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Abstract
This paper examines how contemporary understandings of ‘health’ and ‘care’ are engaged with and practiced by women with disordered eating. Based on findings from an Australian study investigating why people with disordered eating are reluctant to engage with treatment services (March 2012 to March 2015), we demonstrate how young women use elements of a ‘health habitus’ and ‘care’ to rationalise and justify their practices. Moving beyond Foucauldian theories of self-discipline and individual responsibility we argue that Bourdieu’s (1977) concept of habitus and Mol, Moser and Pols’ (2008, 2010) concept of care provide a deeper understanding of the ways in which people with disordered eating embody health practices as a form of care and distinction. We demonstrate how eating and bodily practices that entail ‘natural’, medical and ethical concerns (in particular, the new food regime known as orthorexia) are successfully incorporated into participants’ eating disorder repertoires and embodied as a logic of care. Understanding how categories of health and care are tinkered with (Mol et al., 2010) and practiced by people with disordered eating has important implications for health professionals, family members and peers engaging with and identifying people at all stages of help-seeking.

Keywords: Disordered eating, healthy anorexia, healthism habitus, care, symbolic capital, orthorexia, distinction.
Introduction

It is well documented that disordered eating is difficult to treat as people may deny that they have a problem and are therefore resistant to seeking help or treatment (Vitousek & Watson, 1998). While disordered eating presents many immobilising and negative aspects, there are simultaneously many reported protective attributes, producing ambivalence, which in turn makes it very difficult to treat (Author 2, 2010; Williams & Reid, 2010). Thus, there can be a difference between the ways in which people with disordered eating understand their practices (as ‘not sick’ and often productive) and the clinical view of a disorder and subsequent need for intervention and treatment.

Drawing upon interviews and ethnographic fieldwork with women with disordered eating in Adelaide, South Australia, this paper explores how participants work to rationalise their behaviours not as a medical illness, but as a central part of their daily lives, a plan and strategy that is justified by recourse to normative practices of healthism and care. Crawford coined the term ‘healthism’ in 1980 as a discourse that ‘represents a particular way of viewing the health problem, and is characteristic of the new health consciousness and movements’ (1980, p. 365). Since Crawford’s conceptualisation, significant socio-political changes (such as the rise of neoliberalism and increasing appetite for health consumerism) have extended and cemented the idea that one should take responsibility for one’s health and place the pursuit of healthy lifestyles at the centre of moral virtue, personhood and citizenship. As many scholars have highlighted, health has become a ‘self-project’ (Pond et al., 2010, p. 736), and for women in particular, ‘taking care of oneself’ through careful attention to appearance and weight is elevated to a moral status of virtue (Fullagar, 2002).

Healthism is an exemplar of Foucault’s (1991) concept of biopower and governmentality, and has been well documented in relation to health activities and public health programmes (see, for example, Peterson et al., 2003; Coveney, Begley, & Gallegos, 2012). Foucault discussed ‘care of the self’ in his work on sexuality (1984/1988), and how modern social institutions such as hospitals and schools have
produced expert discourses of knowledge. This knowledge is also ‘institutionally unbound’, in that
disciplinary power is embodied and ‘invested in everyone and no one in particular’ (Bartky, 1990, p. 80).
Participants in our study practised self-discipline by constructing themselves as subjects who actively
sought knowledge around health, nutrition, biomedicine and exercise to self-regulate and monitor their
diet and weight (Blackman, 2008). As a dominant ideology of wellness, healthism provides a ‘truth’ and
logic about healthy living and is exercised through ‘a form of rationality…that is implicit in the processes

Our analysis extends this Foucauldian frame by examining how the habitus of healthism is embodied
by participants not only as a means of maintaining their disordered eating, but also as an active pursuit
of care that produces symbolic capital and distinction. Habitus entails an understanding of what to eat
and the way to eat it.; of distinctions between what is ‘good and what is bad, between what is right and
what is wrong’ (Bourdieu 1998a, p. 8). Habitus enables different tastes and distinctions to be embodied,
and for these practices to signify certain values and distinction. Thus the focus in this article is not the
effects of discourse on a body, but on how participant’s embodied their habitus; how ideas about
healthy eating were rationalised, internalised and performed as good health care.

In their discussions of care, Mol and colleagues (2010) suggest that the specificities of care have
become eroded and lost (2010, p. 9). This could be because, as feminists writing on the ‘ethics of care’
have noted, care has traditionally been devalued due to its associations with the feminine and the
private sphere (Parton, 2003). Rather than conceptualise care and health as taken-for-granted or fixed
categories, we follow Mol et al.’s lead and attend to the complexity of these terms, of how participants
played with and adapted ‘healthy eating’ as a form of care; an active practice in which they sought to
improve their lives (2010, p. 15).

Following a description of the study and research methods, this paper begins by introducing the
contradictory term ‘healthy anorexia’ to highlight the central discourses of health and body maintenance
that people in our study drew upon to rationalise their disordered eating. We position these discourses within a ‘habitus of healthism’, leveraging Bourdieu’s (1977) concept of habitus to understand the conditions that shape people’s embodied experiences. It is within this habitus that participants were able to pursue their self-interests in healthy bodies, and do so in what they considered to be a purposeful and reasoned manner.

Some scholars have already noted the ways in which food preferences are used as an excuse for not eating by people with disordered eating (see for example, Gilbody, Kirk, & Hill, 1998). Others have highlighted how eating disorders are value-driven enterprises that engender moral elevation and purity (Vitousek & Watson, 1998; O’Connor & Van Esterik, 2015). In developing these theories of behaviour we suggest that the incorporation of particular food regimes allows participants to link together a constellation of collectively recognised health and moral values into a performance and logic of care (Vitousek & Watson, 1998). Care is described through a variety of food and eating preferences, and in this paper we focus specifically on orthorexia, a new food regime with an explicit mantra for ‘healthy’, ‘pure’ and ‘natural’ eating. Some participants used orthorexia to reject dieting, instead claiming that they were following an ethics of care tied to the purity of food and body. Mol suggests in exploring an ethics of care framework, the complexities of practicing care highlight that what is considered ‘ethical’ is tied up in specific local norms, where different types of ‘good’ care may co-exist and be in constant negotiation (2010). Embodying orthorexia as a daily practice of care enables the body to become a source of distinction and power based on the possession of symbolic capital (Bourdieu, 1990, p. 138), and in this instance the capital is directly tied to the visibility of ‘a healthy [thin] body’ and the embodiment of moral virtue. We argue that orthorexic practices are embodied enactments of care, in which implicit ethical values are endlessly tinkered with (Mol et al., 2010), adapted and reshaped.

The final section explores how participants describe restricting practices as medicinal, drawing upon perceived expert discourses to demonstrate how they take care of themselves, even when ‘starving
down’. As they researched health and medical fields, gave tips to friends on food choices and weight loss, bodies became performances of symbolic capital that were distinct from others who repeatedly failed at dieting. Such distinction reinforced a logic in which one was ‘taking care of oneself’. In conclusion, we argue that it is these symbolically laden constellations of a healthism habitus and care that are reshaped to support disordered eating practices. Understanding how people embody disordered eating as a form of health and caring has implications for intervention and treatment modalities, as it helps to explain why people would resist seeking treatment when they are already so heavily invested in their own care and health.

The study

Through a mixed methods approach including ethnographic fieldwork and psychological evaluation, this study focused on examining the cultural contexts of women, food and disordered eating, with the aim of developing strategies for early intervention. Data collection occurred over 15 months (January 2013 to March 2014) and involved 25 women, ranging in age from 19 to 52. Most of the women were under 30 years of age, university students and of Anglo-Australian backgrounds. Following ethics approval, participants were recruited through snowball sampling methods, with posters being placed around two metropolitan university campuses. The criteria for recruitment included women who were over 16 years of age and had not seen a health professional for disordered eating, had not been given an eating disorder diagnosis, or had been diagnosed but had delayed seeking treatment or did not wish to pursue treatment.

Recruitment in this project did pose a central tension around differences between psychiatric classifications and people’s everyday understandings of their practices. We wished to engage with women who did not identify with the clinical label of an eating disorder or see themselves as necessarily conforming to a psychiatric classification, yet we also needed to work within the parameters of diagnosis set out in the universal handbook of psychiatric classifications (at the time the study was
conducted, the Diagnostic and Statistical Manual of Mental Disorders DSM-IV). The research team was multi-disciplinary, and included social scientist/anthropologists, a psychiatrist and psychologist (both of whom specialised in eating disorders). In South Australia treatment for eating disorders involves specialised mental health services (comprising psychiatry, psychology, nutrition and social work) and diagnosis is an integral part of accessing these services. We recognise that the language associated with psychiatric diagnostic classifications have value in clinical contexts and the wider community (including policy and practice contexts), but equally that terms such as ‘health’, ‘illness’, ‘disorder’ and ‘care’ can have different meanings in other contexts.

In light of the sample we aimed to recruit we therefore did not mention eating disorders specifically in recruitment advertising, instead posing questions such as ‘Are you continually thinking about your food and your weight?’ and ‘Do you enjoy the feeling of not eating or excessive exercising?’. The aim of this approach was to capture ambivalence towards recognising practices as disordered and an associated ambivalence towards seeking professional help. As this was a difficult sample to recruit, participants were also recruited through advertising on social media websites [omitted for review purposes].

After reading the research information prospective participants contacted Author 1 through email or by telephone asking for further information on the study. Prior to giving consent, all participants were fully informed about the research and the nature of their participation and understood they had the right to withdraw from the study at any time. Participants were provided with a copy of their signed consent form, along with information and resources on available eating disorder services in the initial meeting.

In total, sixty-eight semi-structured interviews took place in people’s homes, in interview rooms at one of the universities, in cafes and in public places. Ideally we had hoped to conduct most interviews in participants’ own environments to observe their everyday spaces and to create a more ‘natural’ setting. However, many of the younger women were still living with their parents and siblings and had not spoken to anyone about their eating issues and did not want the interviews conducted in their homes.
In order to ascertain if participants might fit the diagnostic criteria of an eating disorder, the Eating Disorder Examination (EDE; Fairburn, 2008) was conducted with each participant. Author 1 was trained in the administration of this instrument, a semi-structured diagnostic interview that lasted between 40 minutes to an hour and a half. After completing the EDE the results were sent to a researcher trained in the use of the EDE who used SPSS to analyse the data. Of the 20 participants who consented to partake in the EDE, the majority (75%) fell into the Eating Disorders Not Otherwise Specified (EDNOS) category. Of the overall sample, six of the participants had a previous eating disorder diagnosis (anorexia nervosa) from a health care professional, and had had limited contact with health providers. The other nineteen participants had not previously sought professional help and had never received a diagnosis. All women described years of eating and body issues that had usually started in childhood or adolescence.

Despite the well documented critiques of such a universal and discursive instrument (Gremillion, 1992; Lee, 2004), the EDE is the internationally recognised ‘gold standard’ of disordered eating assessment. Gremillion argues psychiatric assumptions about disordered eating are themselves culturally informed and not static nor objective (Gremillion, 1992). Therefore, in recognising the power which psychiatric labels have to reinforce such assumptions and limit other explanations, we used terms such as ‘disordered eating’, ‘eating issues’, and ‘eating and exercise practices’ throughout the interview process to address practices, beliefs and experiences which may not be captured by the parameters of psychiatric questioning alone, but nonetheless became crucial to understanding not only the participants’ own experiences but how they viewed their own practices. Furthermore, this allowed participants who felt intimidated by such terms as ‘anorexia nervosa’ to describe their experiences in their own language (e.g., ‘mental health quirks’).
In terms of research rigour, the inclusion of the EDE was important to ascertain if participants might conform to psychiatric classifications and to ask them their responses to such evaluations, and provide them with information for resources and services. During the data collection the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was published, in which the EDNOS category was replaced by Other Specified Feeding and Eating Disorders, (OSFED), which has a number of informal subcategories aimed at capturing a larger group of people who slip past the other categories (Touyz & Madden, 2013).

The research team discussed how to address informing participants of their EDE results, taking into account that Author 1 was not a trained clinician, but valuing an open and reflexive dialogue with participants. Keeping in mind the National Statement on Ethical Conduct in Human Research (2007), which states that it is important to acknowledge the specific vulnerabilities of people with mental illness, we informed participants that they met some of the criteria, but did not go into specifics and advised them to see a clinician or health professional if they wanted to pursue this further. It is important to note that many participants were not surprised that their practices aligned with a psychiatric label, as they recognised that their eating patterns were unusual and this led them to participate in the project.

**Analytical approach**

Grounded theory principles guided the research methods, coupled with a thematic analytical approach to data collection and analysis (Corbin & Strauss, 1990; Ezzy, 2002). In line with Ezzy’s (2002) approach to analysis, we developed ‘an ongoing simultaneous process of deduction and induction, of theory building, testing and rebuilding’, neither ignoring the influence of pre-existing theory or forcing data into the theory (2002, p. 10). All interviews (including semi-structured and EDE interviews) were professionally transcribed, and fieldnotes were written up following each participant meeting. This data was coded first on the computer in a Word document, and then through the software programme NVivo by Author 1. All interview and fieldnote data were printed in order for Authors 1 and 2 to become
familiar with the themes and check the rigour of the coding. The diaries were coded using Post-It notes and circling key words and phrases soon after they were returned.

The initial stages of data collection (open coding) involved the exploratory process of experimenting with codes, and sitting with, and absorbing, the data (Ezzy, 2002, p. 87). To become closer to the data Author 1 transcribed the pilot interviews and open coded them within the same week afterwards. In the collaborative meetings that followed between Author 1 and 2, this led to the reshaping and adding of interview questions as well as the development of axial codes and themes. For example, after the pilot interviews we decided to add questions about the theme of ‘dieting versus restriction’, which led to an understanding of how participants distinguish themselves from people who diet and frame themselves as healthier. Ezzy argues that ‘theoretical questions, and answers, are shaped and reshaped in the ongoing dialogue with the experience or subjects being studied’ (2002, p. 62). This highlights why multiple interviews with each participant became a fruitful methodological tool for the interrelated process of coding and theorisation. Furthermore, constant comparison was central to developing codes as data started to gather around themes. During the final stage of coding, central themes, such as ‘healthy anorexia’ and ‘natural eating’, were compared with the existing theories of ‘healthism’ explored in this paper.

**Contradictory embodiments: ‘healthy anorexia’**

It was a key informant, Kelly, who alerted us to the term ‘healthy anorexia’. Kelly contacted us to be a part of the project as she wanted to know more about anorexia. Now aged 40 and the mother of two primary school age boys, she always arranged to meet us when the boys were at school as she didn’t want them to know about her ‘unusual’ eating practices. In her early 20s Kelly had been given a diagnosis of anorexia nervosa due to her severely low weight and extreme restrictive food practices. However, Kelly never actively sought treatment or professional help with her fasting and bingeing. Since diagnosis, Kelly described the changing nature of her disordered eating and mental health challenges,
including going through binge eating phases, the heavy use of recreational drugs to aid weight loss, and being diagnosed with borderline personality disorder and post-traumatic stress disorder. A turning point for Kelly’s practices occurred when she became pregnant in her early thirties and realised she would have to start taking more care with how she maintained a low weight, beginning with giving up her drug use. Still not wanting to seek help for her eating, Kelly’s techniques for restricting became focused on nutrition and more ‘healthy avenues of starving’. Kelly stated proudly that she had become a ‘successful anorexic’ because she had ‘mastered starving’. By this she meant maintaining a level of health: ‘I thought I was doing quite well, that I was a healthy anorexic. I knew I still had anorexia, I knew that that was still one of my main focuses as far as my eating [was] concerned, but I thought that I was healthy’. We asked Kelly what she meant by ‘healthy anorexia’, and she described how she used her local General Practitioner (GP) to monitor her health:

P: Yeah, well the doctor tells me that I’m healthy.

So the doctor tells you you’re healthy?

P: Yeah, see he doesn’t know I have anorexia. He doesn’t know that, he doesn’t know how I eat, he doesn’t know how I live. But when I go to the doctor and say ‘have I got something wrong with me?’, he says ‘no’…he says I’m really healthy.

Kelly regularly sees her local doctor to ‘take her bloods’, and to check her blood pressure, oxygen saturation levels and thyroid function. While visible thinness is not a health concern for her, she stated that she was worried about ‘having a heart attack’, and so uses her GP as a ‘tool’ (Williams & Reid, 2010) to care for herself and legitimise her healthy anorexia. She often justifies her position by contrasting her level of health with that of overweight friends and family, stating: ‘most people are overweight, and they’re always struggling, they’re always on diets, they’re always sneaking off to Macca’s. They’ve got more problems than I do. My menu’s quite planned out, it all works quite well. But they’re struggling all the time. And their health - they all look terrible’. 
Healthy anorexia refers to the idea that someone can still be healthy, while maintaining their disordered eating. In her ethnographic work in an eating disorder unit in the UK, Lavis notes that ‘health is framed as something that is produced in spite of anorexia but … as also possible through it. Pro-anorexia websites often have a plethora of tips on how to ‘stay healthy’, meaning to produce … anorexic health’ (Lavis, 2012, p. 241). This, we argue, is part of the rationalising discourse that people with eating disorders use to care for themselves and maintain their practices. Kelly gives an example of purposely choosing a culturally legitimate healthy activity to help maintain and hide her disordered eating. She said:

Things like yoga...I searched out...I can’t do cardio because I suffer with low blood pressure because of my weight...So, something like yoga, and I remember reading about yoga and it saying that the picture of a perfect yoga instructor is someone with absolutely no body fat and a smile on their face. I was just like BAM, I’m going to be a yoga instructor.

Kelly illustrates an awareness that the pursuit of health is an enactment of caring for herself, because ‘good anorexics are, healthy anorexics’ (Lavis, 2011, p. 243). Her constant striving for health exhibits ideals of self-discipline and self-care, the driving tenets of achieving a healthy lifestyle (Crawford, 2006) that position Kelly as a self-regulating subject. Yoga calls upon a level of skill and dedication that Kelly could slip into with the assurance that her desire for thinness would not be questioned.

**The healthism habitus**

Although Kelly’s understanding of healthy anorexia could be interpreted as idiosyncratic, her experiences are drawn from a much broader set of socially sanctioned and collective ideas that she internalizes and performs in her everyday life. Crawford (2006) argues that the pursuit of health ‘has become one of the more salient practices of contemporary life, commanding enormous social resources, infusing every major institutional field and generating an expansive professionalisation and commercialisation, along with attendant goods, services and knowledge’ (Crawford, 2006, p. 404). The concept of ‘healthy lifestyle’ is key to contemporary neoliberal societies, so much so that it can be described as a habitus. Bourdieu described habitus as providing a cognitive map of an individual’s social world and the dispositions or
procedures to follow appropriate for that person in a particular situation (Cockerham, Rutten, & Abel, 1997, p. 327). As Kelly demonstrates, her habitus thus provides a generalised structure that is ‘internalised and converted into a ... general, transferable ... disposition that generates meaningful practices and meaning-giving’ (Bourdieu, 1984, p. 170). In a healthism habitus what Kelly does with her body in terms of the choices she makes around the consumption of certain foods, types of exercise, and pursuit of body fitness all become important ‘bearer[s] of value’ (Bourdieu, 1998b, p. 128), signifying Kelly’s conformity (or opposition to) the dominant habitus.

A healthism habitus generates a field of taken-for-granted dispositions in which health is directly correlated to weight management and thinness is read as a marker of robust physical health (Aphramor, 2005). Moreover, thinness is also associated with feminine beauty and success (Bordo, 1998), and women are scrutinised more harshly according to these gender constructions. Gemma who use to be overweight, and now eats ones small meal a day illustrated this in her recounts of social situations where women would regularly praise her for her rapidly shrinking physique, and ask how she has achieved such quick weight loss - clearly positioning her as a success and asking her for expert dieting advice. Parallel discourses of health, thinness and femininity are powerful ‘structuring structures’ of participants’ habitus, in which health and appearance are continually worked upon and transformed. In our study, bodies became projects (Shilling, 2003) that were guided by participants’ habitus, signifying how the embodiment of particular foods and eating regimes created perceptions of care and health.

**Food choices and intolerances are a form of care**

While Kelly played with her food and exercise choices in order to maintain healthy anorexia many other younger participants were similarly able to draw upon ethical food choices and intolerances as a cover for their limited food choices. Jane, who is 25, and partakes in restrictive eating practices and over exercising (but has never received a diagnosis or sought professional help), admits to telling her family
she is vegetarian and lactose intolerant to avoid having to defend what she describes as her ‘fussy eating’. Jane laughed as she said:

When I was at my well grandparents, they’re all into food. They used to like buy these, you know like the cocktail pies and sausage rolls, yeah that stuff…and I’m like the only way to get out of this is if I say I’m vegetarian...[laughs]. So then I just did, and I said I'm not eating any of that anymore because I'm vegetarian' and then they’re like ‘oh okay’, so then they get me salad, and then that's good because I get what I want and I get out of eating a lot of stuff.

A number of studies highlight a link between eating disorders and the restrictive eating styles of vegetarian/vegans (Vitousek & Watson, 1998; Gilbody et al., 1998; Karabudak & Kiziltan, 2005; Sullivan & Damani, 2000). Along with moral and ethical beliefs motivating a vegetarian lifestyle, health reasons play an increasing role reflecting a conscious choice of a healthy diet as a means of achieving a sense of health, preventing and curing illness, and a way to lose or maintain weight (Knight, 2015; Karabudak & Kiziltan, 2005; Barr & Chapman, 2002). Nine participants in this study said they were either vegetarians or vegans and a further six participants discussed limiting their meat intake or at some stage identifying as a vegetarian (60%). The sample represents a notably higher percentage of vegetarians compared to the general Australian population which, according to Knight, is about 3% (Knight, 2015).

Gilbody et al. (1998) argue that ‘vegetarianism legitimises food avoidance, extending the range of bad or nonpermissible foods, justifying this choice to oneself and to others’ (1998, p. 90). This is demonstrated by Michelle, who in responding to a question about eating socially with friends said:

...because I'm vegetarian, was vegan, and I guess being vegan gave me a bit of liberty to make those decisions as well because it was, ‘Oh no, I can't go there because I can't eat’, even though half the time it was probably because I wasn't comfortable being there.

In addition to her vegan diet, 20 year old Lucy explains how other health factors are important to her eating routines and maintaining control over what and where she eats:

I have coeliac disease as well. So I can't have gluten. So sometimes if I like am really not feeling comfortable sort of eating out, I'll just be like I'll just make my food here.' And I'll just like go out with them and not have meals at the restaurant. I cook all my own food at home. Like, I eat completely separately from my parents but you know...[and] like eating beforehand so I
I don’t have to eat from the restaurants that I haven’t cooked and I don’t know what’s in it. So, sort of just like saying like, I guess like lying and making up reasons why I can’t like eat at places…

While people in our study did use normative cultural practices to hide disordered eating and spoke of lying or exaggerating food intolerances or ethical standings, we suggest that there is another layer of complexity to this rationale. Author 2 has already pointed to the ways in which people with eating disorders use ‘agency play’ (Author 2, 2010, p. 79) as a political strategy to adapt to, circumscribe and invent certain ways in order to achieve a desired outcome. Bethany, who approached us concerned with her cycle of restriction, binging and over exercising, explained how she’s never really liked drinking milk or consuming dairy—it made her feel ‘funny in the stomach’. She said that she ‘had tests done and…was never officially like lactose intolerant or coeliac’, yet still decided to cut out dairy all together and limit her gluten leading her to feel ‘more healthy now than ever’. Bethany was identified in our project as meeting the DSM-IV criteria for EDNOS, demonstrating the power of the healthism habitus and the well-intentioned pursuit of ‘good health’.

While vegetarianism, veganism and a range of food intolerances enabled participants to gain greater control over what they ate without being questioned, their ‘healthy’ food choices also transformed these practices into a logic of care. Mol introduces the concept of logic of care in her edited book of the same name. While we do not engage with the broader arguments that Mol poses in relation to the separation of a logic of choice and care (as her analysis stems from a clinical health care setting), we do find value in her analysis of the taken-for-granted concept of care.

In her analysis, Mol asserts that care is ‘not a well-delineated product, but an open-ended process’ (2008, p.22). She suggests that ‘it might do better to explore the way in which the logic of care meticulously attends to the unpredictability’s of bodies with disease. Caring, or so it appears, is a matter of attuning to, respecting, nourishing and even enjoying the mortal bodies’ (2008, p.14). Care is
enacted and flexible, in which people can shape, reshape and adapt care to new circumstances and relationships. Rather than viewing people with disordered eating practices as only in need of care – we argue that people in our project considered themselves to already be practicing care in their daily lives. Participants were actively involved in their eating disorder, in its continuation, and in caring for their bodies; an active ‘practical tinkering’ that ‘sought to improve life’. Lavis similarly argues that people with anorexia ‘bricolent innumerable and infinitesimal transformations of and within the dominant cultural economy in order to adapt to their own interests and their own rules (de Certeau, 1984, p. xiv), actively making anorexia through health advice that derives [in this instance] from the clinic’ (Lavis, 2010, p. 242, our emphasis).

Extreme care: Orthorexia and digestive labouring

To demonstrate this complexity of care in participants’ everyday worlds, we examine how a new food order termed ‘orthorexia’ has entered the health habitus and was utilised by some participants. Characterised as ‘extreme care for and selection of what is considered to be pure, healthy food’ (Bartrina, 2007, p. 313), orthorexia is an extension of vegetarianism, diets and food intolerances, and uses the tropes of ‘natural’, ‘pure’, ‘raw’ and ‘real’ to establish a moral ethic of care. Beginning as a ‘fixation for proper nutrition and healthy foods that leads to dietary restrictions and nutritional deficiencies over time’ (Koven & Senbonmatsu, 2013, p. 214), orthorexia can become part of everyday bodily practices tied to a moral order of food, discipline and weight maintenance. However, while priding themselves on these moral imperatives, they simultaneously act against their moral framework and important values such as honesty (as demonstrated above), as disordered eating becomes ingrained in their health and care regimes.

According to Vandereycken (2011), there is little data on the prevalence of orthorexia and it has largely been neglected in the professional and scientific literature, and is more often quoted through the
internet and social media. Four participants identified with its characteristics and many participants knew of and followed the practices of ‘clean eating’ and ‘raw food diets’ and associated their diet with achieving a sense of purity and cleanliness, which are foundational to an orthorexic regime.

Thirty-two year old Charlotte (who had struggled with severe disordered eating for 17 years) described the ‘comfort and refuge’ that she found in the safe space of restriction, likening it to an ‘odd idea of nurturing and self-care’. ‘We live in a society that is obsessed with food’, she said, and spoke of an ‘orthorexic-type voice’ being present when choosing food to eat:

I kept going back to the pantry, trying to find something that fit the criteria that would be okay to eat. And I could discount everything in the pantry for one reason or another, based on antioxidants, or fibre or glycaemic index, or the level of refinement or preservatives, or colourings or sugars or, you know? There wasn’t a single thing in that pantry that was okay, if I put all of our society’s messages and health professionals’ advice together about what’s okay and what’s healthy to eat.

Charlotte lamented how people with disordered eating are vulnerable to the panoply of advice circulating in our healthism habitus and how immobilising this can be:

In the end I went ‘fuck it’, and just grabbed something. Because, well I started crying first. And then I just went, this is ridiculous. But you know, and that’s the problem, is people who are prone to this do put them all together. They don’t just pick one and follow with that. They’re trying to meet all of these requirements at the same time and it’s impossible.

The ‘requirements’ that Charlotte referred to related to an ethics of care—to the ability to select the ‘right’ type of foods that would care for her body and demonstrate her ethical relationship with the world. Charlotte considers herself a vegetarian, and agnostic, Buddhist Christian. She attends a ‘left-wing Uniting Church’ and relates disordered eating to a ‘Protestant work ethic’ in which she finds self-control and hard work as culturally rewarding. Eve, 49, a primary school physical education teacher, similarly follows stringent eating rules and describes a sense of pride, righteousness and accomplishment in her continual labour to eat the ‘right things’. ‘Health’, she said, ‘is viewed as something you have to work at every day’, and it is the feelings of ‘willpower’, ‘strength’ and moral goodness around food choices that she finds rewarding and pulls her in to maintaining her disordered eating.
Many food and eating practices that participants engaged in (such as the paleo diet, no-carb diet, raw food diet, clean eating diet, macrobiotic diet, no sugar diet, low-fat vegan diet, gluten free diet, natural diet, organic diet, cleansing diet, South Beach diet) come under the banner of orthorexia. Knight’s research on the popular South Beach diet argues that the proclaimed ‘real food’ regime ‘affirms the association of unprocessed food, moral virtue and health, but ties all three to a Calvinist ethic of austerity, sobriety and hard work’ (2012, p. 112). Unprocessed foods are said to be better for your digestive function because they ‘put your stomach to work’ (Knight, 2012, p. 112). For example, when eating uncooked broccoli that is ‘crunchy, hard and cold, and covered with a layer of nutritious fibre…your stomach really has to work in order to get at the carbs’ (Agaston, 2003, p. 47 in Knight, 2012, p. 113). The idea that a healthy food regime has to be earned through hard work, ‘digestive labour’ (Knight, 2012, p. 113), and restraint is reflected in participants’ practices. Charlotte explains that through engaging in restrictive food practices ‘you believe that what you’re doing is leading towards something positive. Whether it’s health or whether it’s, you know, purity, virtue, you know, self-control’…‘It’s like this twisted version of the Protestant work ethic’.

Intertwined with this idea of ‘digestive labour’ is the theme of ‘natural health’, a position that participants used to distinguish themselves from others who were not careful with their eating choices. Eve described her food rules:

A major rule is no refined sugar. No saturated fat…Unprocessed. Real food, natural food. Food without stuff added to it. So really fresh, clean, [I] don’t like rich sauces with lots of cheese and lots of flavours added and things like that. [I] just like fresh, clean food as nature intended it…[I] prefer just really natural…simple clean food.

We asked Eve what she meant by ‘clean’ foods. She said: ‘Clean. Makes my body feel clean [and] it’s eating the right food that doesn’t leave you feeling bloated and uncomfortable. So just very fresh, very healthy, very raw food. A clean feeling.’ Avoidance of processed foods is echoed in the moral logic of the South Beach diet—‘lazy processed food produces fat bodies’ (Knight, 2012, p. 113)—extending popular assumptions of ‘you are what you eat’.
Taking care: Restricting as medicinal

The links between restricting as a demonstration of taking care of yourself were further exemplified by Kelly, who undertakes restriction as a ‘medicinal’ practice. Restriction, she said, ‘to make myself feel better about how bad I’ve been treating my body while I’ve been bingeing’. She goes on to explain: ‘if I can make the starve a little bit more medicinal … it makes … me mentally think ‘ohhh see it’s not so bad that you’re starving you’re getting out all that junk’. Healthy and medicinal practices, such as eating ‘an avocado and … drink[ing] a big lemon juice and water’ to satisfy cravings and stop mood swings during a ‘starve down’, are incorporated into Kelly’s logic of care, as it allows her to use her ‘starves more effectively’. Following instructions from a detoxification book written in 1976 by a spiritual leader who fasts for 30 days to achieve a cleansed body and higher spirituality, Kelly will ‘fall back on medicinal ideas … and research further to confirm that what [she’s] doing [actively pursuing her ‘healthy anorexia’] is okay’. Coveney (1999) notes that this convergence of nutrition as a spiritual process (1999, p. 25) is salient in contemporary practices of slimming and fasting, which point to the ‘widespread idea that impurities from food can be cleansed from the body through detoxification’ (Knapton, 2013, p. 474).

Many participants positioned themselves as responsibly acting citizens who had incorporated expert medical knowledge into their daily routines and belief system. Evidence that these practices are culturally sanctioned was provided by a number of women who spoke of their expert status in their social networks. Some described how friends would ask them how they lost weight, and managed to ‘stay thin’. Kelly, for example, took great pride in holding this superior position and sharing her knowledge with friends and acquaintances. She laughed about the way that friends would come to her and ask her for ‘health facts and tips’ and said ‘I love to read about nutrition and health and I know heaps about physiology and digestion and all of those sorts of things so I can give people really wonderful advice about health’. This advice was, however, tempered with the view that participants could impart special knowledge on how to ‘starve more healthily’. In taking up this position in their
social networks, and emphasising their eating habits as a form of self-care, many participants garnered symbolic capital that in turn reinforced their practices.

Embodying such daily practice enabled participants to occupy a particular social space of distinction, ‘to differ [and] to be different’ (Bourdieu, 1998a, p. 9). They knew that their bodies and practices were part of a habitus that promoted a particular representation of the female body, and they used their bodies to physically and morally stand out above the crowd by excelling at its own rules (Author 2, 2010, p. 87). Restriction, clean and natural eating were highly reflexive demonstrations of care of self, positioned against the ills associated with anything ‘bad’, ‘unhealthy’ and ‘artificial’ (Knight, 2012, p. 103).

**Conclusion and Implications**

This paper has explored the complexities of health and care in the lives of women with disordered eating. By introducing the contradictory concept of healthy anorexia we highlight how participants tinker with and reframe popular health pursuits, allowing them to engage with dominant ideologies of self-care and moral citizenship. Lupton (2000) has pointed out that the intensification of discourses around food since the 1990s, and in particular the benefits of a healthy diet, represents the production of knowledgeable and prudent healthy subjects (Lupton, 2000; Nicolosi, 2006). The women in our study are making choices that conform to this healthism habitus, in which healthy eating is most commonly associated with a diet that is low in fat and carbohydrates and a sign of ‘good moral character and individual worth’ (Galvin, 2002, p. 112).

Ethical food choices, intolerances and orthorexia were used by participants as a cover for restrictive diets, allowing them to narrow their food choices. At the same time, the moral connotations of restricting and the protestant ethic of constant ‘body work’ mean that bodies become important bearers of self-care and symbolic capital. Participants spent ‘time in search of dietetic perfection, organising, researching and selecting food’ (Nicolosi, 2006 p. 39), and utilised health and medical knowledge to restrict ‘medicinally’, thus easing the effects of a starving body.
However, these choices represent not only conformity to the current healthism *habitus*, but a logic of care. Care, as Tronto (1993) and Mol (1993) suggest, has political malleability and can be used to support different political agendas that inform cultural imaginings of food and eating (cf. Mol 2010). Disordered eating was in itself a complex form of care, in which ‘care’ was actively tinkered with by what was at hand, in this case, the dominant and normative healthism *habitus*. This tinkering could also involve withholding care, of depriving oneself of sleep and seeking coldness to ‘burn more calories’ and to make the body work hard. This contradiction of care is part and parcel of the logic, in that restriction [of food or medication (Lester, 2014)] becomes ‘a powerful means of enacting and experiencing a moral practice of deprivation’ (Lester, 2014, p. 249).

In this logic of care, ‘good and bad are thus intertwined—’good intentions may have bad effects’ (Mol et al., 2010, p. 12–13)—and may be misrecognised as such, but engender a logic that is hard to dispel. When you are invested in the healthism *habitus*, and extreme care, as all of our participants were, you are ‘caught up in and by the game, of believing the game is “worth the candle,”’ or, more simply, that playing is worth the effort (Bourdieu 1998a, p. 76-77). The healthism *habitus* carries what Bourdieu refers to as *illusio* (ibid):

> … it is the fact of being invested, of investing in the stakes existing in a certain game, through the effect of competition, and which only exist for people who, being caught up in that game and possessing the dispositions to recognize the stakes at play, are ready to die for the stakes (ibid).

Certainly for those participants who had experienced many years of disordered eating there was recognition of how defeating and non-productive everyday practices of restriction were. As Charlotte explained, orthorexia can be viewed as ‘a quest for health gone wrong’.

Understanding the dynamics of care is important in disordered eating. More often, it is these people who require care, yet ‘most people with an eating disorder do not seek help for their eating behaviours’ (Evans et al., 2011, p. 271). If we look at care from their vantage point, we can begin to understand why
people might not identify their practices as a problem and therefore not come forward to seek help. If disordered eating is itself experienced as a practice of care, then the need to seek other forms of mental health care is unwarranted. Disordered eating is rife with contradictions and ambivalence, and to understand how they ‘hang together somehow’ (Mol, 2002, p. 5). In considering how participants spoke of disordered eating practices as a way of managing suffering in their daily lives, it is essential to understand how the complexities of health and care discussed in this paper contribute to resistance in coming forward and asking for professional help.

Participants tinkered with “lifestyle choices” in relation to what was available in their habitus and highlights modes of care that often run counter to rational choices. As Mol suggests ‘our desires may not be rational, but, or so the logic of care has it, neither are our minds. Instead they are full of gaps, contradictions and obsessions’ (2008, p.29).
References


Author 2 (2010)


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1 Mol (2008) outlines two systems at play in healthcare settings - the logic of care and the logic of choice. The logic of choice highlights the impact that neoliberal ideals can have on health care, in which customers (patients) are expected to exercise choice as an individual act that will lead to a positive final end point.