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LOYOLA UNIVERSITY CHICAGO

THE USES OF EXPERTISE:
SCIENCE, MEDICINE AND BODY/SELF-FASHIONING

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

PROGRAM IN SOCIOLOGY

BY

AMANDA J. COUNTS

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One of the main intellectual activities of our century has been the questioning, not to say
the undermining, of authority.

(Said 1996)

Inherently unstable, the body is always in a paradoxical process of becoming –
and becoming undone.

(Albright 2007)

ABSTRACT

This paper draws on empirical evidence collected from pro-anorexia websites and qualitative interviews with dieters to develop an analysis of the uses of medical and scientific expertise in processes of body- and self-fashioning. It builds on previous work by examining how ‘lay publics’ refashion expertise in order to use it for new purposes, sometimes contradictory to the purposes of medicine itself. Four distinct groups are analyzed: Women diagnosed with anorexia; women diagnosed with EDNOS (Eating Disorder Not Otherwise Specified); dieters using traditional methods of caloric restricting; and dieters using a new method called Primal Dieting.

Overall, respondents indicated an ambivalence toward medical and scientific expertise and the criteria used to evaluate expert discourses. Refashioning of expertise was conditional upon three body/self strategies: (1) Moving oneself out of the discredited eating disorder diagnosis EDNOS; (2) Recreating the eating and living practices of ‘Paleolithic Man’ through Primal Dieting; and (3) Creating moral boundaries around those who engage in body-work and diet practices and those who don’t. While it has been suggested that lay practices and belief systems represent an epistemological challenge to expert knowledges, this analysis suggests that there is considerable overlap between frameworks of ‘truth-making’ between the four groups and scientific medicine. This calls us to reexamine the relationship between the lay populace’s engagement with expertise in the twenty-first century, understood here to be simultaneously empowering and disempowering, embracing of and resistant to medicalization, subversive and affirmative of cultural norms of the body.

Introduction and Background

The notion of the ‘lay expert’ has been pivotal in contemporary sociological theories of medicalization. Whereas physicians’ professional power and ambition were theorized as the primary forces driving medicalization in the twentieth century (Friedson 1970; Illich 1976; Zola 1972; Conrad and Schneider 1992), in the twenty-first century, ‘lay publics’ play a new role vis-à-vis processes of *biomedicalization* (Clarke et al. 2003)¹. Increasingly in contemporary postindustrial society, people no longer consider expertise to reside exclusively in medical professionals and instead aspire to claim expertise in relation to their own bodies and experiences.

Within this context, information exchange on the Internet has become a ubiquitous feature of experiences of health and illness (Fox, Ward and O’Rourke 2005a; Nettleton, Burrows and O’Malley 2005). Online communities use communication technologies to facilitate information exchange in order to develop what some have termed ‘lay expertise’ (Williams and Popay 1994). As laypeople aspire to become medical experts themselves, it is imperative that social scientists begin to understand how people negotiate scientific and medical ‘expertise’ and what implications the diminished

¹ Medicalization is defined as the processes through which non-medical problems become defined and treated as medical problems, usually as illnesses or disorders (Conrad and Schneider 1992), whereas biomedicalization describes the increasingly complex, multisited, multidirectional processes of medicalization, including increased patient participation in defining health and illness through ‘technoscientific,’ medicalized frameworks (Clarke et al. 2003).

importance of medical and scientific ‘experts’ might have on people’s experiences of health and illness

Despite the mounting discourse surrounding ‘expert patients’ in medicalization scholarship, people still deal with their own health and illnesses largely in accordance with dominant elements of medical knowledge (Brown 1995). While physicians have lost their cultural omnipotence to some extent (McKinley and Marceau 2002), there persists a strong desire and discourse to frame one’s experiences within the paradigm of scientific medicine. Whether the ‘informed’ or ‘expert’ layperson actually challenges medical authority or simply reappropriates it for new purposes is a question worth considering and a primary concern of this paper. Recent sociological scholarship by Collins and Evans (2007) has called for a rethinking of expertise. Their work makes the case that concept of the ‘lay expert’ has been misguidedly theorized, arguing that having expertise no longer makes one a layperson, thus rendering the term ‘lay expert’ an oxymoron.

While efforts to deconstruct the lay/expert divide by Collins and Evans should be acknowledged, their concerns are largely focused on problems of demarcation between science and non-science. I argue that this reinforces imagined boundaries between lay and expert knowledges. I remain skeptical of the argument that scientific or ‘expert’ knowledges deserve *a priori* privileged epistemological status over non-expert knowledges. Instead, I agree with Armstrong that “modern medicine occupies no privileged epistemological position” (1985:11), and consider the findings of this study to

support other work demonstrating the considerable overlap between lay/expert knowledges (Horton-Salway 2004; Shaw 2002).

Theorizing ‘lay expertise’ and professional knowledge as separate bodies of knowledge, a focus on doctor/patient relationships and the inclination to view the institution of medicine and an instrument of social control are key elements in medicalization scholarship (Illich 1976; Friedson 1970; Starr 1982; Zola 1972); however, these approaches have major shortcomings when it comes to accounting for the complex, contradictory uses of scientific medicine and biomedicalization in the twenty-first century as it pertains to both health and illness.

Taking as a point of departure the limits of the medicalization thesis, this paper begins with a critical discussion of the more recent theoretical perspectives in relation to understanding the relationship between the lay populace and medical and scientific expertise. The structure of this paper is as follows: First, I offer a discussion about the history of theorizing ‘lay beliefs’ and ‘expertise’ in medical sociology, especially as it pertains to contested illness. Second, I discuss the limits of the medicalization thesis as it pertains to Giddens’ (1991) theory of reflexivity and what it might tell us about the tension between scientific medicine and the lay populace in contemporary life. Third, I offer a discussion of contemporary theories of *biomedicalization* and the attendant consequences for understanding health and illness in everyday life. Lastly, I draw on evidence collected from my qualitative study of the uses of medical and scientific expertise among people with eating disorders and people engaged in diet and fitness

regimens in order to examine how definitions of health and illness have become *reappropriated* by non-experts for non-medical purposes, including moral boundary-making and aspirational self-fashioning.

Literature Review

Theorizing 'Lay Beliefs' and 'Expertise'

Medical sociologists have suggested some key theoretical issues about lay and expert beliefs of health and illness, often conceptualizing 'lay' and 'expert' knowledge as separate bodies of knowledge with distinct aims and epistemologies. Hughes' early anthropological definition of lay beliefs as "beliefs and practices relating to disease which are not the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine"(1968:88) provided an original framework for thinking about the divide between professional knowledge and patient views of illness in medical sociology. Freidson (1970) built upon this work by examining the history of the medical profession. He argued that the lay people's conceptions of illness differ from the professionals and that lay accounts had a significant influence on people's behavior when dealing with illness. Furthermore, he argued that professionals should take into account lay beliefs in order to foster better health and combat 'professional dominance' in medicine. Starr (1982) expanded the professional dominance model by arguing that modern society's dependence on the professions created a "system for regulating belief" in which the lay populace must rely on professional interpretations in order to understand the world (16). This early scholarship

created an intellectual backdrop for sociological thinking about lay and expert knowledges as distinct bodies of knowledge in the 1970s and 1980s, often pitted against each other in struggles over the meanings of health and illness.

From the traditional medical professional perspective, lay beliefs about health and illness are often viewed as at best unreliable and at worst irrational and contrary to a person's health (Williams and Popay 1994). In their discussion on lay knowledge and the privilege of experience in medicine, Williams and Popay suggest two key characteristics of lay beliefs: (1) They are many and varied, not necessarily mimetic of medical science; and (2) They are internally consistent and coherent, even when odds with what is accepted by medicine. This approach of privileging lay knowledge as special and experiential, however, ignores the overlap between lay and expert knowledge, ranging from matters as diverse as definition, etiology and treatment (Fox, Ward and O'Rourke 2005b; Horton-Salway 2004; Shaw 2002).

That modern medical professionals have been historically concerned with the potential for lay or 'folk' beliefs to interfere with 'scientific' medicine and 'expertise' in the form of patient non-compliance in treatment (Nettleton, Burrows and O'Malley 2005) may have influenced the focus of medical sociology scholarship. The concern over whether medicine should 'democratize' and take seriously patient 'perspectives' or 'viewpoints' has particularly been a serious concern for contemporary sociologists studying 'contested illnesses' (Barker 2008; Copleton and Valle 2009; Dumit 2006; Epstein 2008; Pitts 2004; Zavestoski et al. 2004). A 'contested illness' is generally

understood as an illness that is regarded as less legitimate or less 'real' in both the medical realm and in everyday life (Bulow 2008). Contested illnesses highlight the political aspects of illness in that they typically involve the lay populace in the form of organized patient groups engaging in a struggle over the definitions of health and illness with medical experts.

Scholarship on contested illnesses have tended to center on conditions with medically unexplained physical symptoms (MUPS) such as fibromyalgia, chronic fatigue syndrome, multiple chemical sensitivity, Gulf War syndrome and premenstrual disorder (Barker 2008; Dumit 2006; Zavestoski et al. 2004; Figert 1996), but some studies have also focused on what could be considered more 'straightforward' conditions such as breast cancer, disability and celiac disease (Pitts 2004; Stone 2008; Copleton and Valle 2009). Within this spectrum of conditions, lay contestations can take various forms, from challenging aspects of the creation and application of diagnostic categories to a condition, to challenging how a problem or set of symptoms came to be defined as a 'legitimate' illness by the medical community, to contesting selected aspects of the illness experience, such as treatment or etiology (Conrad and Stults 2008).

Yet while there are growing concerns about the *overmedicalization* of society by some medical sociologists, other sociologists and advocates for contested illnesses frequently wish to *expand* medical categories and diagnoses. Furthermore, the increasing use of medical knowledge and medical tools among the lay populace to *self-diagnose* with contested illnesses (see Copleton and Valle 2009) suggests an *increased* trust in the

ability of scientific medicine to ‘uncover’ or ‘explain’ truth – not less. Thus by focusing on *differences* between ‘lay’ and ‘patient’ accounts and on its contrast with scientific medicine, studies of contested illnesses have largely ignored analyzing issues of overlapping epistemology between ‘lay’ knowledge and professional expertise.

Ignoring issues of epistemology has led to a misconceptualization of the similarities between ‘lay’ and ‘expert’ knowledges and has failed to recognize the ever increasing conflation between the two. For example, Banks and Prior (2001) describe the medical encounter as a “contest between the physician and patient to define the nature of the patients’ disorder” (12). Physicians and patients are described as using a “different conceptual terrain” with “different hypothesis” and having “conflicting ideas” about the nature and etiology of disease (12). Similarly, Shaw (2002), while critical of the lay/expert divide, nevertheless argues that the blurring of knowledge in the form of *appropriation* of expert knowledge by non-experts is a “trickle-down” process of appropriating simplified versions expert knowledge into the popular imagination. In other words, these scholars construct lay and expert knowledges as distinct *bodies of knowledges* – an idea ultimately unsupported by the findings provided in this paper.

Simultaneous Reliance and Skepticism: The Limits of ‘Medicalization’

A distinguishing feature of contemporary life is a paradoxical stance toward experts, characterized by simultaneous distrust and reliance on expert knowledge (Giddens 1991; Lupton and Chapman 1995; Nettleton, Burrows and O’Malley 2005). Tensions in the global capitalist market and risks associated with industrial development

have resulted in a breakdown of professional and expert categories and authority and an increase in skepticism among lay publics (Beck 1992, Giddens 1991). Giddens theorized late modernity as a time in which an increased availability of information has pushed individuals into a reflexive application of knowledge in everyday life. Within this subjective experience of reflexive selfhood, individuals simultaneously contest and adopt expert knowledge systems, reappropriating them into personal projects such as projects of the body, the self and lifestyle planning.

Another characteristic condition of late modernity is an increased focus on and anxiety about risk and risk-avoidance (Beck 1992; Lupton 1994). Medicine and science, as communicated through the media and the Internet, are integral to the definition and publicizing of health risks. Since many health risks in the biomedical era are invisible (such as genetic risk), they require technical knowledge to access knowledge about them and individuals must usually rely on authorities and experts in order to interpret the meanings of risk in these cases. Practices of diet, health and body weight, however, are practices that individuals can engage in based on personal experience, regardless of their personal medical or scientific knowledge. Thus, the self-management of body weight can be understood as a prime arena for the development of patient 'expertise' (Fox, Ward and O'Rourke 2005a). Practices of diet and body modification are a ripe source of information about how people choose to engage or disengage with expert knowledges about health and the body.

In a study on how members of the lay public respond to diet controversies in the media, Lupton and Chapman (1995) found that health claims from authorities are subjected to constant negotiation and perceived incredulity by the public. While participants expressed concern about their diet, they also expressed a high degree of cynicism in news media coverage about expert health advice on diet. *Constantly shifting* health information induces an imperative to be involved in a constant process of information sifting and reflexivity about health practices. Rather than an absence of illness, health is now a production, an achievement that one must work toward through constant vigilance and self-reflexivity.

Foucauldian approaches to the medicalization thesis have emphasized medical knowledge institutions as elements of control and surveillance over people's bodies and lives. According to Foucault, the medical view of the body termed the 'clinical gaze' emerged near the end of the 18th century as a result of larger social processes of the rationalization of society, creating an outside, disembodied understanding of the body. This view of the body as "something docile, that could be surveilled, used, transformed and improved" was a critical element to clinical examinations and microprocesses of medical power (Foucault 1973:121). The body-made- docile is a key theoretical element in Foucauldian medicalization theses. However, conceptualizations of docility and dependence have been challenged by recent sociological theories of medicine.

While the medicalization theory tends to assume blanket dependence and docility on the part of the lay public, newer theoretical perspectives have shed light on the

transformations of the relationship between the lay public and scientific medicine in the twenty-first century. In their biomedicalization thesis, Clarke et al. (2003) draw on Foucault's concept of "regimes of truth" in order to demonstrate how processes of biomedical knowledge production assume a role in wider constructions of social reality. The biomedicalization thesis examines how scientific medicine has come to occupy the social consciousness and affect everyday life, in the form of both expert knowledges and sociocultural practices, e.g., the formation of health- and illness-related identities and the customization of individual bodies. Described as a "politics of life itself" (Rose 2007), biomedicalization is not just a matter of rendering the lay public a 'docile body' as Foucault suggests, but rather, an *active* participation on the part of the lay public in matters of health and illness and a *transformation* of the roles that health, illness, science and medicine play in the process of self-understanding and self-fashioning in everyday life. This new direction in medicalization cannot be conceptualized as a top-down process but as emerging from "dispersed social locations" in response to the shifting changes of scientific medicine (Epstein 2008).

Reappropriating Medicine: Biomedical Subjectivities, Morality and the Body/Self

In order to understand the place of science and medicine in processes of self-fashioning, it is necessary to relate the meanings of health and illness to aspects of the wider sociocultural system. Previous scholarship in Western contexts has demonstrated that people develop subjectivities from the body practices they form in relation to the dominant medical view of the body (Beck 1992, Foucault 1973, Giddens 1991, Rose

2007). Foucault (1973) has suggested that the ways we perceive and think about the body in medical matters is reflection of the wider power relations in society. Medical knowledge about the body, he argues, is a means of acting on the body in a process of subtle power play, encouraging individuals to engage in self-surveillance and self-governance of their own bodies. In the biomedicalization era, health has come to mean not only the absence of illness, but the moral imperative to work toward health at all times. This move from health-as-an-achieved-state to health-as-a-constant-process transforms our subjectivities into thinking of ourselves as medico-scientific subjects in everyday life (Clarke et al. 2003). That we use knowledge of science and medicine to understand our identities and social lives is a key element in the ‘shifting engines’ of medicalization (Conrad 2005; see also Figert 2010). Biomedicalization creates a new form of subjectivity, simultaneously encompassing concepts of “agency, empowerment, confusion, resistance, responsibility, docility, subjugation, citizenship...and morality” and the intersections of self, medicine and science (Clarke et al. 2003:185).

Theoretically, I situate this study in the context of sociological theories of self-fashioning conducted around food, fitness and the body. Sociological scholarship on the body has suggested that the body is a strategic site or *apparatus* for self-work and self-fashioning (Foucault 1988; Lupton 1996; Maguire 2008; Moore 2010). The use of body work and nutritional science as a form of self-fashioning is particularly salient among what Kelly Moore (2010) has termed the “striver class” – people who are typically middle-class who engage in pursuits of body- and self-making in order to change their

habitus and secure culture capital (Bourdieu 1984). The striver class aims for constant self-betterment through applications of the latest trends in science, health and expertise. These practices of self-making and self-distinction revolve around food and exercise at a historical time period in which eating and controlling the body are associated more and more with values of the self (Lupton 1996). This has lead me to conceptualize the body and the self not as separate entities but as the *body/self*, a concept that recognizes not only that the self is inherently embodied but that the two are increasingly conflated with one another in contemporary processes of biomedicalization.

The ‘fit’ body is an important form of capital and a site of investment and work (Maguire 2008). The *physical* capital of the body has cultural capital insofar as a fit body is presumed to inherit culturally valuable qualities *health* as well as a valued aesthetic *appearance* among the middle-class. Using a Foucauldian approach to self-fashioning, I conceptualize diet and exercise practices not as only bodily practices or a cultural inscription *upon* the body (as Susan Bordo might suggest), but as a *technology of the self* (Foucault 1977). Technologies of self are methods and tools through human beings constitute their selves and their subjectivity. Foucault argues that technologies of self “permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (1988:18). They are also specific strategies and knowledge-practices through which subject-positions can become inhabited – i.e., being a

‘anorexic’ subject, or a ‘Primal’ dieter. I will argue that practices of diet and exercise can also serve as an apparatus for fashioning a moral self.

Recent scholarship on contemporary processes of self-construction has suggested that the concepts of ‘self,’ ‘health,’ ‘morality’ and ‘responsibility’ have become inextricably linked to such an extent that the “pursuit of health has become the pursuit of moral personhood” (Crawford 1994:1347). Crawford has argued that contemporary processes of self-fashioning involves moral boundary work between the ‘healthy/self’ and ‘unhealthy/other’ whereby the attendant moral implications of being healthy and unhealthy are fashioned oppositionally to one another. Links between food consumption, the body and morality in which judgments about ‘good’ and ‘bad’ eating behavior and body size are based on assumptions about ‘good’ and ‘bad’ people (Backett 1992; McPhail, Chapman and Beagan 2011; Metzl 2010). In postindustrial Western society, bodily maintenance has become “the most visible signifier of morality and one’s adherence to the dictates of an ethical lifestyle” (Murray 2009:80-1).

Historically, overeating has been framed as a sign of gluttony and overweight individuals are stigmatized as lazy, undisciplined, greedy and lacking in self-respect, while undereating has been associated with self-discipline, asceticism and moral restraint (Brumberg 2000; Lupton 1996; Malson 1998). Unhealthy eating is regarded as an amoral act, and thus discriminatory diet and body practices – what McPhail, Chapman and Beagan (2011) term “discriminatory health moralities” – serve to reinforce class identities as part of being a good, informed and responsible citizen.

This study builds on previous scholarship on health, food and the body by examining the ways in which medical and scientific expertise on the body contribute to moral self-fashioning in the biomedical era. By looking at two sources of evidence – dieters and people with eating disorders – I was able to shed light on the different uses of expertise as it pertains to body/self-fashioning.

Data and Methods

Sources of Evidence

In this study, I collected evidence from two primary sources. The first source consisted of approximately 500 pages of online accounts collected from electronic support groups for eating disorders known as ‘pro-anorexia’ websites from 2010-2011. Pro-anorexia websites (abbreviated pro-ana) are a shifting mass of websites constructed by and for people (primarily women) living with eating disorders described as a ‘movement’ and/or a ‘community.’ These websites have received sizeable public backlash and media scrutiny as they are popularly understood to be a movement advocating eating disorders as legitimate lifestyle and identity choices. A moral panic concerning the potential for pro-ana websites to ‘spread’ eating disorders to impressionable young women has raised calls for censorship so strong that servers like Yahoo shut down sites daily (Dias 2009) and in 2008, the French government banned the genre outright (Stevens 2008).

The backlash has had important ramifications for the pro-ana community. Since coming to the public’s attention, many websites now aim to conceal their purpose from

the public by touting themselves as ‘dieting’ websites while others with more transparent personas have had to become expert cyber-nomads, moving, regrouping and renaming themselves, relying on underground communication to move entire communities. The transient and nomadic nature of pro-anorexia websites makes it difficult to locate these websites consistently; however, the resilience of the users who continually seek them out and (re)create them speaks volumes about how important these communities are to the people who create them. Just as the body is a site of struggle and resistance, so too are the virtual spaces in which experiences of eating disorders can be shared and told.

Pro-ana websites have a few common characteristics. Bulletin boards (also known as message forums) in which members exchange communication around a specific topic make up the bulk of the websites. Members ‘post’ messages in response to a ‘threaded’ topic that another member has posted. For example, a member might post a topic such as “Proposed changes to the DSM in 2013” and other members ‘thread’ their posts in response to the topic. Messages themselves vary considerably in length, with some posts being brief comments while others can be 200 words or more, creating complex narratives. Other features of pro-ana websites include chat rooms for real-time communication, ‘thinspiration’ (pictures of extremely thin women intended to serve as motivation for weight loss), low calorie recipes and diet regimens, tips and tricks for hiding and living with eating disorders, and diaries for members to share their weight history (including high, low and goal weights), daily caloric intake and exercise regimens with fellow members.

Most websites have smaller subforums contained within the main forums specifically tailored for the three most recognized diagnoses of eating disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS). A few communities even have subforums dedicated specifically for those wishing to recover from an eating disorder, as such members are often requested to refrain from posting on the main forums where people are aspiring to maintain their practices. For the purposes of this study, I have chosen to conceptualize the EDNOS boards and the AN boards as two separate groups. Thus, the analysis presented will provide a comparative analysis of each of group's similar and distinct uses of expertise.

Each subforum contains 'stickied' threads (topics that remain 'pinned' to the top of the forum for ease of access) detailing the diagnostic criteria for each eating disorder as designated by American Psychological Association's (APA) diagnostic toolkit, the Diagnostic and Statistical Manual of Mental Disorders (DSM). That pro-anorexia websites incorporate clinical and medical frameworks into the structuring of their subcultural is fascinating insofar as so many of the accounts posted on these websites are critical of medical and cultural perspectives on what the female body is and 'should' be. This constant and simultaneous tension between reliance on, and skepticism of, dominant medical models is what originally interested me in this study.

I collected online accounts from March 2010-May 2011 using what can best be described as a non-participant observation ethnography of five pro-ana websites that I are

typical of pro-anorexia websites². Researching conversations on online message boards is similar to ethnographic research in which the researcher plays little or no role in the conversational constructions (Hardin 2003a). I did not ask questions or solicit information directly through participation in the websites. No members of these communities were directly contacted. I obtained accounts by entering publicly accessible discussion forums in which material had been inactive for several months.

The selection of specific threads were chosen for their relevance to the research – namely, topics about eating disorder diagnostic categories, negotiations and contestations over diagnoses, and the aspirational qualities of having (or not having) an eating disorder. While I am necessarily limited to citing only a few examples, the online exchanges presented here are highly typical of pro-anorexia websites, even if they are not exhaustive. Although the accounts presented cannot reflect the full breadth of topics and themes discussed by this community, I have made an effort to ensure that no account presented is uncharacteristic or atypical of a website's ethos and routine transactions unless otherwise noted.

While these websites are indeed open to the public, I have chosen to withhold specific details of the sites, including names and web addresses in order to protect the anonymity of the communities to prevent any further unwarranted attention. Direct quotes from the online ethnography will be anonymous but they will be followed by an

² Given that these websites were indeed publicly accessible via major search engines, they tended to be on the less 'extreme' end of the pro-ana spectrum, with each of them having subforums for those wishing to recover. More 'extreme' pro-ana websites may ask users to make a 'suicide pact' that they will continue to starve themselves until they die and not let others force them to eat. These websites are typically concealed in the cyber-underground and are not publicly accessible or searchable.

explanation of what eating disorder diagnosis that participant self-identifies with as well as the title of the thread in which their account was posted in order to provide context to the statements.

Of specific interest were statements of identifying practices – i.e., posts that implicated or self-implicated a member as EDNOS or anorexic – and the attendant accounts about what it feels like to belong to either category. Constructions of identity around eating disorders are common on these websites and sharp lines can sometimes be drawn between them. For instance, on several occasions I have observed members being reprimanded by other members for posting in a subforum to which they don't 'belong,' such as a EDNOS member posting on the AN subforum, with some claiming that Ana is a way of life that one can only understand from the lived experience of anorexia.

The second source of evidence for this study was collected from 11 individual interviews conducted in the spring of 2011 with people engaged in diet and fitness regimens in order to change their weight or shape. These interviews were intended to provide a comparative analysis of how the non-eating disorder population engages with expert discourses and what the similarities and differences might be with regard to the application, contestation and refashioning of expertise in another form of body modification practices. While I had anticipated that most of these interviews would be with 'traditional' dieters aiming to follow the food pyramid guidelines, eating whole grains, limiting portions and cutting calories, a new group of dieters came to my attention – Primal dieters. Primal dieters seek to recreate the eating and living conditions of a

fictional Paleolithic man whom they call ‘Grok’, modeled after what they assume to be an average hunter-gatherer circa 10,000 years B.C. This form of dieting is a very new phenomenon, having sprung up in 2009 after the publication of Mark Sisson’s book *The Primal Blueprint*. As much of a lifestyle and an identity as it is a diet, Primal dieters believe that the advent of agriculture and the subsequent consumption of grains by humans has been the primary source of what they call ‘diseases of civilization’ – that is, cancer, heart disease, diabetes and obesity. They implicate big-business, government and medical professionals as playing a part in the ‘duping’ of America in adopting a food pyramid in which grains are the foundation of the modern diet.

Just over half my sample (6 out of 11) self-identified as ‘Primal’ dieters, which lead to a rethinking about the uses of expertise in the dieting population. I found more differences than similarities between the ‘traditional’ dieters in my sample and the Primal dieters, thus I chose to conceptualize them as two separate groups. Like posters in the pro-ana community, Primal dieters take a contrarian view on the human body and nutrition science. Combining what they understand to be modern genetic science and evolutionary biology, Primal dieters seek to dispel the ‘myths’ of modern medicine, asserting that eating lots of red meat, butter, cholesterol and fat and are not only OK in moderation but should be enjoyed liberally as the base of a health-promoting diet. They eschew what they call ‘Conventional Wisdom’ (abbreviated Mark Sisson as CW) of dieting such as calorie restriction, increased exercise, and consuming low-fat and whole-grain products.

Similar to Atkins in many respects, this formulation of dieting makes it OK for men to engage in dieting by tempering its associations with femininity and vanity in what has been called the ‘masculinization of dieting’ (Bentley 2005). Five out of the six Primal dieters in my sample were men³, and none of them referred to their practices as ‘dieting’. Most of them considered it a complete lifestyle approach with an attendant philosophy of living. For example, ‘living’ Primal means not just eating primal but include things like hiking, taking cold showers, lifting heavy things and moving slowly throughout the day, sleeping with the sunset and waking with the sunrise, etc. – all things that Paleolithic man is imagined having done daily.

It should be noted that most of the Primal dieting ‘gurus’ that the Primal community turn to are men who write books and daily maintain blogs on the Internet. Such ‘gurus’ include: Mark Sisson, author of *The Primal Blueprint: Reprogram Your Genes for Effortless Weight Loss, Vibrant Health and Boundless Energy* (2009) and creator of the Primal Diet blog Mark’s Daily Apple; Rob Wolf, author of *The Paleo Solution: The Original Human Diet* (2010); Kurt Harris M.D., author of the Internet blog “Archevore: One man's opinions on health, science, and the essentials of diet”; Gary Taubes, author of the 640-page tome *Good Calories, Bad Calories: Fats, Carbs, and the Controversial Science of Diet and Health* (2005); and Timothy Ferris, author of *The Four Hour Body: An Uncommon Guide to Rapid Fat-Loss, Incredible Sex, and Becoming Superhuman* (2010), whose formula isn’t ‘Primal’ per se but incorporates most aspects of the diet and serves as an important source for Primal dieters looking to experiment with

³ The one woman who did identify as a Primal dieter did so in conjunction with her Primal dieting husband.

different macronutrients and exercise routines. While these books and ‘gurus’ were not a primary source of information for my study, I found myself having to turn to them constantly in order to understand the sources of expertise of the Primal dieters in my sample, who referred to their discovery of these authors as life changing.

After receiving approval from the IRB, I conducted interviews in the spring of 2011 using a semi-structured interview guide approach (see Appendix C). Participants were recruited using a mix of recruitment flyers (see Appendix B) as well as participants referring other participants who were interested in my study. To be eligible, participants had to be currently engaged in diet and/or fitness regimens and have had experienced a change in weight, size or shape as a result of these regimens in the past year. Questions were open-ended in order to elicit the richest narratives possible and to allow discussion of issues that participants considered important but were not necessarily included in my agenda. Some sample questions included: When did you first start thinking about changing your weight or shape? Where did you learn about diet and exercise? Do you envision an end to your practices? What does dieting or exercise mean to you? Does this differ from how other people – friends, family, doctors, the media – see dieting and exercise?

My decision to look at two sources of evidence – dieters and people with eating disorders – had different aims. While much of the medical sociological literature has been focused on illness and illness categories, sociologists are only beginning to shift their attention toward practices and meaning-making around *health*. By analyzing one group

focused on illness and diagnosis (people with eating disorders) and another focused on productions of health (dieters), I was able to better understand the different uses medical and scientific expertise. As will be discussed in the findings section, the refashioning of expertise was conditional upon three different body/self strategies: 1) Moving oneself out of the discredited eating disorder diagnosis EDNOS; 2) Recreating the eating and living practices of 'Paleolithic Man' through Primal Dieting; and 3) Creating moral boundaries around those who engage in body-work and diet practices and those who don't.

Ethical Considerations

An increasing number of social studies of health and illness use the Internet as a source of primary information (Baker 2008; Bell 2009; Copleton and Valle 2009; Dumit 2006; Fox, Ward and O'Rourke 2005b; Giles 2006; Pitts 2004). Using the Internet as a source of information has both advantages and disadvantages when compared to traditional research methods (summarized by Adair et. al, 2006; Robinson 2001). Online communities can create a sense of belonging where individuals can express themselves naturally and report varying degrees of detail about their experiences at a breadth and depth that is often difficult to get at using more formal research methods. Furthermore, in cases where there is a possibility of social isolation due to stigmatizing illness or membership to deviant or oppositional subcultures, such as eating disorders and pro-anorexia, the Internet allows people to connect in ways that might not normally be possible. Because postings to the Internet are generally regarded as material in the public domain, many researchers proceed without asking for ethical approval or informed

consent from research participants, although there are differing practices and ethos among researchers in this respect and no standard protocol has been reached.

My philosophical and methodological stance toward participants of both the online ethnography and the individual interviews is that of “empathetic neutrality,” where empathy is a “stance toward the people one encounters, while neutrality is a stance toward the findings” (Patton 1990:58). Such a stance can minimize the risk of exploiting the narratives of participants for the benefit of the researcher or the researcher’s agenda. While many researchers who study pro-anorexia websites approach the topic as a source of danger to public health and concern themselves with exposing the ‘deleterious’ effects of participating in such websites (Tierney 2006), I do not wish to enter into the public health debate about pro-anorexia and take no particular stance as to whether it’s harmful or liberating. Whether pro-anorexia websites promote or ‘cause’ eating disorders is also outside the scope of this study. Nor do I wish to evaluate the merits or harm of Primal dieting. My interest is more philosophical – the use of expert discourses in lay narratives as it pertains to sociological theories of science, medicine and expertise.

Findings and Analysis

The following analysis looks at the ways in which professional expertise is constructed and deconstructed by the participants, presented here as four distinct groups: Anorexia subforum participants (Anas), EDNOS subforum participants, traditional dieters and Primal dieters. Each group had distinct ideas about what it means to be an expert and who possesses expertise as well as what experts get ‘right’ and ‘wrong.’

Pro-Anorexia Forums - Anorexia Subforum Participants (Anas)

For self-identified anorexic participants on pro-anorexia websites, professional expertise is contested whenever medical diagnostic criteria presents a possibility to ‘open up’ the anorexic subject position to people deemed ‘unworthy’ of the diagnosis. The proposed changes to the upcoming DSM-V (due for publication in 2013) is a frequent topic on pro-anorexia boards, rife with debates among participants about what changes should be made to the current criteria and what should be retained. Petitions to change the criteria have been circulating on the Internet for years, with several thousands of people petitioning the APA to get rid of the weight requirement that has denied them a diagnosis of anorexia. These proposed revisions are not without their detractors, however, particularly on pro-anorexia forums where many anorexic participants (referred to as ‘Anas’) are vehemently vocal about their opposition to the changes. As one participant sarcastically remarked, “You can call it whatever you’d like if that makes you feel better, but it’s the same damned thing in a slightly heavier body” (AN participant, “Changing the DSM criteria for anorexia nervosa,” 2010).

In the pro-ana community, the clinical definition of anorexia is both experiential and aspirational, contributing to a sense of self. Anorexia signals the moral qualities of restraint, self-discipline, uniqueness, and even holiness, cleanliness and ascetic asexuality. Feminist theorists have emphasized the thin female body as a particularly powerful medium for communicating the self. A woman is seen as smarter, better, more put together and less vulnerable if she is thin, communicating self-confidence and control

over the body through the application of the mind. Women with eating disorders often speak about the importance of this signifying practice in its ability to reflect a self who can rise above the need to eat – a rare feat in a society in which food overabundance is the norm. Historically, femaleness has been associated with a tendency to overindulge and to act impulsively. In a ‘man’s world’ in which characteristics associated with masculinity acquire additional cultural capital, keeping one’s female nature under wraps represents an important project. Bordo (1993) has argued that since ‘femininity’ is often signified by the round, soft and rotund body, eating disorders can be understood as a form of symbolized resistance against traditional modes of femininity. Fat is lazy, vulnerable, and needy – things all associated culturally with being female.

The aspirational qualities of achieving a diagnosis of anorexia is particularly evident in how Anas police the boundaries of their community. Anas will dismiss ‘normal’ eaters, dieters and even those diagnosed with other eating disorders as a derogatory term known as ‘wannarexic.’ ‘Wannarexics’ are those who wish to “walk in Ana’s path”⁴ but are seen as lacking the discipline required to fully starve themselves. Ana participants present a strong need to pit themselves against dieters and EDNOS members in order to make a clear distinction between those in the serious, anorexic community and ‘wannarexic’ posers. Some communities have even implemented rules that require members to post their weight and height measurements before accepting members to the forum. One forum states its policy as follows:

⁴ Participant quote

This is not a place for the morbidly obese or people who are in the normal range. This forum is about people with anorexia, not people who want to “live the life they’ve always wanted” but couldn’t because they don’t have the willpower. You need the psychological aspect and the overall (statistically proven) physical aspects of anorectic individuals to post here.

Anorexic members of the forums are unforgiving of outsiders without eating disorders coming to the board and asking for weight loss advice. In a response to a thread posted by a new member asking for advice about how to lose weight fast, an Ana participant responded:

Look. Clearly you’re looking for some fad crash diet or whatever to lose weight in a (ridiculously short) period of time. This is a site dedicated to eating disorders. We don’t dole out “get thin quick!” advice here. You’re looking for a miracle, but this is a disease. You can lose 7 lbs in 10 days but no one here is going to tell you how. You come across as wannarexic. (AN participant, “looking for advice,” 2010)

There is a strong sense among the Ana boards that their community is special and endangered, under constant threat from outsiders who either don’t understand their experience (‘haters’) or dieters and wannabes who threaten to invade their pure Ana ‘sanctuary’ (see Dias 2009). ‘Wannarexics’ are thought of as ‘groupies’ who wish to associate themselves with the practices of anorexics but who cannot commit to actually practicing them. ‘Wannarexia’ embodies not only envy over the emaciated body of the anorexic, but the mindset and the ‘pure’ practices associated with anorexic bodies, thus the discipline require of anorexics and the resulting aesthetic appeal of the thin body are described as an accomplishment and something to strive for. The achievement of being able to call oneself anorexic is said to “make other people jealous, which gives confidence to the anorexic that they are doing something “right” (AN participants, “So

we love ana but we hate her,” 2010). One participant and website owner expresses anger over feeling invaded by wannarexics:

Enough is ENOUGH! I’ve fucking HAD IT with the wanarexics and Ana groupies who cling to the aberrant notion that they belong in a Pro Ana community. We have strayed so far from our roots that we have become a watered down dieting site. This is ANA’S HOUSE! I REFUSE, TO SIT IDLY BY AND CONTINUE ABETTING AND ENABLING THOSE WHO DO NOT WALK IN ANA’S PATH! Those of us who GENUINELY EMBRACE THIS ASCETIC JOURNEY are being outnumbered. ENOUGH! (AN participant, “sick of the wannarexics,” 2010).

In order to protect the boundaries of their community, Anas emphasize and embrace the professional expertise of current diagnostic criteria for anorexia. In particular, they emphasize the quantifiable diagnostic criteria for anorexia – weighing less than 15% below the expected weight by height (17.5 BMI or lower) and the amenorrhea requirement (going without a menstrual cycle for 3 or more consecutive months).⁵ These criteria hold the most exclusionary power when it comes to boundary making between anorexics and non-anorexics in that very few people will meet these requirements, estimated at less than 1% of the population (Vitousek, Watson and Willson 1998). Thus by emphasizing numbers, anorexics embrace an ontology of the body in which the physical body is privileged over the subjective experience of the mind. Regardless of whether EDNOS members or dieters ‘obsess’ over food and their bodies, and despite whether they’ve lost weight, Anas insist that the phenomenological experience of anorexia is *necessarily rooted* in the emaciated body. For example, one Ana participant speaking from experience emphasized that anorexia, though a “mindset,”

⁵ See Appendix A for the current diagnostic criteria for eating disorders.

is fundamentally different at lower weights than higher weights. In a discussion with an EDNOS member over whether the weight requirement should be changed, she argued:

My whole point can be summed up into weight loss vs. Ana. They have NOTHING in common, even though on the surface they result in the same thing. There are aspects of the illness which present ONLY when the body is in a significant depleted state, as occurs at BMI's of 17.5 and below. Because of the physiology of starvation, those of us practices the exact same behaviors at lower weights vs. higher weights are treated differently – hence the distinction between AN versus EDNOS, for good reason! (AN participant, “sick of the wannarexics,” 2010).

Thus for Ana participants, professional expertise is adopted whenever it presents the possibility of excluding ‘unworthy’ outsiders from what they deem a special diagnostic status. As will be demonstrated in the next section, these barriers present many difficulties for those seeking to belong to the category of ‘anorexic’ and provides an important site for their refashioning of expertise.

Pro-Anorexia Forums - EDNOS Participants

EDNOS participants on pro-anorexia websites consider expertise to reside in the lived experience of having an eating disorder – not in the medical professionals who are entrusted with the authority to describe and treat them. Discussions about the validity or invalidity of eating disorder diagnoses and their applicability to the ‘real’ experience of having an eating disorder is a frequent topic of debate on pro-anorexia forums. Many participants report being skeptical of medical professional’s ability to accurately understand and address their problems. Professional expertise is frequently dismissed as invalid or uninformed, particularly by those diagnosed with EDNOS.

Researchers have documented that eating disorder patients report being ‘misunderstood’ by professionals as one of their biggest barriers to recovery (Katzman and Lee 1997; Gremillion 2003; Vitousek, Watson and Willson 1998). Feeling discredited by an ambiguous diagnosis like ‘not otherwise specified’ only serves to exacerbate their frustrations. In a thread about EDNOS diagnosis, one participant noted:

Im a little disappointed that researchers or scientists or doctors or psychiatric forces or whoever the fuck figures this shit out slacked off in the places it gets “a little extra complicated.” Its like they don’t want to touch that category, or take it seriously unless you’re “xtreme” to one angle, one that’s already been textbooked up. At least that’s the impression it gives people with a dumb shit name like “not otherwise specified.” (EDNOS participant, “NOT OTHERWISE SPECIFIED – your thoughts?,” 2010)

Other participants agreed, reporting frustration with being seen by doctors as being “too varied” or “too messed up to be given a proper name”⁶ and that expert categorization paints too simplistic of a picture to give justice the complex phenomenological experience of living with EDNOS. For example, one participant dismisses expert categorization as arbitrary: “To me, a diagnosis isn’t an exact science. ‘Experts’ try to categorize things and all things cannot be categorized neatly” (EDNOS participant, “NOT OTHERWISE SPECIFIED – your thoughts?” 2010).

That experts ‘get diagnosis wrong’ is a continued source of resentment among participants. Some call EDNOS a “mongrel bag,” “stupid,” “bullshit” or a “reject”⁷ diagnosis. Many view the diagnosis as a way for experts to make their job easier for

⁶ Participant quotes.

⁷ Participant quotes.

themselves when clients present fluctuating behavior that cannot be categorized using standard models for what an eating disorder is:

Honestly, whoever decided this NOS bullshit should be shot in the face. Doctors think that because we have all sorts of criteria we can just be given some catch-all diagnosis...well I'm sorry but I'm afraid it's not that easy, we fluctuate all over the place! Everyone [on this site] knows this. NOS is a reject button in my opinion... it says that you're not really whatever it is that they are NOS'ing you for. FUCK NOS. Just fuck it.(EDNOS participant, "Not taken seriously")

The most contested form of expertise among EDNOS participants were the two quantifiable diagnostic criteria for anorexia, that is, weighing less than 15% below the expected weight by height (17.5 BMI or lower) and the amenorrhea requirement (going without a menstrual cycle for 3 or more consecutive months). EDNOS participants dismiss the weight requirement as a nonsensical requirement for something that is primarily understood to be a mental disorder, not a physical disorder. On an EDNOS forum discussing the proposed changes to the upcoming DSM, participants discussed that diagnosis "should be based on the behaviors predominately" and that making BMI the focus of a mental illness "doesn't make sense. Their general consensus was that it doesn't matter how much someone weighs or how often they purge but that it's what's on the "inside" – i.e., the inner subjective experience of caring about food and weight – that counts. They were adamant that eating disorders should not be defined by any physical state of the body, but disturbances of the *mind*, and thus were highly critical of any attempt to locate the illness in the body. One participant stressed her frustration with doctors who don't 'understand' the true nature of eating disorders:

Doctors treat [eating disorders] like it is only physical which is a load of crap. The criteria are also silly.... What if someone's BMI is in the AN range but they still get their period, according to a doctor they wouldn't be considered anorexic? It's ridiculous. ED diagnoses should be set along psychological guidelines, not physical ones. (EDNOS participant, "Upcoming changes to the DSM criteria for anorexia," 2010)

With regards to these proposed changes, many expressed hope that the DSM-V would eliminate the body weight criterion and amenorrhea criterion will be eliminated, making them eligible for a diagnosis (of self-diagnosis) of anorexia. This stands in opposition to the Anas, who suggest that the weight criterion is an important component not only the physiological experience of eating disorders but the *phenomenological* experience of eating disorders. Thus whether or not DSM criteria is adopted as a legitimate form of expertise varies whether a person is diagnosed with a discredited eating disorder like EDNOS or whether one is trying to hold on to the valuable diagnosis of anorexia.

For those in the EDNOS category, the adoption of professional criteria as a 'legitimate' form of expertise is generally predicated on what I call the 'qualities of self' criteria for anorexia, i.e., intense fear of gaining weight and an undue influence of body shape on self-evaluation. Nowhere in my online ethnography did I find an EDNOS participant contesting these criteria; rather, many stressed their importance through narratives describing their everyday experience of struggling with 'disturbed' thoughts about their weight and the attendant behaviors that comes with being obsessed with calories, weight and nutrition. EDNOS subforums contain large amounts of talk about the inner subjective experiences of enumerating their 'disordered' thought patterns and feelings related to food. I did not find this in comparable amounts on Ana subforums,

which tended to focus on pictures and numbers of actual members' (very thin) bodies and straightforward recounting of calories consumed in the day. An example of this type of narrative is the following:

I'm a calorie-counter myself, I make sure my food portions are significant less than what I serve my 2 kids (and they're only 6 and 7). But yeah I do feel like shit every time I feel full. I'm in a fairly healthy weight range (according to dr's but on the other hand I see my fat rolls and stomach and find myself obsessing over how I look in that regard. (EDNOS participant, "Do you ever think you're not obsessed enough?")

I suggest that the rejection of the quantifiable, physical criteria are rejected while the 'qualities of self' criteria are more generally accepted because these 'qualities of self' can be demonstrated through narrative while objective, quantified criteria can be more easily measured and 'failed at.' It is the quantifiable, 'objective' criteria that hold more exclusionary power and represent the greatest barriers to moving themselves out of the EDNOS position. Thus demonstrating the 'qualities of self' criteria through narrative allows EDNOS participants to move themselves into the more valuable anorexia diagnosis if they simultaneously dismiss the quantifiable criteria as an illegitimate. The adoption or rejection of specific criteria, then, serves as an apparatus around which one can move in-and-out of the subject positions of EDNOS and anorexic as one sees fit. Diagnosis, in conjunction with the deconstruction and reconstruction of expertise, becomes a 'disordered' mode of self-fashioning.

It is difficult to dismiss the sense of anger and rage that underlies their reasons for rejecting expertise. Their feeling that experts 'get the diagnosis wrong' bolsters their sense of anger over having their experience be dismissed as illegitimate. This clash over

‘expert’ and ‘lay’ perspectives supports the notion of EDNOS as a contested illness in the traditional sense. However, the aspirational qualities that underlie their motivation for achieving a diagnosis – rather than their desire for access to treatment – makes it a unique case. In the absence of a fight to get treatment, belonging to a diagnostic category provides another function to those in the pro-ana movement – diagnosis is experiential and aspirational, contributing to a sense of self and a primary mechanism of self-fashioning around the body and medicine. In light of eating disorders being described as an illness of the self (Sauko 2000), it is plausible to think of eating disorder diagnoses as a form of self-construction, in a similar practice to what Foucault has termed “technologies of the self” (1988). For example, one participant elucidates this aspirational element:

I ASPIRE, I WORK TOWARD being AN anorexic, instead of this complete crock of this that’s called ED-NOS. I don’t want to devalue anybody’s experience, but there’s such a high value with labels in our situations, I think. Like we will somehow be ‘better’ and ‘more sick’ if we have anorexia. (EDNOS participant, “Doesn’t everybody start out as EDNOS?....,” 2010).

Feelings of fraud and failure pervade the narratives of EDNOS subforums. Participants describe feeling like “failures,” “frauds,” “not good enough,” “thin enough” or “disciplined enough”⁸ to maintain the status of legitimately ‘eating disordered.’ As one participant describes, “I’ve never felt good enough for an eating disorder, like I’m a fraud or a liar for being on here. I feel like I don’t really have any problems, I’m just being stupid, even if I purge multiple times a day, everyday, I feel like a fuck-up” (EDNOS participant, “feel so fat and worthless,” 2010). Because ‘expert’ authority vis-à-vis

⁸ Participant quotes.

diagnostic standards and criteria stand in the way of those diagnosed with EDNOS moving themselves into the morally valuable category of anorexic, professional forms of expertise are rejected over the experiential.

Yet it is interesting to note that despite rejecting the expertise of medical professionals, calling the APA “sleazy” and “useless” and the DSM as an instrument “for insurance purposes only,”⁹ EDNOS participants still place a great deal of importance the expert labels ascribed to them. Furthermore, several participants are involved in processes of *self*-diagnosis, coming to the boards declaring themselves as one diagnosis or another despite having never visited a professional. This interest in self-diagnosing into expert categories, despite disagreeing with how professionals arrive at the categories, is indicative of the simultaneous *reliance on* yet *skepticism of* expert authority on illness.

Traditional Dieters

Dieters who employed conventional methods of weight loss including limiting caloric intake and portions, adopting a low-fat diet, increasing exercise and incorporating popular ‘health’ foods such as whole grains, soy products and fruit are treated here as ‘traditional dieters.’ In general, this group tended to accept professional expertise less problematically than the other three groups. For instance, at no point in my interviews did I encounter a traditional dieter calling an expert or a source of information ‘bullshit’ or other derogatory terms, nor did they seem to have a sense of knowing ‘better’ than any experts. These dieters named sources such as Webmd.com, Prevention, Shape and Fitness magazines, the USDA food pyramid, college nutrition courses and other prescribed

⁹ Participant quotes.

exercise routines as trusted sources for health advice. Such experts typically follow what Primal dieters would call Conventional Wisdom, which they would reject as being too straightforward, simplistic, biased, and not based of ‘true’ science.

Most participants made choices about what to eat and how to exercise based on what I call ‘passive information-sifting practices’ – that is, adopting diet advice from conventional ‘experts’ such as doctors, nutritionists and diet magazines without established cross-referencing practices. Traditional dieters looked for majority opinions (unlike Primal Dieters who looked for anti-majority opinions) and followed prescribed diets and regimens. For example, Rene, a 20-year-old undergraduate student, began her diet and exercise routine after viewing an informational on a weight-loss program called Turbogym. She described her experience with it as the following: “I was starting college and there was more free time. I saw this infomercial on weight loss, a program. It was a DVD collection that gave you guides of what you should do each day.” Included in her DVD collection was a 10-day, ‘jump-start’ diet plan that Rene described as containing “certain things that brought nutrition to my attention.” Rather than going on a laborious search weighing different sources as a Primal dieter might, Rene went with the first guide that was presented to her and followed it during her first year in college in order to lose 10 pounds.

Similarly Christine, a 24-year-old graduate student and a regular reader of Prevention, would use the monthly magazine as her go-to source for new exercise regimens and diet advice. Rather than cross-referencing her information – something that

Primal dieters value – Christine would take the advice outlined in the magazine and ‘run with it.’ She explains:

In my search for information on diet, they [Prevention] recommend that you should eat every couple of hours. So I had tried to incorporate that piece of advice and the advice that you shouldn’t eat late, like close to bedtime. That can help you maintain weight and lose weight. Just from the certain bits of advice that I have gotten along the way, I have adapted to my own day and gone that way.

Rene also used Prevention as a primary source: “I would read Prevention and think, why not give it a shot? I really liked the magazine and so whenever I was at work I would look through it and pick the things I could do to lose the weight.” For both participants, Prevention wasn’t a one-time shot to try something different – both were subscribers to the magazine and would regularly incorporate its advice each month, without a purposive pursuit of other opinions

To a certain extent, these excerpts suggest a level acceptance of expertise *prima facie* that Primal Dieters would simply not be comfortable with. There is a sense among traditional dieters that experts ‘get the body right’ – listen to the experts, apply their methods and you will lose weight. This sort of straightforward consumption of data might be read by Primal dieters as passive, gullible and un-inquisitive. There is no sense of anger or rage as there are among the Primal dieters, who feel that experts ‘get the body wrong’ and who challenge traditional approaches to health and weight loss. Rather, time-honored advice is valued over coming up with new and novel ways to reinvent the modern human diet.

Another difference among traditional dieters is that they valued cutting calories and limiting consumption above all other weight loss tactics. When seeking diet advice, their primary strategies would involve not only learning how to eat more fruits and vegetables but learning how to substitute higher-calorie foods for lower-calorie foods. For example, Brian, a 20-year-old undergraduate student, substituted Greek yogurt for mayonnaise and hummus for ranch dressing, which he described as an easy way to save calories and fat. Rene would eat only chicken or turkey and eliminated red meat entirely, since “red meat has more calories.”

Three out of the five participants were vegetarian or were trying to cut out meat. When asked why she had made this choice, Katie, a 36-year-old graduate student, had a very simple explanation for it: “It’s just not that good for you. I don’t believe that it’s good for you. When I eat it I don’t feel right.” Brian also tried to limit his consumption of meat, stating that eating enough fruits, vegetables and whole grains will ensure you get “99% of all you need.” Christine, a vegetarian, framed her choice in decidedly apolitical terms: “I decided to become a vegetarian. Not for any kind of eco-friendly, we love animals reason but because I thought it would be an easier way to lose weight.”

While two out of the five traditional diet participants were men, traditional dieting took on a decidedly ‘feminine’ persona with regards to food choices. Vegetables, fruits, grains, low-fat food and white meat – the type of food associated with traditional dieting – are also associated with femininity (Bentley 2005). Lupton has argued that there exists a symbiotic metaphorical relationship between femininity and vegetables in which “the

eating vegetables denotes femininity, while femininity denotes a preference for vegetables” (1996:107). Red meat on the other hand is an archetypically masculine food, the consumption of which has been historically linked to aggression and power (Lupton 1996). It is little wonder, perhaps, that diets such as Atkins and Primal dieting enthusiastically eschew traditional dieting food in favor of a meat- and fat-centric approach that embraces traditionally masculine ways of eating as a way to appeal to ‘alternative’ dieters – that is, men. This move from a focus on limiting consumption and eating light foods to embracing meat and fat has been called the ‘masculinization of dieting’ (Bentley 2005).

This brings me to the next big difference between Primal and traditional dieters. Most of the traditional dieters described being unhappy with their weight or appearance as their impetus for pursuing weight loss. Many had gained a few extra pounds in college or graduate school and were looking to return to their former size, if not a little smaller. Christine described a moment upon graduating college in which she could no longer fit into her high school graduation dress and decided to “[get] back into healthy diets and exercise and away from French fries and waffle machines.” Despite citing ‘healthy diets’ as her reason for beginning her efforts, Christine also described following advice by celebrity personal trainers in *Shape* in order to imitate celebrities whose bodies she admired: “They’ll give you kind of a free version of the same routine that Madonna uses or Courtney Cox uses to get her arms or something. I’m like oh! I want Courtney Cox’s arms! I’ll do that.” Rene also cited aesthetic reasons as her motivations for dieting. She

described wanting to look better to a person she felt romantically attracted to her first year of college: “I thought that if I lose weight then I would be more attractive or something like that. So that really motivated me to do something better and maybe that itself could bring some positive results.”

Whereas traditional dieters may have been concerned with aesthetics, not a single Primal dieter in my sample cited being unhappy with their appearance as their reason for pursuing dieting. Rather, they cited pursuing health, longevity, and even ‘puzzle solving’ as a pleasurable pursuit when it comes to adjusting one’s diet in light of new evidence as presented in Primal nutrition. These motivations might be viewed oppositionally against traditional dieters ‘feminine’ concerns about aesthetics, further supporting Primal dieting as a ‘masculine’ pursuit in opposition to feminine dieting.

Finally, traditional dieters were pursuing a specific goal weight loss goal. Courtney was trying to lose the 20 pounds she gained in college while Katie was interested in returning to the pants size she was prior to dating her ex-boyfriend. For Rene, her numbers weren’t specific but she described one of her goals as “trying to eat the rainbow every day.” Having specific goals like this suggest that traditional dieters are satisfied with ‘arriving’ at an end point and value a sense of finality in which their pursuit of diet and health information can be put to rest once a certain goal is achieved. This suggests that for traditional dieters, dieting might be seen as *functional* rather than an *aspirational* component of their self-identity. Traditional dieters didn’t view their dieting practices as ‘saying something’ about their *selves*, rather, they viewed it as a means to an

end for weight loss. Furthermore, Experts did not ‘get in their way’ of pursuing their goals, as they might for someone with EDNOS pursuing a diagnosis of anorexia or for Primal dieters, who view wrestling with expertise as a moral crusade against the tyranny of experts who ‘poison’ the world with grains. Contesting expertise as it relates to body/self-fashioning will be of primary importance in this next section about Primal dieters.

Primal Dieters

The Primal dieters in my sample had very strong ideas about what it means to be an expert and what constitutes expertise. For Primal dieters, expertise is fashioned oppositionally against what they call ‘Conventional Wisdom.’ Expertise is contested whenever it comes from Conventional Wisdom authorities, i.e., the USDA, ADA, AMA advocating low-fat and low-cholesterol diets. Primal dieters eat diets that are high in saturated fats (60% or more of calories coming from saturated fat is considered ideal), red meat, cholesterol, and avoid all grains, including what traditional dieters deem as ‘heart healthy’ whole grains. They place value in what I call speculative evolutionary practices, that is, reconstructing what they believe humans would have eaten in the Paleolithic era prior to the agricultural revolution.

Mark Sisson, author of *The Primal Blueprint*, describes his book as an effort to ‘distill’ health information given by evolutionary biologists, paleontologists, geneticists, anthropologists, physicians, nutritionists and other scientific researchers in order to create rules of behavior that have “promoted optimal gene expression and survival over the

course of human evolution” which have been “misinterpreted in the modern world” (Sisson 2009:6). Sisson views himself as an expert information-sifter who doesn’t trust traditional sources of health advice, deciding for himself how to use the findings of scientific studies rather than relying on the ‘experts’ to decide for him. He encourages his readers to do the same and to write in to his daily blog, Marks Daily Apple, to share their experiences.

This engagement with and often rejection of expertise encourages a sense of skepticism and an adoption of a contrarian point of view in order to ‘prove the experts wrong.’ My participants valued contrariness in the people they chose to trust for health advice. When asked about his information-sifting practices in deciding who to trust, Alex, a 37-year-old self-described anarcho-capitalist and Primal dieter, put a contrarian point of view above all else: “I won’t trust anyone unless they publish an alternative, contrarian viewpoint.” Alex explained that he trusts bloggers more than research scientists because bloggers were more likely to post contradictions to what they advocated and to provide links to opposing viewpoints. Scientists, he argued, conceal opposing viewpoints in order to protect their career and corporate interests.

When asked about what sources they relied on, Primal dieters would often name specific authors and bloggers who they considered to be self-experimenting, Primal diet ‘gurus’ such as Timothy Ferris, Mark Sisson and Rob Wolf. Other experts included people doing meta-analyses of scientific research on diets and evolution in order to deconstruct the findings that support Conventional Wisdom. Brett, a 30-year-old

biotechnology engineer and Primal dieter, described the person he would trust the most as a “smart person doing meta-analyses of diet research.” He valued an ‘outsiders’ perspective to health as opposed to a doctor’s or governmental agencies such as the ADA:

[The] typical ADA recommendation for heart health and the Department of Agriculture’s recommendations for what good food is is a waste of time. There are so many correlated, complicated correlations between foods that you eat that you need a really smart person on the outside looking at what all these studies say and seeing something different.

Alex believed that the most trustworthy source was someone doing a meta-analysis of diet research and that reading the papers themselves is a waste of time: “What I trust the most is really smart people doing meta-analyses of, looking through 100 scientific studies and gleaning a different pattern. Scientific papers, I can read them, but there are so many conditions that a single paper is useless.”

This contrasts very heavily with the traditional dieters in my sample, who named sources such as Webmd.com, Prevention, Shape, primary care physicians, the USDA food pyramid, and college nutrition courses as their trusted sources for health advice. These sources would be described as Conventional Wisdom by Primal dieters and were specifically rejected. When asked about whether or not he trusted his primary care physician, Alex explained that doctors “can’t back up why they think what they think” because they “don’t have the references handy.” Furthermore, he explained their ‘expertise’ as a mere result of habit and nurturing within their field, rather than their ability to sort out scientific information. Chad, a 43-year-old graduate student and Primal

dieter, similarly distrusted his doctor, due to what he interpreted as a lack of keeping up-to-date on current information: “How often do you have to renew an MD? You don’t.”

There is a sense of general anger and outrage over what Primals perceive as the misguided nutrition advice given out by the USDA, doctors and other expert sources.

Alex had tried a variety of diets before settling on Primal, and he explained his frustration with that process as follows:

There’s a lot of anger in the Primal community that the USDA put out food pyramid guides and the ADA says all this crap. They’ve just been bombarded with absolute nonsense, you know. There’s a deep satisfaction in seeing how there’s evidence all around, there’s so many different ways in which [Primal dieting] solves a puzzle. Like, how is it that I exercised like crazy and went on crash diets and never lost weight? Why did I lose weight and put it right back on again? How is it that people can fucking kill themselves over dieting and fail miserably? Well it makes a lot of sense now, thinking in this paradigm, I can see what others are doing and why it isn’t working for them.

While McPhail, Chapman and Beagan (2011) have suggested that the middle-class makes discriminatory food choices that are sanctioned by experts, my participants arrived at decisions about what to eat by reading contrarian meta-analyses of scientific studies on food and nutrition. These meta-analyses are essentially *deconstructions* of expert sources, used to demonstrate the fallacies of the logic and conditions under which these studies were conducted, then refashioned into what they deem sound logical arguments for what cavemen would have really eaten.

By placing value in diet advice that is contrary to popular opinion, Primal dieters accepted the expertise of self-experimenting ‘gurus’ such as Timothy Ferris, Mark Sisson and Rob Wolf who do their own their own studies on the body by using their own bodies

and sharing their conclusions with the Primal community. Primal gurus convince their readers that their “n=1” studies (their words) are a legitimate source of knowledge by cross-referencing their results with the deconstructed meta-analyses of conventional diet science as well as their ‘sound logical’ arguments. Over and over again my participants stressed the role of ‘logic’ in coming to conclusions about the applicability of incorporating Primal practices into their life. When deciding what to eat, Brett explained “Why would red meat somehow become bad for us over the past 10,000 years after agriculture? It’s trivial to believe that the US government put out guidelines that weren’t based in any sound logical reasoning.”

Because of its emphasis on eating lots of meat, fat and “lifting heavy things” (Sisson 2009) Primal dieting takes on a decidedly male persona. Amy Bentley (2005) has theorized that Atkins-type dieting has allowed more men to come out of the ‘dieting closet’ and feel more comfortable discussing openly their dieting and bodily practices. She argues that unlike more traditional low-fat diets that feature ‘feminine’ foods such as fruits and vegetables, fish, grains and low-fat dairy products as well as the overall limit to consumption, Atkins, like Primal dieting tempers the feminine association with dieting. Because of this, men are able to embrace dieting without an element of threat to their masculinity (Bentley 2005).

I suggest there is something more than just its emphasis on eating meat and fat that appeals to men. Even more so than Atkins, Primal dieting encourages going against expert authority. There is a certain sense of smugness about ‘being on the edge’ when it

comes to knowing what they deem as the latest nutritional and evolutionary scientific thinking.. Brett explained going against authority is an essential part of being Primal:

It involves a certain disrespect and disregard for authority because the very essence of it is this massive, massive contradiction that everything you've been told is wrong... So you know, massive blowback to the vast majority of advertising, vast majority of nutrition guidelines. It takes a certain kind of personality to delight in that.

This contrarian, lone-ranger element to Primal diet exacerbates its male persona. The Primal dieter doesn't need an expert to tell him what to eat – rather, he will decide for himself what's scientifically sound diet advice, and will use the 'master's tools' to dismantle the 'master's house' (Lorde 1982).

In contrast to the traditional dieters in my study, Primal dieting doesn't seem to imply an 'end' or 'arrival point' at which one is truly 'in the know' and can apply a particular form of the diet for the rest of their lives. Arriving at an 'informed' point is not what is valued; rather, being involved in the constant reevaluation of what is good, 'logical' science, as well as being involved in constant self-experimentation, is valued as a signaling mechanism of being an informed demi-expert on science and nutrition. Several participants mentioned that they were not looking for any particular result or anything they "would ever gauge," but that they enjoyed the "puzzle solving"¹⁰ aspect of Primal dieting. Putting things 'in the hopper' and grappling with new and often contrarian ideas about food and nutrition signals moral qualities of sophistication, self-responsibility, and not being gullible (read: feminine) about conventional wisdom from conventional sources. It is a mode of self-fashioning, rather than just a body practice.

¹⁰ Participant quotes

Going ‘against the grain’ assumed valuable qualities for Primal dieters. One participant explained that after starting his Primal diet, “the people who didn’t like me to begin with still don’t like me, but they respect me because this is who I am, going against the grain” (Alex). My participants often fashioned themselves oppositionally against ‘traditional’ dieters and people who weren’t engaged in conscious body-work and dieting practices. When asked to think about someone in their lives who hasn’t made changes to their diet based on Primal reasoning, participants’ invoked moralizing language in their conceptualizations of boundary work:

He just doesn’t have the inquisitive mind that I do. He is very trustworthy of people with social stature. He tends not to want to research anything and wants to trust other people who have done the research. I feel like we’ve been lied to by researchers in so many places, so I think, uh, it is important for me to try to validate my opinion. If they tell you low fat is healthy he will eat low-fat, but I want to know why they say these things (Chad)

One participant in particular viewed himself as being on a moral crusade to save humanity against the ‘diseases of civilization’ by sharing what he’s learned from Primal dieting. Alex viewed himself as being a type of lone-ranger, willing to sacrifice his time and energy in order to prove that Primal dieting can solve the problems of obesity, diabetes and heart disease. He explains his reasons for sharing his experiences on his personal blog as follows:

I think it is important that people suffer so that society becomes better as people learn, don’t touch the hot stove because you are going to get burnt. Don’t eat this because it’s bad for you. I hope that someday I get vindicated. Somebody is going to be victorious over the other based on my small community. If a hundred thousand people in the world were smaller, I’d say we have a pretty good N=100,000 study going. I would feel solid about that. If I don’t stick to it, who

will? If I help one thousand people lose weight, live longer, have better sex, better mental focus, get off of medications, then I get satisfaction from that.

Ben expressed a similar affect of ‘knowing better’ than others who aren’t Primal dieting to such an extent that he expressing willingness in imposing his moral perspective about it onto others: “They’d be happier and live longer if they were [Primal dieting].

Objectively, I think, I guarantee you.” When asked whether longevity was a personal value, Ben explained: “It is a personal value but I enforce it on others. All values are personal values. And we all choose to enforce them on others. But by enforce I don’t necessarily mean like laws, in this instance, but I mean encourage strongly.”

This general feeling that Primal dieters are on a moral crusade to save humanity against the perils of being duped by medically- and governmentally-sanctioned nutritional science suggests that for Primal dieters, dieting practices, like the body, have become a key site for strategic body/self-fashioning. Being an expert information-sifter and an informed, responsible and ‘in the know’ citizen against a backdrop of ‘obesity’ and ‘diseases of civilization’ involves a constant reformulation and deconstruction of expertise. In the case of Primal dieting, these practices have an underlying moral quality reflected in what they understand to be what makes primal dieting special – contrariness, anti-authoritarianism and an ability to be a savvy information user.

Discussion

As the analysis has suggested, the uses of professional expertise are many and varied. While traditional dieters tended to adopt professional expertise about diet and nutrition less problematically than the other groups, the refashioning of expertise among

pro-anorexia participants and Primal dieters was condition upon three body/self strategies: (1) Moving oneself out of the discredited eating disorder diagnosis EDNOS; (2) Recreating the eating and living practices of 'Paleolithic Man' through Primal Dieting; and (3) Creating moral boundaries around those who engage in body-work and diet practices and those who don't. Of the main aims of this paper has been to demonstrate how customization of expert medical and scientific knowledge has been employed by different groups in processes of body/self-fashioning. Analysis of the four groups has attempted to this, but now it is necessary to bring together some of the themes and group dynamics into a more coherent whole.

Three main themes emerged from the analysis. First, there was the varying conditions under which professional expertise is contested, adopted or refashioned by each group. For Anas, medical criteria was contested when it opened up the anorexic subject position to potentially 'unworthy' groups. For EDNOS participants, medical criteria was contested when it excluded them from the envied anorexic position, in particular the quantifiable medical criteria that presented the most exclusionary power when seeking to move themselves into the category of anorexic. Medical criteria was adopted, however, whenever it presented the possible of being 'performed' through narrative – that is, the 'qualities of self' criteria versus the body-oriented criteria. For traditional dieters, professional expertise is accepted more or less unproblematically and there is a general sense that experts 'get the body right.' For Primal dieters, however, advice from traditional 'experts' are always mistrusted and must be grappled with in

order to come to ‘true’ scientific conclusions about the body. Primals adopt the expertise from anti-authoritarian, self-experiments ‘gurus,’ although this expertise will be refashioned through their own self-experimentation of ‘n=1’ studies.

Regarding the construction of expertise, for both EDNOS and Primal dieters, customizing knowledge plays an important role in self-fashioning. Belonging to a discredited group may encourage the refashioning of expertise in order to legitimize one’s position while pursuing varying goals. For EDNOS, that goal is to legitimize their status as legitimately ‘eating disordered.’ While Primals don’t appear to be seeking any sort of outward legitimation, I would argue that they seek to legitimize their ability to think logically and scientifically by adopting the same epistemological tools and language of medical and scientific experts to reappropriate them for new purposes, i.e., justifying the consumption of high-fat diets.

The second theme that emerged was the moral qualities of engaging with expertise. For Anas, professional expertise that ‘kept out’ undesirable people from the diagnosis of anorexia supported their feelings that anorexia was a difficult and morally valuable pursuit, associated with self-discipline, asceticism, control and restraint that most people are simply incapable of. For EDNOS participants, an anorexia diagnosis is aspirational and medical criteria were refashioned in order to move themselves into the category of anorexia by rejecting some criteria while embracing others that could be performed through narrative. Traditional dieters embraced a more stable ontology, valuing time-honored dieting advice that lead to slow and stable weight-loss. I suggest

that the lack of moral undertones to their practices reflects the fact that for traditional dieters, dieting was viewed as less of a self-fashioning strategy and more of a functional ‘tool’ with which to reach specific goals. Primal dieters, on the other hand, viewed their dieting practices as an approach to life and greater forms of truth-making. For them, being a Primal dieter signals a lack of gullibility, being a sophisticated information-sifter and taking life into their ‘own hands.’ This emphasis on puzzle-solving and using ‘logic’ and ‘science’ gave a decidedly masculine twist to their dieting practices and also fashioned them oppositionally against the majority of ‘traditional’ dieters whom they viewed as passive and irresponsible information-sifters.

Related to the moral qualities of action is the third theme – the gendered aspects of engaging with expertise. Gendered qualities of action colored each group’s approach to refashioning. First, a gendered approach to expertise was evident given that the pro-anorexia groups were primarily women and the Primal dieters were primarily men; however, subtler qualities about the influence of gender emerged throughout the analysis. For example, while pro-anorexia participants who identified as both Ana and EDNOS worked collectively to come to definitions about what expert criteria ‘ought’ to be, Primal dieters emphasized “n=1” studies and self-experimentation. ‘Truth’ is grappled with individually, whereas ‘truth’ is arrived at collectively among the groups who were primarily women.

Ontologies of the body were also approached differently in relation to the gendered identity of the group. Groups identified what’s ‘true’ about bodies differently,

as well as the link between bodies and minds. For example, EDNOS participants strongly emphasized the importance of the subjective experience and de-privileged the importance of the body when it comes to defining health and illness. To them, experts ‘get the body wrong’ in that they overemphasize the importance of body weight, while they argue that the ‘true’ phenomenology of eating disorders is not rooted in the body but the mind. Anas also tended to speak about the importance of the subjective, however, they would sometimes privilege the body over the mind whenever the presence of a ‘wannarexic’ or EDNOS member would threaten the purity of their boards. Primals, however, viewed the body and mind as completely separate entities and stress the importance of using ‘logic’ to overcome our embodied tendencies to desire sugar and grains in contemporary life. Like EDNOS participants, they feel that experts ‘get the body wrong,’ but for different reasons that have nothing to do with valuing the inner subjective experience of being a ‘Primal.’

While anger and rage were commonplace among both pro-ana and Primal groups, these feelings took on different meanings. For Anas, anger and rage are the result of so-called ‘wannarexics’ endangering the boundaries of their community and threatening the ‘specialness’ of Ana. EDNOS members felt anger and rage over experts ‘getting the diagnosis’ wrong and unjustly excluding them from a valued category. Their feeling that experts ‘get the diagnosis wrong’ supports the case of EDNOS as a contested illness. In the absence of being diagnosed by a medical professional, participants use and refer to their *own* expertise to decide what diagnosis should be conferred. Furthermore, several

participants are involved in processes of *self*-diagnosis, coming to the boards declaring themselves as one diagnosis or another despite having never visited a professional. The interest in self-diagnosing into expert categories, despite the anger and rage over how professionals arrive at these categories, is quite interesting. Furthermore, that Primals try to replicate the methods of science by employing self-experimentation techniques while simultaneously trying to *discredit* the institution of science warrants further thinking about whether and how these groups actually pose a challenge to the institutions of science and medicine or whether they simply reappropriate their tools for new purposes.

Concluding Remarks

In summary, this paper has aimed to analyze the uses and rejection of professional expertise in contemporary processes of body/self-fashioning. I have used two empirical sources, subdivided into four distinct groups, to demonstrate how the refashioning of expertise is contingent upon different body/self strategies. The analysis shows that ideas about ‘expertise’ are the situated constructions of participants in debates about the ability of science and medicine to adequately account for personal experience. ‘Expertise’ – be it personal or professional – is treated as a form of knowledge that can add credibility to a speaker’s account or to undermine the accounts of others, often in the interest of constructing an aspirational body/self in relation to a desirable group membership.

Understanding the conditions under which professional knowledge is contested, adopted or refashioned is vital to understanding the intersections and overlaps between professional and ‘lay’ expertise. These uses of medical and scientific expertise suggest an

ambivalent relationship in which medical and scientific authority are used by the lay public not as an outright adoption of contestation of authority, but a mixture of both. Both groups, EDNOS-ers and Primal dieters, use the same epistemological tools and language of medical and scientific experts, but reappropriate them for new purposes – moral boundary making and aspirational self-fashioning. These uses of medical and scientific expertise suggest an ambivalent relationship in which medical and scientific authority are used by the lay public not as an outright adoption of contestation of authority, but a mixture of both. Both pro-anorexia groups and Primal dieters use the same epistemological tools and language of medical and scientific experts, but reappropriate them for new purposes – moral boundary making and aspirational self-fashioning.

While it has been suggested that lay knowledges, practices and belief systems represent an epistemological challenge to expert knowledge (Epstein 2008; Williams and Popay 1994), the analysis here suggests that the relationship between lay expertise and expert knowledge is not such a clear-cut divide. Considerable overlap between the epistemological tools, language and conceptual frameworks of health and illness existed between the pro-anorexia groups, Primal dieters and scientific medicine. Whereas I first approached my study of the EDNOS population as a contested illness story with lay perspectives pitted against medical expertise, I have come to understand that there is a simultaneous reliance on and skepticism of expert authority on eating diagnosis and that EDNOS participants will incorporate a mix of contesting, adopting or refashioning expert criteria at varying points in time. Similarly, Primal dieters, while skeptical of nutritional

scientific experts, will replicate the same methods and trust the source if it comes from an anti-authoritarian diet ‘guru’ author or blogger.

This paper contributes to the literature of contemporary medicalization processes by examining the various uses of professional expertise among different groups. It lends weight to the biomedicalization thesis (Clarke et al. 2003) by demonstrating an active participation in matters of health and illness among ‘lay publics,’ supporting the notion that biopower now operates on the level of *customization* rather than normalization. Furthermore, it suggests the emergence of a new biomedical subjectivity in which agency, empowerment, resistance, responsibility and morality and converge at the intersections of self, medicine and science. This calls us to reexamine the relationship between the lay populace’s engagement with expertise in the twenty-first century, understood here to be simultaneously empowering and disempowering, embracive of and resistant to medicalization, subversive and affirmative of cultural norms of the body. Research should continue to examine the overlaps between frameworks of ‘truth-making’ between lay groups and scientific medicine, as well as how engagements with and deconstructions of professional expertise come to matter in processes of body- and self-fashioning.

APPENDIX A
CURRENT DIAGNOSTIC CRITERIA FOR EATING DISORDERS

CURRENT DIAGNOSTIC CRITERIA FOR EATING DISORDERS

Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV, APA 1994)

Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimal normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85 percent of that expected).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone administration, e.g. estrogen).

Specify type:

- Restricting type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge eating or purging behavior (i.e. self-induced vomiting or misuse of laxatives, diuretics or enemas).
- Binge eating/purging type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge eating or purging behavior (i.e. self-induced vomiting or misuse of laxatives, diuretics or enemas).

Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - 1. eating, in a discrete period of time (e.g. within any two-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - 2. a sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting; or excessive exercise.

- C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

- Purging type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.
- Non-purging type: during the current episode of Bulimia Nervosa, the person has used inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Eating Disorder Not Otherwise Specified

The EDNOS category is for disorders of eating that do not meet the criteria for any specific eating disorder. Examples include:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is still within the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than three months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g. self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.

APPENDIX B

PARTICIPANT RECRUITMENT MATERIALS

Have you successfully changed your weight or shape through diet, exercise and/or weight lifting?



MALE and FEMALE VOLUNTEERS NEEDED

We are looking for participants in a research study about how people have successfully lost weight, gained weight, or changed their body shape or composition through planned changes in diet, exercise and/or weight lifting regimens in the past year.

As a participant, you will take part in a confidential interview about the diet, fitness and/or wellness techniques that you have used to reach your goals in the past year. Participation would involve one session lasting approximately 30-45 minutes and you will receive \$5 Starbucks gift card as compensation for your time.

For more information or to volunteer for this study, please contact:

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APPENDIX C
INTERVIEW GUIDE

Interview Guide

1. Tell me about when you first started thinking about changing your weight or shape.

(I will listen for and possibly follow up with: What was it that first made you decide you to change your weight? Was it your decision? Did other people influence your decision?)

2. Tell me about your diet/exercise plan.

(What foods did you decide to eat or not eat? What exercises did you decide to do or not do? What was your routine? How long have you been on this plan? Have you been successful? How do you measure success?)

3. Where did you learn about diet and exercise?

(Did you read any magazines? Visit any websites? Watch T.V. programs? Did you learn from a friend or family member? Doctor?)

4. Tell me about your diet and exercise goals.

(How long will you continue to diet/exercise? Do you envision an end to your diet and fitness regimens? Will you continue indefinitely?)

5. What's the hardest thing about dieting and exercising?

(What barriers or obstacles have you encountered? Has anyone or anything hindered the pursuit of your goals?)

6. Since you first began dieting/exercising, do you do things the same or differently?

(Would you change anything about your routines?)

7. What does dieting/exercising mean to you?

(Can you remember what it felt like when you first lost/gained weight? Do you enjoy dieting/exercising? Do you think that there are ways in which people who diet or exercise are different from people who don't?)

8. Are there any other things we have not discussed that you feel are important?

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