possessing distorted reasoning or misperception of reality. From a feminist perspective this approach ignores that, for most people in Western culture, especially in regard of women, slenderness is equated with competence, self-control and intelligence. The feminist perspective does not question the anorectic's painful suffering. However, what is at stake is the question of whether that suffering is caused by individual pathology which marks a clear difference between the profile of eating-disordered women and those who do not display such a disorder. For feminists, there is no firm demarcation between the normal and the pathological, as most women are affected in some way by the cultural construction of female beauty as involving slenderness. This means that most, if not all, women have some problems in relation to the consumption of food. Instead of a strict and discernible demarcation between the normal and pathological, there is a continuum of eating problems which ranges from dieting to the extremes of anorexia and bulimia. Behind this lies a culture which is driving more, and younger, girls and women

into the regimes of rigorous dieting and exercise, largely by encouraging the fear of gaining weight. The feminist approach does not, then, deny the severity of the anorectic's situation but instead calls attention to the severity of the cultural situation that has produced it, particularly for women. What we are all exposed to are homogenising and normalising images and ideologies concerning femininities and notions of female beauty. (And increasingly for men, images of muscular, fit and youthful masculine beauty). However, the unique configurations of each person's life will determine how actual women are variously affected. Although there is clearly heterogeneity of situations and responses, no one is situated outside the empire of normalising directives.

For example, Bordo (1988) has claimed that anorexia is a product of three cultural axes which mark the socially and culturally mediated relation we have with our bodies and the way that, through this mediation, they are normalised. Firstly, there is the dualist axis on which the body is felt to be separate from the experience of being a person and a mind. This goes back to the legacy of Rene Descartes and his separation between mind and body, the body being a mere automaton whereas the mind was the seat of the person or soul – the 'I'. This leads to the second cultural axis, that of control, where the body is seen merely as a mute instrument to be controlled by the person. In fact, in most accounts given by anorectics about their anorexia, the issue of control looms large, as Bordo illustrates with examples drawn from interviews with anorectics and also from their writings. The third axis is gender/power, in which women are subjected to images of female beauty which include youthfulness, slenderness and, in some instances, a kind of boyish, lanky athleticism. This is the ideal 'image of a woman in which she is not yet a woman', and equates with the noted tendency of anorectics to want to retain their more gangly adolescent physique and to resist the more developed female form which is often perceived as fatter and more curved. This latter female physique is often equated with what is regarded as voracious female appetites that cannot be controlled – on the surface, the desire for food as felt in hunger, but on a more suppressed level, the appetite for sex, which according to male ideology is insatiable unless strictly controlled. As Bordo (1988: 108) says,

> 'On the gender/power axis the female body appears, then, as the unknowing medium of the historical ebbs and flows of the fear of woman-as-too-much. That, as we have seen, is how the anorexic experiences her female, bodily self: as voracious, wanton, needful of forceful control by her male will'.

The feminist approach is therefore important in the study of anorexia as it analyses the cultural context in which women experience their bodies. However, it puts more emphasis on the notion of the woman's body as signified rather than signifying: that is to say, it concentrates on how the female body has been signified in a male dominated culture with a largely male influenced ideology. There is less emphasis on the way that women actually live their bodies as a means of expression, and Iris Marion Young (1990) is one of the few feminists to have attempted an analysis from a phenomenological perspective. In a phenomenological framework the body is not only seen as a signified entity, something which is made to signify in the realms of ideology, discourse or power relations, but is also seen as an expressive device which communicates something about the lived experience of women: about their struggles and the contradictions they face in the culture in which they are situated.

Baerveldt and Voestermans (1998) have attempted a phenomenological study of the body in cases of anorexia nervosa and suggest a similar approach to the one we are advocating here. They place emphasis on the body as a communicative entity and stress the importance of bodily communication as a continuous flow of co-regulative skills deployed in ongoing social interaction. However, a problem

with their phenomenological approach is that they suggest anorexia may be the product of a disturbance in the realm of these social skills and practices. While on the one hand they criticise some feminist and social constructionist approaches to anorexia for 'rendering the body of the anorectic as a mannequin that shows the effects of domination and submission, or as a battleground for feminist arguments, dilemmas and discourses, [which] keeps hidden the anorectic's bodily production of meaning' (Baerveldt and Voestermans: 177) they themselves do not enquire into that bodily production of meaning. Instead they suggest that;

> 'The failure of anorectics, if one may put it that way without morally judging those women, is a matter not so much of a distortion of their body image as a lack of co-regulative skills that serve the selfing process. These skills are not developed adequately. In consequence, the women who suffer from anorexia are much more vulnerable to the pitfalls of an extreme dualistic relation to their own bodies, resulting in bodily dissatisfaction and need for mental control' (Baerveldt and Voestermans: 177).

The problem with this conclusion, however, is that it is not phenomenological in essence and delivers anorexia back to the clinicians and mainstream psychologists. The suggestion that anorexia is a 'failure' of social skills is a moral judgement, whichever way you look at it, and the conclusion that the treatment of anorexia should focus more on social skills training in the anorectic's environment is to keep this problem enmeshed in the world of the clinical psychologist. Indeed, Baerveldt and Voestermans retain much of the language of the clinician, referring to the anorectic's 'distortion' of body image and 'failure' to 'develop adequately'. The only resort then is to refer the anorectic for some kind of clinical treatment. Baerveldt and Voestermans judge both the anorectic and the feminist response to anorexia far too harshly, failing to attempt to understand the meanings revealed in the anorectics symptoms and the social meanings uncovered in the feminist interpretation of the condition.

In our phenomenological approach we want to suggest an alternative building on Merleau-Ponty's (1964b) concept of 'introception'. This concept was developed in an article on child development in which Merleau-Ponty suggested that introception, as opposed to introspection, is primary in the psychological development of individuals. Introception is the feel that we have of what it is like to live in and through our bodies and to perceive other people and things in our bodily relationship to them. Introception, then, partly depends on the way my body is, on the presence or absence of body parts, organs and their functions, and also on the relation of my body both to the world and to others within culture. Following Merleau-Ponty's multidimensional approach to perception and embodiment, we can now also develop a multidimensional view of personhood through the idea of introception. That is, identity is constituted around the physical body and the way in which we develop a feel for what our body is like, as sensed by ourselves and as visible to others: yet at the same time the feel and the image we develop of our body is also linked to how we learn to express ourselves symbolically within culture and the values that a culture places on certain body types, or parts of bodies. Body-image and self-image – the two must be interrelated if not identical – is to be located neither within the body, in its perceptual organs or cognitive processes, nor outside the body in culture and discourse. Instead, it is dependent on how these elements are interrelated in the course of a person's life. In this view, the meaning of the lived experience of body-image and self-image is not internal to the body, but depends on how physiology is articulated and identity is formed within the networks of social relations and practices.

From this phenomenological perspective, we cannot say that anyone has a false or distorted image or perception of their body. What we can say is that there are always some discrepancies between our own feeling of being our body and the image we develop of it, and the perceptions and images that others have of us seeing our bodily-self from another perspective. Put simply, I never see myself exactly as others see me. In anorexia this difference between first person experience and second person experience is merely more exaggerated. But then the question follows as to why that should be and why the anorectic experiences her body the way she does: what is the meaning of the anorectic's introceptive feel of her body?

Given that phenomenology advocates a multidimensional approach there is no one answer to this question. However, we can outline an approach in general. To begin with, we must take as primary the culture in which we live and the social meanings by which we act and live our lives. Yet in phenomenology, culture is lived from a particular embodied perspective and we develop perceptions of our body and its relation to the world from that situated position. Therefore, there are always bound to be personal factors in the introceptive feel we develop of our bodies and our relation to the world. It is these personal and situated factors that will contain clues as to why some women but not others develop anorexia despite the cultural pressures on all women to be sleek and slender.

The next distinctive aspect of the phenomenological approach is that the body is not to be treated as an automaton, as it is in the medical model, but as a person whose body expresses their life and their relation to the world in an active, communicative way. The body will contribute something to this process but that does not mean that the anorectic body is pathological. For example, Gatens (1996) has argued that there is a contingent yet necessary relation between the body and culture. An illustration of this is in the relationship of power and gender where the sexed body acts as a demarcation of what is male and female and also signifies power. In male dominated societies it is the male body that comes to signify power and authority, and it also serves as the model for the order of civil society. This does not mean that the different bodies of males and females have this signification universally, but that aspects of different bodies signify in a variety of ways in specific cultures. The same can also be said of the anorectic. As Bordo (1988) points out, most anorectics are pursuing the boyish body ideal of today, which seems to be surrounded by an aura of freedom and independence. However, the body shape of most mature women does not fit this ideal and therefore they must spend hours each day dieting and exercising, or simply give up trying to attain it. In opposition to this, the bodies of mature women tend to have more body fat than the bodies of younger boys and are also rounder and more full. In turn this 'womanish fat' seems to symbolise women's supposedly voracious appetites and also, for many women, the domesticity they associate with their mothers (Bordo, 1988: 102).

Thus for many women anorexia appears to be a fight against their own bodies; not the pathological body, but the average adult female body that is complexly and ambiguously symbolised in contemporary Western culture. Living a body so ambiguously symbolised is the problem for many women, rather than an internally distorted perception of their own body or cognitive malfunctions in the processing of information. In pursuit of their ideal body image and against the fact of their embodiment as adult women, most anorectics end up mutilating their bodies: however, the pathologies that result from this, along with the effects of prolonged starvation, are a product of and not the cause of their condition. Perhaps what feminism has not fully explained is why women are driven to do this to themselves? Bordo remarks that the body of the anorectic is an illustration of how deeply power relations are etched on our bodies and how well our bodies serve them. Yet this is a view of humans

as cultural dopes, hopelessly locked into the logic of power relations without a hint of the idea that these relations are actually lived.

However, Bordo does provide a clue in her writings as to what the motivation of the anorectic might be when she says that the incidence of anorexia has grown as the power of women in society has increased. We can say that, looking at the situation through the nineteenth, twentieth and into the early twenty-first century the power and success of women within society has slowly increased. Women are now doing far better in education than men and are gaining the knowledge and skills that put them in a far better position of gaining good employment and economic wealth. However, looking at positions of power in society, in government or in leading business corporations, men still outnumber women in terms of their attainment of power and authority. The contradiction most women face is of growing achievement within society yet still, in the present moment, being shut out of positions of power and influence. Although this may change in the future, in the recent past and the present this has created an unbearable tension between ambition and apparent success, on the one hand, and failure to achieve ultimate goals on the other. The tension here may drive women into control of those things that are at hand and open to being controlled, such as her own body. In these instances, women are not to be seen as puppets caught in the webs of power, or as passive bodies inscribed by power relations or discourses, but as active embodied beings living out the contradictions and tensions in their lives through the materials at hand, including their own bodies.

There is also the question here of what an image of the powerful female body would be like? As Gatens claimed, the powerful, capable, normal body traditionally has been symbolised in Western culture by the male body. Men have expressed their fear of female power in the view of the female body as insatiable and devouring. But what would a positive image of a powerful female body be like, one created by women themselves? This we don't yet know. And neither does the anorectic. When she looks for symbols of power, she finds the male not the female body image and this may be part of the problem she finds living her body as a modern woman.

What we need to consider now is how all these points relate to therapeutic work with anorectics and how they may change clinical practice. Therapy is such an established part of the treatment of anorexia that we cannot escape it. Also to change definitions of anorexia we need to engage with clinical practice, as many concepts are formed by clinicians. Clinical practice is the mainstream in the conceptualisation and treatment of anorexia, so that to ignore it would be to relegate critical ideas to the fringes of theory and practice with little effect for the treatment of most women. Our conclusion will then look at how some of the ideas we are developing here might be applied to and change clinical practice from within.

Conclusion. From the Broken Dialogue to the Dynamics of Introception: Some Indications for Clinical Therapy.

The conceptions of eating disorders clearly have changed over time, from mythological conceptions (the first recorded cases were known as 'holly anorectics') to a mass industry on anorexia incorporating concepts from clinical psychology and medicine (e.g. articles on anorexia appearing in newspapers, magazines and so on). However, although ideas within society about anorexia are

constantly changing as they circulate through the media, in mainstream clinical research and practice very little has changed. The notion that anorexia is an illness remains basically unchallenged. Clinicians categorize symptoms into syndromes that are operationally defined and analyzed 'objectively'. Individual women are offered reductionist explanations and biomedical cures for their symptoms.

From a clinical point of view, the diagnosis of anorexia is based in the notion of the 'abnormal body' and in the conception of the body as an automaton (Toro, 1990; Puente Muñoz, 1998). Feminists already complain about this clear division of 'normal' and 'abnormal' feminities. Whereas healthy teenagers are assumed to be normal, anorectics are considered abnormal. In this account, the use of questionnaires, among other empiricist methodology, is used to classify and categorize the symptoms in order to determine whether a person has anorexia or not. Through these methods a dichotomy is created between the normal or abnormal. This focus on the physical body and the assumption of biomedical factors that can be observed and measured in an objective manner, remove the potentially confounding nature of the woman's bodily experience.

Within the existing research on eating disorders, each of the variables which appear in the biomedical, psychosocial or multi-factorial models is clearly operationally defined, reinforcing the assumption that they are discrete antecedent entities with independent causal influence in the evolution of specific syndromes. The very premise of causal relationship moves the study of anorexia to general laws which are applied in a range of cases. In this attempt, the goal of clinical practice is to remove the possibility of bias or of values, and to examine research questions by testing hypotheses in a precise and replicable manner. By the same token, the woman's account of her anorexia is considered to be a biased or 'subjective' form of reasoning (Fernandez-Ballesteros, 1994). The anorectic and her body is treated, in this context, as an object for medical research and practice. The subjects (doctors), detached from all objects (including the anorectic patient), fixes the object of the anorectic's body in its gaze, monitoring and knowing it with full certainty. The object is determinate and definable, with clear boundaries, separated from other objects.

In this sense, it can be said that placing anorexia within the bounds of clinical therapy and objectifying the person and their body creates a broken dialogue between nature and society, between men and women, between pathology and normality, between doctor and patient, and between anorexia as illness and human experience. The language of clinical psychology, which is a monologue of reason about eating disorders, has been established at the cost of creating these dichotomies of experience.

An important aim in clinical therapy, according to our view, should be to develop ways in which anorexia can be, in a sense, un-mastered: that is, stripped of its status as 'objective' and 'other' and reconfigured in the language of relationship and recognition, a turnabout with implications for all areas of theory and practice. This path, from a broken dialogue to what might be called the 'dynamics of introception', also necessarily leads to a transformative and political dimension on anorexia.

Merleau-Ponty's concept of introception was defined as the feel we have of what is like to live in and thorugh our bodies and to perceive other people and things in our bodily relationship to them. The perceiver and the perceived are always united by a situated relation and its partial perception. Here, presence and absence are constant partners in the world, no longer a dichotomy. Because of this, it cannot be argued that the clinician represents objective truth, reason and reality, while the anorectic is defined only by absence – of reason and the 'correct' perception of reality. Instead, it must be argued that both the clinician and the anorectic are involved in an ongoing and situated relationship in which

they are constructing their surroundings and being constructed by the other. The phenomenological approach emphasizes how we see and experience from different perspectives, therefore a clinical approach informed by this view would involve the necessity of reciprocal understanding between the therapist and the anorectic.

This concept of introception brings us to the metaphor of 'the fluid'. Fluids, unlike objects, have no definite borders; they are unstable. This does not mean, though, that they are without pattern. Fluids surge and move, and a logic that thinks as fluid would tend to privilege the living, moving, pulsing over the inert dead body of the Cartesian world view. Furthermore, under this new logic of ambivalence and fluid absence and presence, the clinician cannot see without being seen and, as a result, the anorectic is simultaneously active. Her commitments and body practices have a positive force for change. In this sense, the distress and misery experienced by anorectic girls cannot be ignored and passed off as the result of illness, but must be engaged with in the context of a mutual human relationship situated in a particular culture.

In this attempt to see the anorectic experience as a positive force, we will also use some pragmatist ideas (Rorty, 1989) in order to give some indications for an 'alternative therapy'. These include the concept of,

- Foundationlessness. While clinical practice emphasizes universal knowledge, we think that knowledge is located in the local and the contextual. Therefore our values are grounded in a society and psychological attempts only reflect local moral orders and not human essences, so anorexia has a value in itself as a social and moral condition. The accounts of anorectic women should not, then, be reconstructed through the language and values of the clinician and instead therapy should be a dialogic process.

- Fragmentation. The psychological paradigm often considers surface behaviours to be caused by deeper unconscious motives or mechanisms. But in our view, the depth of emotions must only be considered a spatial metaphor applied to a person. Instead, we see ambivalence between opposites as a way of understanding anorectic reality. The spirit of both rather than either/or predominates, reflecting this ambivalent reality. For example, we have already dwelt on the contradiction faced by modern women in the opposition between increasing success in society but continued marginalisation from positions of power. Such contradictions in society could become the focus of clinical practice itself, so that clinical practice is not seen as opposite to, and not engaged with, society. It also takes into account the ambivalent and fragmentary reality that is often a central aspect of the anorectic's experience. However, even a dialogically informed therapy will experience limits in effecting social change and cannot be taken as a panacea for the problem of anorexia.

- Pragmatism. Following Rorty (1989), truth is defined in terms of what is good by way of belief. In our imperfect construction of reality (what Merleau-Ponty viewed as partiality), we can never assume that we have arrived at a final and definitive description of it. Constructions cannot be evaluated in terms of their truth because there is no ultimately correct way of construing anything. Our constructions then, are to be judged not in terms of their truth but for their usefulness. The pragmatic approach would pay less attention to the syndrome criteria, and – emphasizing the practical context of action - more to the meaning that would allow the anorectic girl to create new possibilities for action.

We believe that the above points provide new indications for an alternative therapy with anorectic women and men. This reflects the multidimensional approach of phenomenology taking into account the way that people live their bodies with the world, especially the social world. From this point of view, where culture is seen as lived through the body, we cannot work with notions of the defective or pathological body, one which suffers 'distortions' in perception. Instead, the anorectic's experience has to be taken as a reflection of her lived reality and worked with in a positive and dialogical manner. As we have indicated in the points above, this would mean the therapist giving up their objective position, or their privilege of accounting for the anorectic's underlying problem in terms of some favoured theory. Instead, the therapist has to work in a phenomenological and pragmatic way with the anorectic's own meanings, rather than substituting meanings of their own. Perhaps within the anorectic's own embodied and lived experience there will be elements that can be used in the alleviation of her suffering.

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