AN ETHNOGRAPHY OF DISORDERED EATING IN URBAN CANADA

Janis Tanner
Bachelor of Arts, University of Lethbridge, 2004

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfillment of the
Requirements for the Degree

MASTER OF ARTS

Anthropology
University of Lethbridge
LETHBRIDGE, ALBERTA

To my daughters

Abstract

This thesis examines the problem of disordered eating based on ethnographic fieldwork in emergency shelters, soup kitchens, and eating disorder support groups, as well as interviews with medical professionals, and other residents of a Canadian city. This person-centered ethnography that explores the eating behaviors of not only those who have been diagnosed with 'eating disorders', but also those who are unable at times to provide themselves with food reveals that in spite of a prevailing discourse that determines eating as an independent act, food choices and eating patterns are dependent social 'works of the imagination' affected and shaped by social determinants and cultural norms. From eating disorders to type 2 diabetes and 'food as gift,' the lived experience of individuals indexes the ways in which food, power, and identity are enmeshed and embedded within culture. This critical perspective argues that disordered eating is socially and culturally produced and reproduced.

Acknowledgements

This honors thesis is the result of the encouragement, understanding and confidence of many individuals. It is my pleasure to formally thank Dr. Steven Ferzacca, my mentor and supporter over the years. I will be forever grateful for his patience, guidance, encouragement, and faith in my abilities. Thanks also to Dr. Catherine Kingfisher, Dr. Dayna Daniels, and Dr. Melanie Rock who contributed their intellectual feedback. Fieldwork and writing were made possible by financial support provided by a Social Science and Humanities Research Council (SSHRC) Master's scholarship.

I wish to acknowledge the community professionals, who gave of their time and knowledge regarding eating disorders, and helped me to create an information network by referring me to other professionals in the field of health care. I also acknowledge individual non-profit agencies including The Society, The Shelter, The Kitchen, and the Disordered Eating Support Group whose participation made this research possible. A special thanks to the individual participants in this research, who unselfishly shared their life experiences regarding their relationships with food.

This project has taught me the value of social networks. I am truly blessed to have the love and support of my family and friends, who have encouraged me along the journey and allowed me the time and opportunity to pursue the dream of a university education.

Table of Contents

Chapter 1: Introduction

This thesis is a person-centered ethnography that explores the language of food as expressed in the eating behaviors of females and males in a mid-sized urban community in Canada. It examines the problem of "disordered eating" not only among those who have been diagnosed as having 'eating disorders,' but also among those who are unable at times to provide themselves with food, and reveals that in spite of a prevailing discourse that constitutes eating as an independent act, food choices and eating patterns are dependent social 'works of the imagination' affected and shaped by social determinants and cultural norms. It is through the lived experience of these individuals, their emotions, cognitions, perceptions and motivations surrounding their behaviors that we can explore the ways in which food, power, and identity are enmeshed and embedded within culture. Within this triad, one is mutually constitutive of the other - they are inseparable.

Disordered eating is not bound, as commonly accepted, to individual psycho-pathologies such as anorexia and bulimia. Rather, it is a broad continuum of 'disorders' that are affected and shaped by social relations as well as social determinants and cultural norms, some of which are specific to difference by age, gender, class, or ethnicity, while others operate in society at large. In the context of this thesis I define 'disordered eating' as eating habits or patterns that are not the accepted norm within a culture. These abnormal eating behaviors are dealt with through various institutions within a society, and the manner in which they are dealt with varies according to culture. Within Canadian culture many deviant behaviors, which includes particular eating behaviors, are medicalized and brought under the control of biomedicine. This thesis focuses on the manner in which discourses within Canadian culture have created a continuum of

disordered eating ranging from temporary to permanent, minimal to extreme, and includes not only the officially defined eating disorders but also eating-related illness such as obesity, type 2 diabetes, depression, and the dependence of a particular segment of the population on the receipt of 'food as gift.' The cultural discourse of capitalism that emphasizes individualism, often conflicts with the social discourse of community that emphasizes cooperation; the cultural discourse of post-colonialism, albeit perceived as aiding indigenous peoples, has produced inequalities. Treatment for disordered eating, regardless of age, class, gender and ethnicity reinforces the cultural proposition of individualism, thus perpetuating rather than alleviating the disordered behavior. Ironically, in a culture that proposes individualism 'food as gift' is evidence that the social discourse of cooperation is still a value held by many cultural institutions. By cultural standards, 'food as gift' is labeled as disordered eating and creates inequalities as those individuals accessing this service are ultimately held responsible.

Within the disordered eating continuum the experiences of individuals are diverse. However, the common denominator is that they are all food-related, and in Canadian culture we are enculturated to perceive disordered eating as an individual problem, an independent act rather than a dependent social one. The stories of the individuals depicted in this research project were stimulated by their memories of food, but these memories also evoked other issues and relationships in their lives. Food has been a tool with which to negotiate social identity and relationships within culture, and during the course of their lives food has been used to cope with and manipulate situations and events. The cultural value of individualism creates inequalities and particular kinds of subject positions, thus affecting the identity of the individual.

Food and Eating in a Cultural Social Context

Food and eating are tools with which to structure society (Douglas 1966). Food is necessary for human physical health, but is also used as medicine, as an object of exchange, in ritual ceremonies, and as a symbol of relationships. As a primary resource necessary for human survival, food and commensalism are vital to the establishment and maintenance "of kinship and friendship networks in all societies" (Lupton 1996:37). Food consumption and the rules controlling this activity are "important means through which human beings construct reality" (Counihan 1999:113); they reflect social concerns people have about the physical, social, and symbolic world around them, and help them to create order (ibid) within the human community.[i]

Historically, eating customs and taboos dictated when, where (private or public), and with whom food could be eaten. All cultures have their own norms, values, and beliefs that are learned through socialization and enculturation; it is through these processes that individuals evaluate the way in which their social role is related to their self-identity. Because food consumption has its roots in culturally defined social roles, it has been used as a tool with which to negotiate social relationships and shape identity within society. Food and eating have long been topics of anthropological studies as related to the role they play in systems of subsistence and exchange, ritual, and the negotiation of social relationships (Ferzacca 2004:16). Food is a language that structures and connects social groups.[ii] Anthropologically speaking, then, disordered eating is also an expression of exchange and social identity within a particular culture, which is experienced and manipulated through the consumption of food.

Across cultures, food itself is coded as feminine (Lupton 1996:105). Women are associated with the preparation and serving of food, while men are involved with the eating of food that others have prepared. The gender hierarchy within a culture refers to the association of "maleness" with social power, but not necessarily for men only (Gailey 1987:xi). Women attempt to change their subject position of 'female' through eating, which is associated with 'male'; thus, they abuse the female food. As well, eating disorders are labeled as female disorders by the male dominated discourse of biomedicine because it is an attempt by females to gain maleness or power. Obesity differs in that historically it has been considered a symbol of wealth and power, therefore, male. For this reason it is more acceptable for males to be overweight. In sum, food is associated with femaleness, while eating is associated with maleness; therefore eating is maleness and power. This symbolism is reinforced and reproduced by folklore and media communications within a culture and is part of the socialization process.

As a symbol of class in contemporary Canadian culture, eating practices and food are very significant. Starchy, sweet, and fatty foods are more commonly consumed by those with a lower socioeconomic status (SES); obesity is stereotypically considered more prevalent in this group. Slenderness, as a symbol of wealth and prestige, is attributed to the consumption of lean meats, fresh fruits and vegetables, which are more expensive commodities and thus only afforded by the higher SES groups (Powdermaker 1997:207).

Food is also indicative of ethnic identity as "people articulate and recognize distinctiveness through the medium of food" (Counihan 1999:7). It is through food that we define 'us' and 'them' according to what is classified as food and what is not. Food systems not only reveal the environment of a particular culture, but it is through food that

"human beings mediate their relationship with nature and each other across cultures and through history" (ibid).

Consumption activities and taste are not universal; they are produced and reproduced, are not static, and vary across families, societies and cultures as food classifications, eating practices and taboos change. Following the Industrial Revolution, food production and preparation that were family subsistence activities became commodities within a capitalist system, and as such, objects of exchange that create distance and differentiation, or negative reciprocity, rather than solidifying relationships (Counihan 1999:113). 'Food as gift' is not traditionally perceived as disordered eating, but I classify it as such in this thesis to demonstrate that "some have control over access to food; others do not. Hence food becomes a vehicle of power" (ibid). According to Mead (1997), the issue of the availability of food is always both political and ethical. Food became the reward for adherence to the capitalist value of individualism under the guise of nutritional science; those who did not conform to this value were brought under biomedical surveillance through the medicalization process. The meanings assigned to eating and food play an important part in the production and reproduction of traditions, beliefs, and values within a culture as well as the individual experience.

In the Beginning: an auto-ethnography

In contemporary Canadian culture, we are bombarded on a daily basis with issues surrounding food. Reading the morning paper we are confronted with headlines that instill us with paranoia as we read 'Childhood Obesity Reaching Epidemic Proportions' (my words). As we drive our cars and listen to the local radio personalities, some of whom advertise particular weight-loss programs, share how it has produced results for

them, and advise their listeners to follow suit. On route to our destination we also pass a myriad of restaurants, fast-food outlets, and grocery stores. And, if that were not enough, billboards, public transportation vehicles and business vehicles are used to advertise not only food venues but also how we can rid ourselves of excess calories and weight if we succumb to this advertising. After a day at the office, we relax in front of the television, only to have our favorite program interrupted by food, beverage, exercise equipment and diet regime advertising, some of which are endorsed by government health agencies. All of this information is received, interpreted and acted upon by individuals; the variation of which is infinite, some with negative societal responses. Are we as a society, through the process of socialization and enculturation, producing, and reproducing the very problems that we label as deviant and are striving to eradicate?

As a means to understand disordered eating within a Canadian cultural context this portion of the chapter will use an anthropological tool called 'autoethnography.' While an ethnography studies other people or subjects, in autoethnography the ethnographer reflects on their experiences of the self in particular social positions; the ethnographer looks inwards and becomes a subject of their own research, a member of the 'other' group or culture (Russell 1999). My life experiences illustrate that the escalation of the capitalist ideal of individualism in the 1970s, and the transition from a more social milieu to one of independence, especially for women, caused ripples across generations that were not always positive.

The family unit, which has historically been the icon of Canadian culture, has undergone dramatic restructuring over the centuries. The purpose of the family has been very diverse: it secured alliances between kin groups and communities of 'others,' it

provided for legitimate reproduction, it facilitated the nurturing and education of progeny as to their social roles, and it cared for its aging members. Women have traditionally been an integral part of this process, and throughout history the shifting body ideals have had a direct relation to their social position (Brown and Jasper 1993:20).

My parents were married in 1950, which was post-war time, and settled in a small agriculturally-based Canadian community. I was the fourth generation of two pioneer families, both of whom resided in this area; therefore, I was surrounded by a large extended family. Growing up in small town Canada in the 1950s and 60s, life revolved around the family unit and, as in most families, there were many celebrations of one kind or another throughout the year. A main aspect of these celebrations was the ritual feast, a myriad of traditional favorites lovingly prepared by our mothers, grandmothers and aunts, and we graciously accepted these symbols by indulging sometimes to the point of discomfort (Brown and Jasper 1993:138). Food for me represented family, love, and happy times. It also represented the importance of being an accomplished cook, a socialized female role, as the women of these families were known for their culinary expertise.

My father worked away from home in the public sphere and my mother remained in the private sphere to raise the children and tend to the household duties. Mom said that very few women worked outside of the home at that time, and those who did were usually teachers, nurses, or secretaries. She also commented that body shape and weight were not an issue in this era, as the focus was on the family unit.

Body shape was not a concern for me until about eight years of age, when a class photograph revealed that I was much bigger, not fatter, than the other girls my age. This

event made me conscious of size, and by the age of twelve years body shape and size was a serious concern for me as these two factors were crucial in establishing one's social position within the school experience. Another important factor was fashion, thus indicating that the ideologies of thinness as well as consumer consumption were being socialized within the education system.

The 1960s were my adolescent years and the necessity of the perfect body was paramount if one was to be accepted into the desired social group. My genes had not provided me with the thin, boyish figure that was fast becoming the cultural norm for this era when Twiggy made her fashion debut. I became very shape-conscious, and no matter how much reassurance I received from family members, I felt fat (as compared to the social norm). Dieting and exercise became a daily ritual as I desperately tried to conform. Thus began the years of yoyo dieting and endless exercise regimes in my efforts to achieve this thin body ideal for girls and young women. A cultural paradigm was in progress and my confusion of body ideals was not an individual psychological or biological flaw as I would later discover in my endeavor to unravel the mystery of the disordered eating continuum that has plagued our society and impacted my life.

By the 1970s I was married and trying to incorporate my new social positions of 'wife' and 'daughter-in-law' into my previous identity, all the while struggling to preserve the values and beliefs that I had been socialized were the cultural norms – females became housewives and mothers. I did not realize that the conflicts I was experiencing were caused by a paradigm shift wherein women were breaking away from the domestic sphere and entering the public sphere of men. It had become the norm for women to procure a career, especially if there was not the responsibility of children. The

establishment of daycare for children was just beginning, and so too was the 'double day' for women. The career of 'housewife' was on the extinction list, so in order to survive, I was forced to compete with others like me in a workforce glutted with female laborers.

Women in western cultures were learning to focus on their bodies as a form of currency to be manipulated; physical appearance became an important attribute, which affected and continues to affect the way in which women are valued and treated. Women have come to believe that they can change their lives by changing their bodies (Brown and Jasper 1993: 19). This drive to change their physical appearance and the additional social demand for perfection has created an imbalance through the addictive use of diet programs and the inevitable covenant with food (Woodman 1982:12). And, in this age of technology we have too readily turned our bodies over to pharmaceutical remedies in the form of diet pills and anti-depressants; medical procedures such as liposuction, stomach stapling, and breast augmentations; and succumbed to the hype of the media and advertising (ibid).

I remained in the workforce until 1979 when I became a mother, after which I chose to remain in the domestic sphere in the capacity of wife and mother. Even as a stay-at-home mom the dieting and manipulation of food continued in a never-ending cycle through the 1980s. At one point, when my oldest daughter was nine months old, I belonged to a diet club that demanded that I consume only 500 calories per day, which would be considered anorexic behavior today. Yes, I lost weight, but it was only temporary, as I could not successfully maintain such a low caloric intake for any length of time. Over the course of the next ten years I periodically took over-the-counter diet

pills, consumed diet drinks, belonged to exercise clubs, and was guilty of excessive exercise to obtain the desired thin body ideal.

Finally, in the 1990s with two teenage daughters and facing the 'midlife crisis,' I realized that I had been trying to carry the values and beliefs of the 1950s regarding gender roles into the successive generation, ignorant of the paradigm shift that had taken place: politics, the economy, and the roles of men and women were changing within Canadian culture. When my life became chaotic because of this shift it challenged my identity and consequently my subject positions as female, daughter, wife, and mother. In an effort to control my identity, while negotiating my position in these various relationships, I had continually tried to change what I did have control of – my body. This ultimately necessitated the control of food consumption, which would lead to tension in various relationships. My abrupt shift from 1950s to 1990s values was internalized differently by each of my two daughters. Following, are their stories.

My oldest daughter remembered that at about ten years old she noticed other people who she perceived as overweight, and then at about thirteen years old she was teased about being fat. She felt secure in her role in the family and community, and therefore accepted her shape as a natural phase of maturation. Fashions in the early 1990s were not as much shape-oriented as they were manufacturer-oriented, and there was a 'brand label' war raging in the blue jeans industry. It was more important to be wearing the correct brand of jeans in order to be accepted by your peers than to be a certain size. Also, in the mid-90s, fashion became less important and the new rage was the sport of rollerblading, which increased physical activity. This daughter took up this sport and realized that it was also a good way to change her shape, and so put more emphasis on activity than on

diet. As the focus on size returned, this daughter's adolescent years were ending and my youngest daughter was in the middle of those turbulent years.

The younger daughter remembered that family life became chaotic when my role changed; she felt insecure. She was five years of age and just entering kindergarten when my role of stay-at-home mom changed. My husband and I became restaurateurs, which required long hours at our place of business; therefore, the children also spent long hours at the restaurant instead of at home, which was a dramatic change from what they were accustomed to.

At the age of eleven she recalled being conscious of the body shapes of other people, not thin like her, but more rounded maturing bodies. She also noticed that fashion and shape were important criteria for being accepted into different social groups. Between the ages of 14 and 15 years she became aware of the fact that boys paid more attention to skinny girls. Perceiving that she was not getting much notice, she assumed it was because she was fat, and she started weighing herself on a regular basis. She learned from extended family members of her age group as well as from peers, ways in which she could manipulate her weight – for example, only eating half of your lunch and exercising more. The mother of one friend had advised her daughter not to eat too much and to exercise more or the boys would not like her; the parents were frequent users of diet pills and their religion stressed that it was a sin to be gluttonous.

Determined to lose five to ten pounds my daughter heeded the advice of her peers; she would give away her sandwich and eat only the apple for lunch. Her efforts were rewarded as fellow students noticed the new slimness; those who had previously not been friendly, now were. This reinforced her new eating habits and she took them to further

extremes, theorizing that losing more weight would make her expanding social life even better. Within the group of newly found friends, dieting became a competition. She dropped her calorie intake to only 200-300 per day and increased her physical activity; she was fast on the way to becoming anorectic. At this point, her father and I expressed our concern about her dramatic weight loss and her apparent lack of appetite, so she decided to stop the behavior.

About two months later, while babysitting at a friend's house, she recalled being so hungry that she ate everything in the refrigerator. Filled with disgust and guilt about her behavior, but even more with the fear of being fat, she had a compelling desire to 'get rid' of all that she had eaten. Remembering that a cousin had told her how easy it was to purge (by vomiting), she decided to try it. She admitted that the first time was really difficult and that immediately after purging she felt tired, but relieved; she admitted that she was addicted to that feeling from the first experience. Thereafter, any time she ate something she perceived as fattening and felt guilty, she would wait a while and then go off by herself and get rid of it. She found that purging enabled her to enjoy the foods that she liked, that family and friends no longer pressured her about not eating enough, and that she did not gain weight. She realized that there was a problem when she tried to stop the binging and purging ritual, but could not. As a consequence of reducing the purging to only once a day, she gained thirty pounds; her body was storing every calorie that she consumed.

When she finally told me about the situation (that she was bulimic), she said that she was looking for help, felt overwhelmed, and did not know where to start. Looking back, I was less than compassionate. Not understanding the problem, I advised her to 'just

stop' the behavior. Many times over the last eight years I have regretted this reaction, but through much reading and research have found that this is a very common reaction – not that I condone it. Reflecting back I think that this reaction was a form of denial, a sense of failure as a parent, and embarrassment that my daughter could have a stigmatized mental disorder. In fact, I do not think that I even totally comprehended what bulimia was. I did, however, attend a support group meeting for anorectics and bulimics with her, which I felt gave her more ideas as to how she could perfect the behavior than ways to correct it. I also advised her to see our family doctor and to seek counseling, which she did.

As she entered high school, the behavior got worse. The skinny, pretty, popular girls, who had befriended her when she was thin, now ignored her. She felt so ashamed of herself that she vowed to do whatever it took to regain her thin body – no cost was too high. So that no one would detect that the problem still existed, she ate healthily, but purged from one to five times per day, depending on the kind of day she was having. I was at a loss as to how to help my daughter and feared for her life.

This youngest daughter moved in and out of our home for the next three years; the eating disorder behaviors continued. The oldest daughter married; therefore, with an 'empty nest' I decided to get a university education. My life experiences led me to examine eating disorders from an anthropological perspective, to investigate the influence that culture had played in my life experiences surrounding food and eating behaviors, as well as in the lives of my daughters, and ultimately many other females (and males).

Extensive research on eating disorders has led me to understand the cultural meaning of food, the role of biomedicine, and the negative impact of the capitalist value of individualism. Ironically, I have reflected that the very target of my research, disordered eating, had been produced by social relationships in my life and that I was reproducing this value in my children. In Canadian culture we are enculturated to see disordered eating as an individual problem rather than a social one; that eating is an independent act rather than a dependent social one. Disordered eating is socially and culturally produced and reproduced within a particular time frame, and so too are the experiences of the individuals involved, as was evident in the lives of three generations of females in this autoethnography. In her ethnography of Florentine women, Carole Counihan (1999) also observed that notions about food, the body, and the social expectations of females changed generationally, and caused conflict in social relations, especially those between mothers and daughters (194).

In our multi-cultural society and a globalizing world, studies are needed to understand various social and cultural aspects significant not only for the etiologies of dietary disease, but also for the management and therapy of health problems related to food and eating that include anorexia, bulimia, obesity, depression, alcoholism, and type 2 diabetes. I also posit that 'food as gift' should be considered in this continuum. It is anticipated that the following research will bring us closer to collaboration between biomedicine, psychology, and anthropology in order to understand disordered eating and its future affect on society.

Location of Research

The location for my research was the Canadian city of Rivertown and surrounding rural communities. This city has a population of approximately 70,000 and is the heart of an agriculture-based economy. The Rivertown area is steeped in the history of European colonization, and thus has a diversity of ethnic traditions and cultures that are preserved in a multitude of community organizations. Among these diverse cultures, Rivertown and area has a large Aboriginal population, and since I have always been interested in Aboriginal culture, I chose to include this group as the contrast to the stereotypical sample (white). Because food creates social structure, I questioned how it related to the position of Aboriginal people within the greater population of Canada.

When this research project began, my knowledge of disordered eating was limited to previous contact with a professional within the local eating disorder treatment program, a daughter who was diagnosed with an eating disorder, and a friend who had recovered from an eating disorder. Through a process of referrals and networking I was introduced to the individuals who would make this research possible.

The Participants

Over the period of one and one half years and through a process of snowball sampling, I interviewed twelve Euro-Canadian (white) females and one male; five Aboriginal females and four males; twelve professionals in various health agencies; and the facilitator of an eating disorder support group. I also obtained data from participant observation in a community shelter, soup kitchen, and eating disorder support group. Of those with disordered eating problems, four were referrals from a local support group that followed the 12-step addiction model of treatment. The non-professional participants

ranged in age from twenty-two to sixty-six, with a mean age of thirty-two. The sample group also varied in age, socioeconomic status, marital status, and religion.

Methodology

The research methods used were in-depth interviews, participant observation, and literature research. The data collected from non-professional participant were from interview sessions that lasted from half an hour to three hours, those individuals with disordered eating being the lengthiest. Most of the interviews were conducted in the participant's home; however, some took place at my home, or at a neutral location. Each participant was asked a lead-in question about their memories of food as far back as they could remember. This question was all that was needed for those with disordered eating to reveal their life story, while those without disordered eating required continuous prompting with other questions as to dieting, body image, and life satisfaction. I used Kleinman's (1980) explanatory model questions (see Appendix A) where applicable, as well a series of questions from a life satisfaction scale and risk behavior survey conducted by Valois, Zullig, Huebner and Drane (2003) (see Appendix B).

The interview process was informal and focused primarily on the (cultural) meaning of food as well as on issues of dieting and body image as it related to each individual. Other than the lead-in question, there was no structure as to the order of other questions. I referred to a few guideline questions during the interview process and surveyed the guideline at the end of the interview to make sure that all topics had been covered. With the permission of the participant, most of the interviews were tape-recorded. As well I took 'thick' notes during the interview, pausing periodically to make eye contact with the interviewee and to build a rapport with the individual. I felt it was important to let the

participant know that I was truly interested in what she or he had to say, that they were not just objects of research.

The professionals were contacted on a referral basis, informed of my research topic, and an appointment was made to interview them at their professional location. The interview lasted from half to one hour and for the most part they were asked structured open-ended questions (see Appendix C).

Each participant was assured that our conversation was confidential, and that their actual name would not be used.

Conclusions

As a white female within Canadian culture, objectivity on the part of the researcher studying within his or her culture is difficult as presupposed tacit biases must be overcome, thus the importance of auto-ethnography. In order to understand the implications of disordered eating in a modern world, it is important to realize that contrary to popular consensus disordered eating is not a new or culturally isolated phenomenon, but has been shaped by historical and cultural events. Thus the use of critical medical anthropology is a relevant research tool for this endeavour. Although Kleinman's explanatory model has been criticized by critical medical anthropology because it does not consider "that social inequality and power are primary determinants of health and healthcare" (Baer et al 1997:3), I found it useful in gathering particular cultural data.

In the following chapters I will examine aspects of the scholarly literature available on the topics of food and eating, food and health, food and poverty, and medical and societal

institutions as related to disordered eating. As well, I will present and analyze my fieldwork and particular in-depth interviews.

Chapter 2 discusses the historical, economic and political aspects of food, outlines how the discourse surrounding disordered eating has been created, and defines the clinical encounter. In this chapter I examine scholarly literature available on the topics of food and eating, food and health, and medical and societal institutions as related to disordered eating. I endeavour to show that disordered eating is constructed and embedded in culture by the dominant discourse, specifically the cultural value of individualism, and reinforced by biomedicine within the capitalist construct. As well, this cultural proposition is perpetuated through post-colonial discourse, which in turn creates and perpetuates inequalities among Aboriginal people, albeit under the perception that the discourse is to the benefit of Aboriginals. The medicalization and treatment of social problems within the context of individualism is reproducing rather than eliminating disordered eating.

Chapters 3 and 4 represent the way in which the fieldwork chronologically unfolded, expanding my perspective of disordered eating from the eating disorders, obesity and type 2 diabetes to include poverty, homelessness, and 'food as gift.' In Chapter 3, I relate my experiences at a local soup kitchen and homeless shelter, including the stories of those individuals whose lives have been affected by their lack of access to various resources. This portion of my research of 'disordered eating' extends beyond the stereotypical studies of eating disorders, often characterized as specific to a "historical group" of adolescent, middle class, mostly white females, to include obesity, type 2 diabetes and poverty. Disordered eating comes in many forms, reflecting diverse

foodways affected by gender, age, ethnic background, and social class. Chapter 4 examines type 2 diabetes and other diet-related disorders with a particular focus on the effect of acculturation on Aboriginal peoples within the context of colonialism and post-colonialism in Western Canada, including interviews with individuals and healthcare professionals.

In Chapter 5, I deconstruct the 'eating disorder' stereotype by first presenting the stereotype from the perspective of my participation and observations in an eating disorder support group. I then examine the literature research on white males, as well as Aboriginal males and females, and present an interview with an Aboriginal female. I also present cross-cultural examples of food and eating behaviors and reflect on these as compared to contemporary Canadian behaviors using Devereux's ethnic disorder theory (Gordon 2000).

Finally in Chapter 6, using Melford E. Spiro's (1997) Psychological Pre-adaptation Theory, I 'rethink' disordered eating. Spiro theorized that cultural ideologies are reproduced by being transmitted from enculturated actors (adults) to cultural novices (children and adolescents); it is a process that is both social and psychological. He suggested that if it is an internalization process, it is important to consider not only the cultural symbols, but also the mind of the social actors. Also according to Spiro, there are many cultural systems operating at the same time; these often overlap and can cause conflict, causing disordered behavior depending on the level of acquisition and internalization. This disordered behavior, if reproduced as a cliché or a cognitive salient belief may be socialized and enculturated.

In this chapter I also summarize my research findings and make recommendations based on the same. By critically examining disordered eating through the lens of medical anthropology, it may be possible for anthropology to suggest an alternative perspective in coping with disordered eating in Canadian culture.

Chapter 2: Critical Medical Anthropology and Disordered Eating

Food and eating are tools with which to structure society (Douglas 1966). Food is necessary for human physical health, but is also used as medicine, as an object of exchange, in ritual ceremonies, and as a symbol of relationships. From infancy and continuing into adulthood, humans are socialized as to what, how, when and where they can eat. Using critical medical anthropology as a tool with which to deconstruct disordered eating, this chapter explores the structural features – economic, social, and political – as well as food choices and eating patterns that pertain to health problems associated with eating and nutrition.

Critical Medical Anthropology

Critical medical anthropology (CMA) is defined by Baer, Singer and Susser (1997:3) as the study of the ways in which disease and illness are experienced by a human population within a particular social, economic, and political structure at a particular historic moment. This critical approach has been adopted by many medical anthropologists to incorporate the theory "that social inequality and power are primary determinants of health and health care;" they "affect culture and social structure, and consequently human behaviors and human relationships" (ibid).

Medical anthropology (MA) emerged as a sub-discipline of anthropology in the 1950s, post- World War II. Health-related issues became the focus of many anthropologists who were involved in international health work within clinical settings in the capacity of "teachers, researchers, administrators, and clinicians" (Baer et al. 1997:15). As a result, clinical anthropology was introduced in the 1970s as a branch of MA in an attempt to demystify biomedicine. A key figure in this area was Arthur

Kleinman, a psychiatrist with a Master's degree in Anthropology, who introduced an explanatory model of healthcare systems in order to explain the experience and perception of disease from the patients' perspective.[iii]

Kleinman presented disease and the experience of disease for both the healer and the sufferer as culturally constructed and interpreted, and as a culture unto itself. He posited that it was "the interaction of biology, social practice and culturally constituted frames of meaning, such as Western culture's association between obesity and the lack of control," that resulted "in the construction of 'clinical realities'" (Baer et al. 1997:24). This theory is problematic in "that it does not acknowledge power relations or the role of political economy (class relations) in the construction of illness, and medical knowledge" (ibid). Thus, the development of CMA.

In contrast to clinical anthropology, CMA is "more of a Marxist, critical, or political economy approach to the issue of disease and illness" (Baer et al. 1997:26), and emerged as a challenge to socially constructed sources of power, including those in Kleinman's research. This discourse posits that health issues are influenced through political and economic forces at the institutional, national, and international levels, factors which "pattern human relations, shape social behaviors, condition collective experiences, reorder local ecologies, and situate cultural meaning" (ibid:27).

From this perspective "CMA seeks to understand who ultimately controls biomedicine and what the implications are of such control" (Baer et al. 1997:27). Power relations exist at all levels of health care systems including the developed and developing capitalist societies, and socialist-oriented societies. At the macrosocial level, the global economic system is 'capitalism,' and thus it follows that biomedicine as part of this system is highly

capital intensive. Corporate involvement in high technology, drugs, and service complexes are legitimized by the state and reinforced through medical training and research.[iv] The dominant status of biomedicine worldwide "is legitimized by laws that give [it] a monopoly over certain medical practices and limit or prohibit the practice of other types of healing" (Baer et al.1997:29).

At the micro level of biomedicine is the clinical encounter, which includes the physician-patient relationship, and the "therapy management group." The physician has two roles. The first is to control access to the 'sick role,' which determines whether an individual may or may not be excused temporarily from work. However, this is not absolute power, as the patient may not consult the physician. The second role is to medicalize social distress, or those social factors not considered in the disease model and in need of being brought under medical control. The driving force of medicalization is profit, increased social control, and the demystification and depoliticalization of the social origins of personal distress, wherein problems at the level of social structure are transformed into problems of the individual and brought under medical control – stress, poverty, nutrition and diet. Capitalist discourse is reinforced coercively in the doctor-patient relationship (Baer et al. 1997).

At the individual level of biomedicine is the patient and his or her response to sickness, or the sufferer experience, which is influenced by the material conditions of social life. Although biomedicine has been able to prolong the length of life with medicine, surgery and expensive technology, inequality due to gender, ethnicity, age, occupation, and class shows in the health of a particular group of people.

In disordered eating, the etiology and resulting "sufferer experience is a social product, one that is constructed and reconstructed in the action arena between socially constituted categories of meaning and the politico-economic forces that shape the contexts of daily life" (Baer et al. 1997:187). Disease is objectified; the individual is subjectified.

Nutritional Science and Food

In the mid-nineteenth century Europe, biomedicine under the guise of nutritional science developed a commonsense approach to food and eating practices, which was "stimulated by the problems of food and health, food scarcity among the poor and working class, the nutritional requirements of prisoners and soldiers, food storage and transport in the wake of the industrial revolution" (Lupton 1996:70). Scientists categorized foods according to nutrient value, the needs of specific social groups, and finally into binary oppositions of good and bad. A balanced diet of the four basic food groups, as defined by nutritionists, was good and promoted health, all others were bad, or led to ill-health (ibid).

Thus, the medicalization of eating behaviors, or disordered eating, began in the late nineteenth century as the diet of all members of the population was constructed as a 'problem'. Food habits and practices were in effect removed from the responsibility of the family and commodified by societal medical, political, and commercial institutions concerned with deriving a profit from diet (Lupton 1996:72). Nutritional science emerged as a source "of *power*" (Barthes 1997:24).

By the early twentieth century, scientists and "nutrition experts, reinforced by studies of mortality by insurance companies were now warning that excess weight, particularly among the middle-aged, led to early death" (Levenstein 1993:9), and that it was the

responsibility of the individual to maintain a healthy weight by consuming the appropriate number of calories. The fashion industry indirectly reinforced weight and body size. Clothing that had previously been custom made began to be mass manufactured in factories, which introduced the standardization of sizing and gave women the impression that if the standard size did not fit, they were fat (Brown and Jasper 1993:25). It was perceived by individual women that clothing size was directly related to the amount of calories they consumed; thus the production of subject positions in relation to food and eating.

The Depression era of the 1930s saw the rise of food processing companies and the homogenization and standardization of diet, but industrialization and urbanization also played a major part in the shaping of the social role that food would play in Canadian culture as to "who should prepare it, how should it be prepared, and what eating it said about them and their society" (Levenstein 1993:30). Advertising and nutritional science were also instrumental in the success of movies, magazines and radio that reaffirmed the traditional family values of the mother as the preparer of the food, the kitchen as female space and marriage as a career for women (ibid). The father as the head of the family and provider was upheld as commonsense knowledge. Again, we see the creation of subject positions through discursive practices regarding food and eating.

In Canada, the Canada Food Guide (CFG) was introduced in 1942 to help people cope with wartime rationing (Globe and Mail March 12, 2005). It was designed by those in control of economic resources on a national and international level – wheat boards, beverage corporations, beef industry, poultry industry, dairy industry, to name a few. The amount of power each industry held determined whether their product was

recommended for the masses to consume, and in what quantity. The CFG has been an influential factor in the creation of social structure and the development of a political economy related to food and eating.

By the late 1950s and 1960s concern was being raised regarding the rapid changes in Canadian societies "characterized by an economy of plenty, eating too much, and having too many things" (Powdermaker 1997:205). Consumerism as a sign of individual prosperity was in full gear with the introduction of more imported foods, better cars, refrigerators, television sets, and clothes, which contrasted with the previous values of saving and thrift (ibid:206). "In the postwar culture of affluence many aspects of personal behavior were transformed: sexuality, relations between the generations, forms of family life, gender roles, clothing, even styles of food and eating" (Brumberg 1988:11).

Equal rights and human rights activist movements in the 1960s and 1970s shifted North America's attention from micro to macro issues regarding hunger and malnutrition – these issues became associated with ethnicity, and in particular whites versus blacks in the United States. The Protestant work ethic of the working and upper classes upheld the capitalist value of patriarchy, that the male role within society was that of provider or 'breadwinner,' the female role that of reproduction and nurturance. In this era those in charge of social assistance programs focused their criticism on the fact that there were few working men among the hungry; thus, those who were unable to find employment were deemed unworthy recipients. By the end of the 1970s, food aid and "the ideology of helping the poor had gone out of fashion, or rather was no longer of political use, as the government turned its focus once again on nutrition for "average" citizens"

(Levenstein 1993:159); the deserving versus the undeserving (Mead 1997); a return to the individual.

What has been created within Canadian culture is a conflict of discourses: food and eating as social acts versus food and eating as the responsibility of the individual in order to maintain health and productivity.

Ordered versus Disordered Eating and the Clinical Encounter

'Normal' or ordered eating is the consumption of foods, and in a specific quantity, that are considered acceptable to a particular culture – as to what, when and where it can be eaten. 'Foodways' is a term that refers to the behaviors that affect what people eat, and includes cultural definitions of what is food and what is not, the methods of preparation and acceptable combinations of foods, and the rules for distributing particular foods within the culture. Foodways plays an important role in cultural identity, especially among those individuals who are acculturating (Bauwens 1978:111), or adapting to the dominant cultural values, as we shall examine later in the case of Canadian Aboriginals.

Capitalist discourse emphasizes the profit potential of food; however, there are underlying social meanings attached to food (Lupton 1996).

> Class, caste, race and gender hierarchies are maintained, in part, through differential control over and access to food. … In stratified societies, hunger – like poverty – is far more likely to strike people in disadvantaged and devalued categories: women, people of color, the mentally ill, the handicapped, and the elderly. … Race, class, and gender distinctions are manifest through rules about eating and the ability to impose rules on others. In the United States, for example, we value thinness. The dominant culture – manifest in advertising, fashion, and most especially the media – projects a belief that thinness connotes control, power, wealth, competence, and success. … the standard of thinness upholds a class structure where men, whites, and the rich are superior to women, people of color, and the poor (Counihan 1999:8-9).

Food denotes class structure. The general meaning of the word 'taste,' as it applies to food and eating, refers to "the sensation people feel when they take food or drink into their mouths" (Lupton 1996:94). However, in a broader context it reflects "a sense of style or fashion related to any commodity" (ibid). The idea of 'good taste' is a socially constructed ideal that is considered to be a universal standard applicable to all members of a society and a value that should be adhered to. Therefore, "taste is both an aesthetic and a moral category" as well as "a subtle way of identifying and separating 'refined' individuals from the lower, 'vulgar' classes" (ibid:95). Also associated with class is type of food and portion sizes. Men are perceived to be big eaters, especially of red meat and heavy foods that provide them with strength and health to provide for their dependents. Women's consumption is referred to as light, preferring white meat, vegetables and salads, which are indicative of her weaker nature (Lupton 1996:105).

The social roles assigned to men and women are also defined by food; across cultures, food itself is coded as feminine. Women are associated with the preparation and serving of food, while men are involved with the eating of food that others have prepared. Also, the fact that women's bodies are the locus of food production during pregnancy and lactation creates a symbolic cohesion between woman's body and food. Specific foods such as chocolate and sugar have the dual meaning of being both feminine and childlike. Nursery rhymes characterize "little girls as 'sugar and spice and everything nice;' chocoholics are typically women, and treats for children are usually of chocolate or sugar origin. Advertising, in its quest to promote consumption, uses women and children as objects of indulgence and weakness (Lupton 1996: 105).

Humans do not just eat to satisfy hunger, eating is also about social relations. Historically, the status of some foods, as well as the people who eat them, changes. For example, Mintz (1986) described how sugar was originally a spice of the wealthy, but over time became a medicine and finally a food of the poor.[v] Alcohol, which I consider as food, if consumed responsibly (ordered) is acceptable, and especially so for men. In fact red wine consumed in moderate amounts has been endorsed by biomedicine as healthy. Coffee and tea are also beverages that have been given the stamp of approval as healthy. However, historically this has not always been the case. These beverages have fallen in and out of favor depending on the political and economic agendas of the dominant discourse. The shifting 'orders' of eating are anchored in historically contingent social relations.

What, then, is 'disordered eating'? Disordered eating is food and eating behaviors that are considered unacceptable to a particular culture - as to what, when, where, how and in what quantity food can be eaten. Food and eating behaviors enter the clinical encounter in several ways: as a biological diseases such as type 2 diabetes, and as psycho-pathology such as the eating disorders of anorexia nervosa, bulimia nervosa, and binge-eating disorder. Individuals at the level of poverty may experience the clinical encounter from either perspective or from both. The CMA approach can be used to understand how the logic of the clinical encounter has been expanded into other realms of eating beyond the biological and pathological to include social and cultural pathologies such as social dependence or 'food as gift,' as in the case of poverty and homelessness, and Aboriginal diabetes, respectively. Disordered eating is defined, produced, and dealt with relative to cultural beliefs and values that are socialized within the various institutions of a culture.

This, too, is determined through discourse. The physician-patient relationship transfers the etiology of disease from social, political and economic conditions to the individual.

Biomedicine has established language about what could be said objectively about the individual human body, thus creating the subjectivity of the individual. What came to be termed the 'clinical experience' encompassed the gaze of the physician and the submission of the patient; hence, a non-reciprocal situation, a special contract, a pact made usually between one man and another, in which the patient allowed the physician to gather data from their body, and to be observed as a laboratory experiment. It is the interpretation and re-interpretation of this data that constructs medical discourse, as signifiers take on multiple meanings, open to definition (Foucault 1975:xiv-xvi).

The clinic, then, became the domain of science, the micro level of biomedicine that included the physician-patient relationship. Waitzkin (1991) related that it is through medical discourse that physicians reinforce societal values of work, the division of labor, and the unacceptability of deviant behaviors. "Doctor-patient encounters bec[a]me micropolitical situations that reflect[ed] and support[ed] broader social relations, including social class and political-economic power" (9).

According to Waitzkin, within this relationship, the physician has two roles. The first is to control access to the 'sick role', which determines whether an individual may or may not be excused temporarily from work. However, this is not absolute power, as the patient may not consult the physician. The second role is to medicalize social distress. The physician helps the patient adjust to social conditions but does not foster change to these conditions.

In their contact with patients, doctors transmit ideological messages that reinforce current social patterns of work, family, and the division of labor, age, and class. Individual problems are almost always interconnected with structures in society; however, they are not always obvious and go beyond the individual level. The ideas and doctrines, or ideology, of a social group can have a profound effect on social life of the individual members of the group. In Marxian theory, economic forces are directly related to conflicting relations within social classes. For example, 'work' is perceived as good for human beings; it symbolizes health and can be produced economically, and therefore, it is the job of medicine to keep people productive and contributing to society's wealth. Doctors as gatekeepers of the 'sick role' are the only ones who can validate the inability of an individual to work, or to attend school, but they also report to insurance companies those who are eligible to collect insurance (Waitzkin 1991). To this end, the life insurance industry has had a large role in defining 'ideal weight;' for example "from 1943 to 1980, definitions of 'ideal weights' for women of a particular height were consistently lowered, while those for men remained approximately the same. In 1983, a major debate on the definition of obesity began when Metropolitan Life revised its tables upward, based on new actuarial studies of mortality" (Brown 2001:77).

Doctors are not conscious of their role in social control, because they tend to come from upper class backgrounds, and are experienced in helping the lower classes accept this position. There is also a difference in language between the classes and between genders: the doctor is upper class (primarily male), while the patient is working class or lower (including women). Class hierarchy enforces the passive behavior of the lower class. This class distinction, like a patron or fatherly role, is reinforced through

socialization and professional education. Doctors are culturally socialized to detach themselves from lower class problems, encouraging their patients to cope with and accommodate their situation by utilizing the existing health care services that are available such as counseling, family therapy, and drugs. Physicians therefore unconsciously reproduce the existing system but do not alleviate the patient's suffering (Waitzkin 1991).

With variables such as class, age, gender and race there can be issues of dominance and subordination, and changing expectations between doctor and patient in face-to-face encounters. Social issues such as employment and gender roles can be unconsciously somaticized, appearing as depression, addictions, and disordered eating. Doctors do not deal with contextual problems, however, only biological ones. When no biological symptoms are present, they respond with technical solutions in the form of tests, drugs, and counseling. Their responses also reinforce the cultural ideologies such as the importance of work and gendered social roles, and discount the possibility of social change. The result is social control (Waitzkin 1991). In his work, Foucault (1975) made this connection between knowledge and power, or 'power-knowledge;'[vi] the use of technology and access to special knowledge rather than economic resources gives physicians the power to intervene and control people's lives through surveillance or perceived surveillance.

Using case studies, Waitzkin (1991) examined various social problems that enter the doctor-patient conversation – bereavement, isolation, dependency, inadequate housing, lack of transport, financial insecurity, age, gender racial difference, and class. He noted that biomedicine of the late twentieth century had become that of prevention, and that

with economic development health problems had shifted to chronic disease, which has caused a challenge for medicine and public health. Pleasure substances such as tobacco, alcohol, and mood-altering drugs have delayed health consequences, and as well, some sexual activities and overindulgent eating behaviors have long-term consequences. Affects of these self-destructive behaviors, so labeled by biomedicine, carries over into relationships regarding family, friends, work, and the community at large, creating feelings of uneasiness and resentment, as well as being costly for care.

Through incorporating unacceptable behaviors into their discourse, doctors reinforce societal moral values. This professional surveillance aligns the patient's behavior with societal norms and values by policing unsavory behavior, which has been the role of the medical profession for over a century,[vii] and is necessary for preventative medicine to be effective. However, attention to contextual issues remains marginal, and self-destructive behaviors are perceived as diversion-seeking and gratification amid the difficulties of social life (Waitzkin 1991).

In the case of emotional issues, the changing contextual issues generally remain unexpressed and instead doctors suggest lifestyle modifications and compliance with mainstream expectations. Contextual issues such as work, economic security, gender roles, family, aging and substance use are underlying issues that "figure prominently in the emotions that patients and doctors discuss," and "medical encounters provide one forum for the expression of such issues and the personal troubles that they generate" (Waitzkin 1991:229).

The driving force of medicalization and the clinical encounter is profit, increased social control, and the demystification and depoliticalization of the social origins of

personal distress, wherein problems at the level of social structure are transformed into problems of the individual and brought under medical control – stress, poverty, and working conditions (Baer et al. 1997). However, the problem is ultimately the responsibility of the individual.

Another important benefactor of the medicalization process is the field of medical research. Acquiring funding for research is an ongoing process for medical researchers as there are many disciplines competing for limited public and private money. Social factors, such as the character of the affected person and the amount of publicity the disease receives, often influences the availability of funding (Baer et al. 1997).

The process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment is of a coercive nature, that is, in the doctor-patient relationship (Baer et al. 1997:14) or the clinical encounter; the patient must comply.

Health Care and Disordered Eating

Biomedicine is itself a cultural system. The study of the variant versions or subcultures, including the clinic, within the culture of medicine in different societies is coined by anthropologists as ethno medicine (Hahn 1995:132). Both the medical profession and those who experience illness have certain beliefs about the causes of illness, and the roles of healer and patient, as well as the accepted behaviors of each.

The health care system incorporates the interrelationship between the cultural meaning of disease, the experience of illness, and the accepted treatment, as well as the social institutions relating to physical and mental abnormalities within the culture of medicine. These also vary across cultures depending on the "level of technological and social

development, including the status of therapeutic institutions, biomedical technologies, treatment interventions, and professional personnel" (Kleinman 1980:49).

After extensive training, physicians and other professionals endorsed by biomedical authorities such as psychologists, social workers, and dieticians, are endowed with the power of being 'gatekeepers' to the 'sick role.' This role temporarily excuses the individual from societal responsibilities and allows them seek care from either family or social institutions, but ultimately they are expected to comply with professional treatment, to get well, and return to their responsibilities (Estroff 1997:10). Failure to comply with physician-prescribed treatment is perceived by the medical professional as "a moral offense" (ibid).

Individuals with disordered eating behaviors do not usually present themselves to professionals until their habits have manifested into psychological or physiological problems. Until their behavior enters the realm of biomedicine, individuals with disordered eating do not perceive that their behaviors are socially unacceptable.

Conclusions

The biomedical system, at all levels of society, is a discourse of power. This system is not neutral; it is tied to particular epistemes and the resulting state-controlled institutions. We have the illusion that we have choices, but in reality our access to resources varies according to our status in society. The clinical encounter shows that with the ever-increasing expansion of technology, the state defines accessibility to particular knowledge – who is allowed access, who can see, what can be seen. Social power, or restricted access, is gained through disciplines and professions, and the development of esoteric technology. The clinic is ever-expanding into the private domains of society and

becomes a place of experimentation through processes of quantification, classification, and examination; the person becomes objectified, and social surveillance is increased. The clinical encounter, as it is experienced along the continuum of disordered eating, is a tool with which biomedical professionals mediate between the ideologies of the state and societal deviation. Social problems such as disconnectedness with the family institution, unemployment, the dependence on society, as well as the use of substances deemed self-destructive, are brought under the control of biomedicine and medicalized by the state. In turn, the individual is labeled until such a time as he or she conforms to societal ideologies.

CMA is a tool with which to deconstruct social issues in order to understand the historical, social, economic and political dynamics behind particular phenomenon; in this case, the experience of disordered eating. Under the control of social and cultural institutions, it is constantly reinforced that health and nutrition are ultimately the responsibility of the individual; what is not considered is that eating (or the lack of eating) is a social rather than an individual act. By recognizing the structure of medical discourse, with its goal to marginalize the social issues that create personal troubles, CMA is better able to understand the political, social and economic factors that influence disease and illness.

In disease, such as disordered eating, the etiology and resulting sufferer experience is a social product, one that is constructed and reconstructed in the action arena between socially constituted categories of meaning and the politico-economic forces that shape society (Baer et al. 1997:7). Disease is objectified; the individual is subjectified.

The next chapter will explore homelessness and social dependence or 'food as gift' as disordered eating in the context of a clinical encounter. The data presented in this chapter was collected in field work conducted at The Shelter and The Kitchen in the city of Rivertown.

Chapter 3: Poverty as Disordered Eating

This portion of my research of 'disordered eating' extends beyond the stereotypical studies of eating disorders, often characterized as specific to a "historical group" of adolescent, middle class, mostly white females, to include obesity, type 2 diabetes and poverty. Disordered eating comes in many forms, reflecting diverse foodways affected by gender, age, ethnic background, and social class. In this chapter I examine poverty as disordered eating in order to throw light on the proposition that all disordered eating, including eating disorders, reflect and are shaped within social structure.

In order to gain access to the ways in which various citizens of Rivertown procure food and the manner in which this food is consumed within the community, I became a participant-observer in the capacity of 'volunteer' with a non-profit society, hereinafter referred to as 'The Society.' My intent was not to study poverty; however, the first assignment for this organization was at the local emergency homeless shelter, hereinafter referred to as 'The Shelter.' This extended my research into the realm of poverty, homelessness and 'food as gift.'

Homelessness is defined differently within various cultures and states, and also within a particular historical context.[viii] Contemporary authorities, who address the issue of what constitutes shelter, have defined it as:

> offering a security of tenure, potable water, sanitation, and access to services (health, jobs, education, recreation, and public transport). Further, housing should provide adequate protection from the elements and security from intruders. It should be secure from the dangers of fire and structural collapse. And finally, it should ensure that residents enjoy adequate space and privacy....Housing is considered a right, not a privilege, in most international bodies, unlike the United States, which still maintains that housing is a privileged commodity provided by the market (Huth and Wright 1997:2).

The conditions of the destitute and homeless were identified as social problems throughout North America and Western Europe in the latter decades of the twentieth century (Levenstein 1993, Huth and Wright 1997). This phenomenon has been described in studies as either social deviance, or the objectification of pity. This group has been marginalized by society and stereotyped as: "poor people, [including ethnic minorities, and] particularly men and women not attached to family constellations, [and] are either the "undeserving" or "unworthy poor" or old." In effect, their position has been medicalized as "people with severe personal pathologies" (Huth and Wright 1997:55), and brought under biomedical surveillance as persons suffering primarily from addictions.

Homelessness as a Clinical Encounter

Just as food and eating behaviors such as anorexia, bulimia and binge-eating disorder have been medicalized as problematic within the working and upper classes, labeled, and subjected to the clinical encounter, so too has homelessness (Lyon-Callo 2000:330). Like an individual who claims the sick role and becomes a patient is legitimized by a physician and expected to conform to treatment to regain health, the homeless individual is labeled as a client, classified as homeless by a shelter case worker, and expected to reform their behaviors in order to rejoin society. As with health, the state of being homeless is perceived by society to be the problem of the individual, and as such it is the responsibility of the individual to change their circumstances. However, this perspective of the state of homelessness is relatively new; it applies to a specific historic timeframe and differs from the perspective held during other timeframes, for example, the Depression.

The 'invisibleness' of the homeless in Rivertown was exemplified by my own lack of knowledge about this particular group of people. I knew that a 'shelter' existed within Rivertown, but did not know where it was located and needless to say, I had not been there. Mainstream society assumes that local institutions such as churches and social agencies will take care of homeless individuals, and thus dismiss it from their lives. The following is my observations at The Shelter in which I parallel the state of homelessness to the sick role, and the staff-client relationship to the physician patient relationship.

My first encounter with the state of homelessness was a tour of the facility with The Society's volunteer co-coordinator. We drove down a main city thoroughfare, and turned off into a small industrial area. After a few more twists and turns we arrived at a long concrete building, part of which was still under construction. The 'staff' entrance was comprised of two sets of doors: the first was unlocked, the second was locked. In order to enter, we had to push a red button that activated a buzzer; a staff member would then open the door from behind a partial divider-reception area by pressing another button. The building was divided into offices, men's and women's sleeping areas (wet and dry, or drunk and sober, respectively), and a social area where clients watched television, played cards, read, and partook of any food that was made available to them by staff. All areas inside as well as the perimeter of the building were under camera surveillance at all times. It was intimidating.

Over the ensuing weeks I spent many hours at The Shelter primarily during the late afternoon and evening hours, which encompassed the time when 'soup' was served. Serving the evening meal was an excellent opportunity to engage in conversation and observe the food and eating behaviors of both clients and staff. From my observations, I

perceive that The Shelter experience can be likened to the clinical encounter of a hospital or clinic, and that the staff-client relationship can be compared to the physician-patient relationship. Clients freely assume the client role when they enter The Shelter, and the staff assumes the authority of gatekeeper to this role by deciding who may or may not be admitted to The Shelter. Those individuals considered as a possible threat to the safety of the staff or other clients, as a result of substance abuse, are refused entrance; if the staff suspects that the person requesting admittance is in possession of restricted substances, these substances are confiscated. Any medical prescriptions are kept in the security area and clients must ask a staff member for access to their medications. As well, clients enter into an agreement that allows the case worker to gather data about their personal life. In the case of observation, it appeared that this segment of the population was easily accessed by researchers, students and various community agencies.

Once admitted, the client is required to comply with the regulations of The Shelter, which are posted in the social area. Clients are free to leave the shelter at any time, but must re-qualify for admittance every time they enter the facility – even if they are only off premises for a few minutes (usually to have a cigarette). And, as previously mentioned, there are surveillance cameras in every room enabling staff to observe client behavior at all times.

The Shelter staff, like biomedical physicians, mediate between cultural ideologies and the individual problems experienced by the client. Whereas in the patient-physician relationship of the clinical encounter women more frequently assume the patient role, and conversation centers around family (Waitzkin 1991), in the staff-client relationship of The Shelter, men are the primary clients, and conversation is about work (or lack of) and

that their responsibility is to procure employment. To facilitate this process there is a 'life-skills program' available for clients if they so choose.

As patients in the sick role, clients in the homeless role are objectified and labeled. It has been argued that government welfare programs in the 1960s and 1970s led to increased dependency and deviant behaviors (Huth and Wright 1997:56). However, the public has been quick to 'blame the victim,' by perceiving the homeless as deserving their fate because they do not adhere to the Protestant work ethic and engage in self-destructive behaviors such as substance abuse involving drugs, alcohol and tobacco.

There is a definite assertion of power by the staff over clients, or politics within The Shelter. Staff are working members of society, and therefore of higher status than clients, who are not working – even if the client has had more education or has come from a position of affluence. The Shelter staff reinforces the work ethic by rewarding clients who are employed with the preferred sleeping quarters. Working in exchange for their accommodation is expected as clients are assigned tasks involved in the daily maintenance of The Shelter, and those who participate are rewarded.

Also, like physicians in the clinical encounter, The Shelter staff use various techniques to assert this power. They use authoritative language, both verbal and body, walk away from clients, ignore them, and joke about the situation in order to control the encounter. Staff also control access to shelter resources. They decide who has access, when and what kind of food is available (including the rationing of luxuries such as coffee), when technology is available for client use (computers, television, laundry facilities, shower facilities), what hours they are allowed access to sleeping quarters, and who has access to the preferred space.

Homelessness, like other social problems, can result in physiological problems. I posit that homelessness is a form of 'disordered eating' in that food choices are restricted, and eating behaviors and the manner in which clients receive food is not the societal norm. 'Ordered eating' is facilitated through the Protestant work ethic, that is, citizens of society work, receive compensation for their labor, purchase food and eat it, usually within a family scenario. In the case of the homeless, most, but not all, do not work for a variety of reasons, and they are dependent on The Shelter as well as the local soup kitchen (The Kitchen), or 'food as gift,' for food. Clients who use The Shelter facilities are not allowed to obtain food from community food banks, as this service is reserved for those who have a residence with cooking facilities and earn a low income, but are not destitute. In conversations about my research on disordered eating, The Shelter staff stated that it is their belief that the majority of clients engage in some sort of substance abuse (drugs, alcohol, tobacco), and that if a client has any money, he or she spends it on their 'habit' rather than food because they know that there is food available. Staff also commented that about sixty percent of the clients have homes and families that they could go to but choose not to. Therefore, they agree that this behavior is a form of disordered eating.

Some of the volunteer work I did involved entering records as to clients registered on a daily basis into a main computer system. It appeared that most clients were male, and of mixed ages from late adolescence to elderly, but disproportionately over forty years of age and Aboriginal. For example, out of seventy registered clients, less than ten would be female and one third would be less than age forty. Although disproportionately Aboriginal, forty percent are of other ethnic backgrounds including Euro-Canadian,

Asian, and Black. However, in Rivertown the stereotype is that the homeless problem is an Aboriginal problem.

From discussions with staff, women have other alternatives such as a 'transition' home, the YWCA, and a 'harbor' house; therefore, they do not need to stay at The Shelter. However, some women who stay at other facilities frequent The Shelter to visit shelter clients, as they were themselves clients at some time in the past, but this visitation usually (and I expect conveniently) corresponds with 'soup time.' Theoretically, females also have the option of procuring a male to support them; societal institutions provide protection for females and children, upholding the cultural norm allowing for women to be dependent. Men do not have the same provisions, and dependency is not acceptable; thus, the stereotype of the homeless as male.

As well as paralleling the clinical encounter, several other themes surfaced from my observations at The Shelter, which paralleled those observed by Lyon-Callo (2000) in his research as an employee at a homeless shelter in Northampton, Massachusetts. First, social issues such as alcohol and substance abuse and traumatic episodes during youth have been medicalized and individualized through discourse; "homeless people as deviant are constituted, reproduced, and reinforced" (330). Second, CMA argues that this process silences underlying "broader historical and material conditions" (331)[ix] such as age, gender, class and ethnic inequalities, that produce the deviant behaviors.[x] Third, rigid structure of daily Shelter routine as well as surveillance reinforces compliance to Shelter rules for both staff and clients.[xi] Fourth, efforts by staff and various service agencies to rehabilitate and reintegrate clients as members of mainstream society is

somewhat successful; however, it does not address the issue of the availability and access to resources within the community at large and in my research, foodways in particular.

The Politics of Food Choices and Preferences

In my study of Rivertown foodways, particularly those accessible to the homeless, I have noticed a preponderance of processed food, and especially 'sweets' that comprise the diet of these people. Anthropologist Sidney Mintz (1986) has done extensive research into the historical, social, economic and political use of sugar, which is relative to diet-related diseases of modern times. He depicted the historical evolution of sugar from a medicine, to a preservative, to a direct-use product; and, from a luxury commodity of the wealthy to a staple of mainstream society, and particularly the poor.[xii]

The acceptability and preference of foods varies across cultures and within a particular time frame. "Contemporary food preferences that lean towards finger foods, fun foods, snack foods, and fast and convenient foods express basic American cultural values" (Fitchen 2000:342), or Canadian in this case. An indication of membership in a particular society is expressed in adherence to its' dominant values; thus low-income people express this through the foods that they choose. Canadian culture's ideology of "freedom of choice" is exercised not only by the affluent, but also by the poor, who perceive that desirability is of more importance than the price (ibid). As a result, they purchase status-invested foods: brand labels and heavily advertised foods, as well as fast foods, rather that the cheaper generic foods. For a culture as a whole, these foods contribute to a diet that consists primarily of processed foods that are high in sugars and fats or "junk food" (ibid).

As well as the consumption of junk food and status-invested foods as an expression of adhering to dominant values, ethnic groups hold particular foods as part of their ancestral heritage. For example, any conversation about food among the Aboriginal clients and staff of both The Society and The Shelter inevitably included 'fry bread' and its significance as a 'traditional food' at all levels of Aboriginal society. This food was introduced by Europeans and became the staple of the Aboriginal diet, but the reinforcement of it as traditional demonstrates the power of post-colonial discourse.

Junk foods which by the CFG standards includes fry bread have had adverse effects on the health of western culture populations, but more so on the poor. While the more affluent portion of the population can afford to consume junk food as well as nutritious food, the poor cannot (Fitchen 2000:342). Foods and drink have important contributions to social relationships among all classes. Beverages such as coffee, carbonated beverages (pop), and alcohol provide a sense of hospitality more than a notion of nutrition. Food choices and exchange are part of celebrations and ritual occasions, and one's economic class has bearing on cultural expectations – it is a matter of identity within the culture as a whole, even for the poor (ibid).

The public tends to judge the consumption of status-foods by the poor as their inability to delay gratification and to adhere to the Protestant work ethic. It is also the perception of mainstream citizens that the poor would be able to eat the basics, and thus maintain good health, if they were disciplined and did not indulge in luxury foods. The dominant discourse reinforces the belief that economic status is the responsibility of the individual, which is available to every member of society. Thus, it is perceived that

poverty can be overcome if so desired; if hunger and malnutrition exists, it is as a result of improper eating habits on the part of the individual (Fitchen 2000).

From my observations at The Shelter individuals do have choices regarding their food choices and eating habits. At The Shelter, the staff room is the center of food storage and distribution. A table just inside the entrance to this room holds a double hotplate used for heating two large pots of soup. Along one wall is a refrigerator which stores perishables, and a long counter-cupboard unit that is piled high with boxes of breads and pastries. The latter is divided according to evening meal, afternoon snacks, and breakfast. These are further divided as to expiry dates; the foods that are the oldest are used first.

Soup is served every evening. The variety and ingredients varied but from my observations it usually contained protein, vegetable, and starch in some form. As well, various breads, and occasionally luxuries such as processed cheese slices are served as an accompaniment. Soup is served from 7:00 – 8:00 p.m., these times being rigidly enforced. Later, sweets in the form of pastries, muffins, cookies, sweet breads, donuts, and the like are put out on the coffee table in the social room. For the most part, sweet foods, coffee and tea appear to be available at all times. Food and beverages are available to and consumed by both staff and clients.

Upon questioning The Shelter staff members about food sources, it was revealed that the soup, breads, and pastries come primarily from The Kitchen, while the coffee, tea, cream, sugar, fresh fruit, and an iced tea beverage that are served in the morning are purchased from local retail grocers. There are plenty of food choices for clients; however, it is their responsibility to adhere to meal times. Those who do not comply have fewer food choices – mostly an abundance of sweets.

The next step in tracing the foodways of the homeless was to seek out The Kitchen and interview those in charge. This task was easier than expected as another volunteer assignment for The Society was to participate in the preparation and serving of a mid-day meal at The Kitchen. All the staff and volunteers participating met at The Society and car-pooled to The Kitchen. As with The Shelter, I had heard of this community service through my own personal church affiliations, but did not know where it was located. Like the Shelter, this facility is not visible to the general population. It is located in a business/office building area, down an alleyway, set back from the alley by a large parking lot, and the sign designating its purpose is worn and faded. It is not visible to the mainstream Rivertown population.

My group entered the building through double, unlocked doors; a few clients were already lining up outside. At first glance it looked like a cafeteria – rows of tables and chairs to eat at, a counter for serving, and a kitchen preparation area behind the counter. However, my sense of smell was quick to detect that the smells that filled the room were not of a positive nature such as "Mom's fresh-baked apple pie," but instead was of rather a pungent nature. After washing our hands we prepared salad, buttered bread, and cut pastry into serving size portions; an already prepared hot dish was heating in the oven; coffee was brewing and juice was ready for serving.

When I had a chance to look around, I noticed that there was a table just inside the front doors, and in front of the bathroom entrances. On this table was a book for volunteers to sign-in and three large bowls containing wrapped candy, shelled nuts, and fresh fruit, respectively. Along that same wall was a storage room filled with various plastic, foil and metal containers used for serving and storing food, and a walk-in cooler

filled with produce, pastries, condiments and juice. Behind the serving counter and next to the kitchen was a large room with shelves and table that were stacked with boxes of breads and pastries. I later linked the pungent smell of the facility to the large quantities of wheat products in this sorting area, which I related to the smell of grain in storage bins that have become wet and started to ferment. Also, in this room is a large walk-in freezer for long-term storage of ready-made dishes and other perishables.

The Kitchen is another Rivertown non-profit community organization, which is coordinated by a volunteer, Marg, and two paid staff members. Through my church affiliations, I was acquainted with Marg, who gladly answered all of my questions regarding the origins of the foods used at The Kitchen and how they were redistributed. Marg related that the food comes from various grocery outlets, bakeries, and restaurants in the city, as well as from private individuals. Some food is delivered to The Kitchen, and some is picked up by a Kitchen employee. All of the food donations are documented, a monetary value attached, and a tax receipt given to those who require one.

Baked goods are collected and redistributed on a daily basis. The Kitchen uses or stores what it needs first; the remainder is then shared with local food banks, The Shelter, employees and volunteer servers. At the end of each day, leftover baked goods are picked up by a local farmer; then redistributed to families that he knows who have low incomes and are in need of food aid. Food that he cannot get rid of is fed to farm animals.

While in the storage room talking to Marg, I noticed a Kitchen employee filling a large pot with canned and fresh fruit. Upon inquiring into what she was concocting, she related that a large wholesale food outlet from a larger city sends cases of canned goods

to a Rivertown food bank. The food bank keeps the undamaged canned goods, and sends the dinted (damaged) ones to The Kitchen. As a health precaution, food from damaged cans must be heated to a temperature over 400 degrees Fahrenheit before it is considered safe for human consumption. Thus, fruit from dinted cans is emptied into a large pot, and fresh fruit that has started to spoil is added. It is then boiled to the required temperature, cooled, strained, and served to clients with their noon meal.

The Kitchen serves one meal per day, Monday through Saturday. This meal is available to all members of the community, regardless of economic status; no proof of neediness is required. Various organizations throughout the city volunteer their time to prepare and serve this meal, and there are enough organizations so that each is required to participate on only one specific day of the month. Most groups meet early in the morning to prepare the meal while some, like The Society, serve a meal that has already been prepared; they just provide the labor for general preparation, serving and clean-up.

Clients were allowed entrance to The Kitchen sharply at noon. As they rushed in, the candy in the bowl by the door was the first thing to disappear as they proceeded to the food counter. Here they were given a divided tray, a fork, and a spoon (no knife) by a server, then proceeded down the food line. At no time are they allowed to 'help themselves' to anything, except salt and pepper. For the most part, clients and servers are separated; however, some servers do mingle with the clients after dinner has been served or sit and eat with them. Clients are allowed to consume as much as they want but are not allowed dessert until after the main course is served. When they are finished their meal, clients are required to take dirty trays and utensils to a designated area. From here,

volunteers remove these dirty dishes to the dish washing area, where they are rinsed by hand and then put through a professional sanitizing machine.

I observed that many Shelter clients ate at this facility and, like The Shelter, the majority of Kitchen clients are disproportionately male and Aboriginal. However, there were also many women and men of all ages and ethnicities who partook of the meal other than those I had seen at The Shelter; there were even babies and school-aged children. Security staff from The Shelter makes their presence known so as to deter any violent outbreaks, which are frequent among the clients; again, surveillance is enforced.

Like The Shelter, The Kitchen can also be considered a clinical encounter. The Kitchen staff and volunteers are the gatekeepers of the access to food, what food and in what quantity it is to be made available, and when this food will be served. Clients assume the passive role as receivers, they are expected to comply with The Kitchen rules, and to make lifestyle changes that will accommodate societal values, thus enabling them to re-enter mainstream society. However, the atmosphere of The Kitchen is more social and one of benevolence rather than surveillance; thus I parallel this experience to that of 'the gift' as expressed by Mauss (1967).

During this first experience at The Kitchen, I recognized my own biases regarding my own status that I had taken into the field. I felt the power position of a server, that of a benefactor, which creates a state of inequality for the client, or receiver of my 'gift' of food as a representative of The Kitchen. While most servers partook of the food we served, either before clients were allowed in or after they had finished, and I knew that the food was good and prepared under sanitary conditions, I could not eat – even if the food choices had been my favorite, I would have choked on it. It took several hours after

leaving the Kitchen before I was able to eat anything. I also noted my reluctance to handle the dirty dishes and wipe down the tables and counters after the clients had left, as though they were contaminated. As an unaware citizen, I was more disturbed by my Kitchen encounter than that of The Shelter. Upon reflection of my behavior, not eating the food voiced that I was not trying to establish social relations with clients; food structures society. Since that first encounter, I have spent many more hours at The Kitchen with volunteer from various groups, and have become more comfortable with the environment. While I have not eaten a meal there, I have joined fellow workers for coffee; an indication that social relations with this group is acceptable. From my experience, The Kitchen, while it endeavours to equalize access to food for all members of society, it also creates inequalities.

Stein (1989) observed this inequality between clients and workers during his fieldwork conducted in several soup kitchens in a midwestern city of the United States. The exchange that occurs in a soup kitchen is the gift of food to the needy, which is reciprocated by an attitude of gratitude on the part of the client. This is an asymmetrical exchange as "the voluntary nature of the original gift is a characteristic that cannot possibly be reciprocated" (246). The benevolent nature of the gift is theoretically supposed to equalize the status of the needy so that they are not degraded or stigmatized by society. In reality this act creates that which is set out to prevent, inequalities and thus social structure (ibid).

The feelings of power and benevolence observed by Stein and myself, as soup kitchen volunteers, were also explored by Mauss (1967), who perceived that every 'gift' or exchange, and in this case food, had an obligation attached to it – that it was not

disinterested. Systems of exchange vary across cultures and states, and include what Mauss termed as a 'total prestation,' "not exclusively goods and wealth, and things of economic value," but also "courtesies, entertainments, ritual, military assistance, women, children, dances and feasts" (Mauss 1967:3). They are given freely or obligatory as gifts or exchange, but create relationships of inequality; of honour and status; as well as social bonds. In the act of exchange, refusal to receive, invite, or give is equal to the refusal of friendship. In other words, the rights and duties about consuming and repaying exist side by side with rights and duties about giving and receiving. In the case of The Kitchen, food is freely given to all who access this community-based service; in return individuals are expected to reciprocate by being or becoming productive members of society.

Historically, gift exchanges symbolized an economic contract ritualized between men, and was considered to be like giving gifts to gods or exchange with gods (or spirits of the dead). Men were named after gods and therefore were the embodiment of them; gods were the real owners of the world's wealth, therefore so were men; the destruction of goods, even people (i.e. slaves) showed power, wealth, and unselfishness – a sacrifice; a gift that the gods must repay. Alms were considered to be the portion of a gift that was reserved for the gods and spirits, and must be destroyed in useless sacrifice or given to the poor and children (Mauss 1967). I perceived that most of the volunteers were from religious and social organizations, and giving food to the poor was a reciprocal exchange between their god and their community, respectively. The notion of alms applies to church organizations that give goods and time to nonprofit organizations such as The Kitchen and The Shelter in the belief that by giving to those in need that they will be

rewarded; an exchange between man and the divine. As well 'gifts' or donations of food from local businesses are exchanged for economic and political gain of reduced taxation.

The gift is the basis of society; however, its conscious direction is political and adheres to the dominant discourse of capitalism. For example, in state social systems the worker exchanges his life and labor for wages from an employer and social insurance against unemployment, sickness, old age and death from the community, or state. The affluent of society, as treasurers of their fellow citizens, are obligated to take care of the individual's life, health, education, his family and its future; the individual must adhere to the Protestant work ethic, as dependence on the generosity of the community is harmful to the individual and to society (Mauss 1967:81).

This notion of the gift is reflected in assistance programs for the needy, at both the local and national levels, and reveals the function of food in our society. From early in life we learn that food has power; it "is given or withheld at the discretion of the donor; food is a means by which we are controlled and can control others; food is used to reward and punish" (Fitchen 2000:343). Foodways are not shaped for the benefit of providing people with food, but rather a means of both economic and political power exerted by the food and agricultural industries.

Nonprofit organizations such as soup kitchens and food banks feed the poor but are dependent on the leftovers of these industries. For example, the 'soup' served by The Shelter is made at The Kitchen and utilizes pastas, meats, and vegetables as well as canned and fresh food goods that are not saleable by local grocers. Low-income people stand in line for food give-aways, which are in reality excess or unsold foods donated by manufacturers and distributors, and consequently a legitimate tax write-off for these

contributors. "Although the public may believe that food distribution is designed, funded, and carried out solely for the altruistic purpose of reducing hunger, one could easily argue that the beneficiaries include not only the hungry but also the well-fed" (Fitchen 2000:343).

In a capitalist economy based on consumption and profit, nutrition is not of prime concern as foods are used "to satisfy a variety of needs beside caloric and nutritional ones" (Fitchen 2000:345). The problem of malnutrition caused by the consumption of less nutritious foods has more negative consequences for low-income people, as they have "no cushion of good health to tide them over periods of inadequate eating" (ibid). As I observed in my fieldwork, even gifts of food from food banks, soup kitchens, and shelters does not mean that the destitute are provided adequate nutrition, as a good portion of the food is highly processed; loaded with fat and sugar. 'Free' food and shelter is *not* without a price. In exchange for these resources, individuals relinquish their membership in mainstream society; and become invisible. The homeless also exchange good for poor food choices, ordered for disordered eating behaviors, and a greater risk of diet-related disease.

Homelessness and Health

A report published by the British Columbia Government in 2001 concluded that homeless people face much the same health problems as the general population, albeit at dramatically higher rates. This report indicated that factors including the increased "exposure to infectious and communicable diseases (e.g. tuberculosis); "an increase in stress," which "can trigger genetic dispositions to diseases (e.g. hypertension);" extended periods of malnutrition, that "can cause some chronic conditions (e.g. anemia and various

degenerative bone diseases);" the increased "likelihood of experiencing violence or trauma on the street or in a shelter;" and living conditions that are characterized by "poor hygiene, inadequate diets, exposure to the elements, lack of sleep and physical injuries" (Eberle et al. 2001:6), which are not relevant to the health of the general public, negatively affect the health of homeless people.

In a 1998 study of Toronto's homeless population, researchers concluded that the public perceives alcohol to be the primary contributing cause of homelessness. Their research showed that: "alcohol misuse is more prevalent among men (36-68 percent) than women; alcoholism is found in all age groups and both sexes; the highest prevalence rates of misuse occurred in the 30-64 age range; prevalence rates were six to seven times higher than among the general population" (Eberle et al. 2001:8).

The Eberle et al. report (2001) also stated that "as many as 40% of the homeless suffer from chronic problems such as heart disease, emphysema, diabetes, high blood pressure and musculoskeletal disorders" (10), and that the occurrence of hypertension among the homeless is substantially higher than among the general population. These physiological diseases are exacerbated by the general lack of medical attention. Also, according to this report, "homelessness is associated with a variety of social problems, most notably family breakdown and abuse, adverse childhood experiences, foster care, youth pregnancy and inadequate parenting skills, and child development problems" (Eberle et al. 2001:16). Ethnicity and the subject position attached is also a factor, noted in the fact that Aboriginal people are disproportionately represented within the homeless population.[xiii]

In the Rivertown Shelter many of the clients openly admit that they have alcohol related problems, however, this problem could be perceived as a coping mechanism for their state of homelessness rather than the cause of it. One client, Joe, an Aboriginal male in his fifties (the stereotype), related that he started drinking to be part of a social group, but that it "got out of hand" and "now he can't stop" [drinking]. This same individual also added that at one point he managed to abstain for one and one half years, but a family break-up caused him to start again.

Conversations with two other male clients (white) revealed that illness other than alcoholism can be the cause of homelessness. These men stated that prior to being at the Shelter they had very high-paying jobs but because of chronic illness (bi-polar disorder and heart disease) they were unable to maintain stable employment, and required many drug prescriptions in order to function. They received social assistance, but were unable to survive in mainstream society on the amount they received. In fact, this issue of unemployment and instability had caused the break-up of one of these men's family.

My interview with Gordon revealed that compliance with cultural proposition of individuality, which characterizes hard work and success, can conflict with the social meaning of food, causing the individual to experience stress. Also, using alcohol to the extreme as a means of managing stress is classified under the medical model as an addiction; however, it is disordered eating.

Gordon's Story

Gordon is male, age 55 years, divorced, has two children and one grandchild, a degree in engineering, and at the time of this interview was unemployed and homeless. His first response to my question of food memories was that he is of Polish descent and meals are

fourteen courses. Gordon also said that he traveled a lot with his engineering career and as a result has tried lots of food. He admitted that he likes all foods, especially different ethnic dishes, and enjoys cooking and experimenting with food.

As far as childhood memories, Gordon said that he was a big child from birth. His European grandmother believed that fat babies were healthy, and in keeping with this value, he was fed whole cream. The family diet consisted of lots of food fried in lard and Gordon especially remembered bread fried in lard and sprinkled with sugar. He also said that being Slavic his family ate lots of sausage, which was high in fat, as well as lots of bread. Gordon also reminisced about Polish desserts that were high in sugar. Today when he eats these foods he is reminded of his grandparents.

When Gordon started school, he was teased about being overweight. He reminisced: "Kids said 'why don't you go on a diet?' which made me feel hurt." He admitted that until then he had never heard the word "diet." He complained to his mother; she took him to a doctor who put him on a diet. Gordon said that he has dieted ever since.

Gordon said that both of his parents were 'heavy' and that his two brothers were also overweight. His father had a heart attack at a very young age and as a result was put on a low fat diet, which Gordon said was great because the whole family lost weight.

When Gordon married, his wife was English and cooked differently. For example, his father would take a beef roast, slice it and fry it whereas his wife roasted it. He said that he started eating more vegetables, especially raw varieties; his wife also introduced him to fish cooked in a variety of ways; it was much healthier eating. However, he craved his mother's way of cooking.

Gordon attributed his current weight problem to his occupation. He said that the extensive travel required by his profession led to a sedentary lifestyle; and the role of engineering consultant entailed 'wining and dining' clientele six times a week, which he said was high in calories as well as addictive. To Gordon, food and alcohol were symbols of social connections. When he sold his business, he realized that he needed help with his disordered alcohol behaviors. However, when he quit drinking alcohol it did not affect his appetite, but it did increase his use of tobacco.

After his divorce, Gordon said that he ate more vegetables than meat, especially raw ones because it was "quick." As a result, he lost a lot of weight and bragged that he had gone from a fifty-eight inch waist to a forty-two inch waist. However, his mother thought he must be sick; she saw nothing wrong with being overweight; she could not see that it was unhealthy. Gordon perceived that this attitude was the result of his mother experiencing food shortages during WWII, and her way of expressing love was through food – "saying no hurt her feelings."

Since he has been at The Shelter, Gordon said that he has not noticed any adverse health consequences, but he has only been there two months. He is now taking a program offered by The Shelter to enable clients to re-enter society and he said that it has been very empowering. In the future, Gordon would like to see his diet include vegetables and meats, but barbequed, or broiled and, he emphasized, 'not fried!'

Gordon concluded our interview by saying that he has good memories as far as family relations are concerned, but bad memories regarding the trauma of having a weight problem – teasing and diets. However, to him food is "still very social." Three months after this interview, Gordon was employed and living on his own.

Gordon's story reflects that to some individuals social relationships are more important than cultural propositions; the conflict of social and cultural values can be manifest in over-alimentation and substance abuse, which in turn can lead to homelessness and disordered eating. Food and alcohol abuse, as defined by biomedicine, does not necessarily carry the same meaning to the labeled individual; it represents various social exchanges within a particular group of people or society, and within a particular time frame.

Social relationships, or lack of them, can result in substance abuse, which in turn can lead to homelessness and disordered eating. Also, men who are unable to fulfill their societal role as 'breadwinner,' regardless of ethnic origin, quickly find themselves marginalized by society, thus requiring to be fed rather than able to feed others. Once an individual has been marginalized, drugs, alcohol, tobacco, and food are used either to self-medicate or as coping mechanisms.

Malnutrition can be either a temporary or more permanent state on the continuum of disordered eating; however it is an everyday "fact of life for the homeless, which places them at risk of intestinal disorders and infectious diseases" (Eberle et al. 2001:12). From my observations in Rivertown, very little fresh fruits or vegetables are made available to homeless individuals. At The Shelter clients receive fresh fruit in the morning "so they get some nutrition during the day," as an employee commented, and during one of my visits, I observed a vegetable tray in the social area. For those Shelter clients who frequent The Kitchen, there is fresh fruit and produce available, albeit of inferior quality to that available to mainstream citizens. However, homeless people do have agency in their food choices, as I observed that many clients chose not to partake of the salad, and

there was still fruit in the bowl available to clients at the end of meals. In conversations with staff, it was revealed that because of deteriorating dental problems many homeless do not partake of the fresh fruits and vegetables; bananas and oranges are the fruits of choice.

Fitchen (2000) attributed "hunger in the United States" to the inadequate access to food resources by particular persons, which was "not the result of insufficient foodstuffs for the total population" (335). She suggested that hunger is embedded within the cultural context of class structure, and that "the food and eating patterns of low-income people" results "from the economic constraints of poverty" and the power of traditional "cultural ideas and practices" that "shape eating patterns that may actually exacerbate malnutrition"(Fitchen 2000:335).

Conclusions

Foodways and homelessness have been incorporated into the biomedical system's discourse of power, which emphasizes the cultural norm of individualism. We have the illusion that we have choices, but in reality our access to resources varies according to our status in society. CMA is a tool with which to deconstruct social issues, in this case, that of homelessness, and the experience of diet-related disease within the culture of homelessness. The narratives of both shelter staff and clients thus far in my research have revealed the uniqueness of each case; that homelessness is not homogeneous. Homelessness is about social relations past, present and future; real or imagined. In the case of Joe, he is torn between peer and familial relationships. For Gordon, it is also about peer relations both as a child in school and as an adult in a demanding profession. The experience of disease and illness as a homeless individual requiring to be fed by

society is a reflection of the ways in which food and eating behaviors, age, gender, ethnicity, and social class create structure in society.

In Chapter 4, I will explore disordered eating as a nutritional disease from the perspective of the local healthcare system, as revealed in interviews with various healthcare professionals. I also examine how disordered eating is manifest in other forms of illness, with a particular focus on Aboriginals, as illustrated in interviews with three individuals.

Chapter 4: Nutritional Disease as Disordered Eating

Food is more than just a means of sustenance; it is a major component in the structuring of society. It is around food that much of our identity and social relationships are culturally constructed and negotiated. As discussed in chapter 2, biomedical surveillance has increasingly expanded into many areas of society. The discourse of this system has significant influence in creating subject positions within the social structure. This chapter reflects the way in which my research unfolded as I questioned: if eating disorders are stereotyped as white, do they also affect Aboriginals through the acculturation process? I expected that by interviewing various health professionals that this question would be answered.

The Regional Healthcare Professionals

The Regional Healthcare System (RHS) is responsible for the health of the population of Rivertown and the surrounding rural communities. The RHS is comprised of various agencies and professionals, some of which are not readily visible or accessible to the general public. These agencies and professionals are not located in a central building in the city, but rather are scattered, seemingly unorganized, and at times invisible. The common way to access their services is by appointment, which usually entails a referral from a physician or other professional (for a list of interview questions asked of the professionals, see Appendix C). From the perspective of CMA, the following narratives illustrate the way in which the cultural proposition of individualism is perpetuated by healthcare professionals.

The first professional I interviewed was David, the administrator of General Health (GH). He was hard to locate; accessible only from a telephone number on the RHS

website. At our meeting, David informed me that GH is a nationwide agency that focuses on ways to be healthy: diet and exercise, not to be poor, to be educated, and to be able to have a holiday every year. These prerequisites of health are in accordance with capitalist values of individualism – disciplined, hard-working, self-motivated, and energetic. According to David, GH is primarily interested in connections between disease and social determinants, rather than "root causes." David was very helpful and gave me several referrals to other health professionals in the RHS, the primary local healthcare agency.

On the top of David's list was the supervisor of the Community Dietician Team (CDT), Emma. Emma was unavailable for a personal interview, but consented to a telephone interview. I informed her that I was doing research on 'disordered eating,' to which her immediate response was that her "job is more prevention than dealing with eating disorders, these are referred to the Mental Health Team" – she assumed that disordered eating meant eating disorders. When I told her that disordered eating was not just eating disorders, but a broad perspective of food and eating behaviors including type 2 diabetes, obesity, and poverty her attitude changed.

Emma informed me that the main educational program of the RHS is the Healthy Body/Healthy Life Program, which is accessible to the public on an outpatient basis; information about this program can be acquired on the RHS website. Part of the program is a course called 'Connections' that is offered through the local college; she added that the 'Connections for Teens' course has not been successful as "it is hard to get them out."

Emma said that she is "more into food security – food banks, and educating new Moms". She educates Moms against using food as a reward; she gave the example: "give

chocolate if pee in the potty;" she also stresses to Moms that it is not important "to clean up your plate." Emma is aware of eating disorders and related that she had two aunts on both sides of the family with eating disorders, and said that their Moms were domineering. She also gave me another example, of a girl in the 'Connections" course who was given a questionnaire to fill out; one question asked "what areas of your life do you have control in?" The girl's answer was that she only had control in two areas of her life; however, Emma did not specify which areas. She said that it is about autonomy.

In Emma's opinion, the reason there is disordered eating is because people do not cooking properly; today there are dual working parents and they have no time to cook. For example, she said that she has heard of kids being given popcorn for supper. Here the interview came to a close as she had an appointment to meet.

My interview with Emma was a prime example of biomedicine expanding into the daily lives of individuals as her main focus is to reinforce that social problems such as those encountered in parenting are in fact the problem of the individual. Parents in turn reinforce this individualism through the socialization process. Ironically, she identified that issues regarding food were about social relationships, especially between mothers and daughters.

Another professional referred by David of GH was the Aboriginal Health Team (AHT) dietician, Tracy. To access this professional, I was led down a maze of corridors, and ushered into a small office. I informed Tracy about the purpose of the interview and she was most enthusiastic. She is not Aboriginal; therefore, I asked her why she chose her particular field of expertise. She answered that she has an avid interest in Aboriginal culture and had a desire to work with these people in the area of improving their health.

Tracy's job is to educate clients. She has looked at all foods in the Aboriginal diet, both current and traditional. Some examples of traditional foods are: berries such as strawberries, red bull berries, chokecherries (used to make pemmican), saskatoons, gooseberries, and raspberries; vegetables such as wild turnip (a big one), wild potato, carrots, onions, and bitter root. Tracy said that it is not realistic for Aboriginal people to go back to their traditional diet but that some do have access to hunting and fishing; they can follow a more traditional lifestyle but it has to be modified. She said that when people say they are 'traditional' it is important to ask: "how are you traditional?" For example, Tracy said that spiritually is the most common claim of traditionality – they combine Christianity and traditional beliefs; the same with health – physician and medicine man (says she knows four in this area). However, some are starting to question the medicine men. Tracy gave me an example of a man she knew who quit all of the biomedical procedures for diabetes, which resulted in him having two limb amputations and he is now on renal dialysis. According to Tracy, rejection of biomedical treatment has been problematic because diabetes did not exist until 1940, the medicine men did not have traditional medicines for this disease; thus, using western medicines does not mean abandoning their culture. This same principle of traditionality applies to foods and activity levels – Aboriginal people were active in past but today they lead a more sedentary lifestyle.

Tracy stated that much of the traditional culture is already lost. In the past various societies passed on traditions orally, and now most of these don't exist. As far as traditional foods, many were after contact (e.g. bannock and fry bread) – "most have never even tasted buffalo." The focus of the AHT is to educate the Aboriginal people

about proper nutrition such as increasing vegetables and fruits; they have limited education and cooking facilities. The AHT is trying to promote the incorporation of traditional foods, and Tracy has been instrumental in adapting the CFG to depict a Medicine Wheel and she has also created a Wigwam Model. For example, added to the CFG is fry bread, and Indian popcorn (small chunks of beef tallow fried in oil), which are high in fat but the adapted CFG "puts a positive spin on it by approving of it in limited amounts". The Wigwam Model depicts four poles which symbolize the four areas of life – emotional (child), physical (youth), mental (adult), and spiritual (elder). Every tribe has a different medicine wheel, colors, and animals, but the four areas of life are the same.

Tracy said that statistics claim that the prevalence of diabetes among Aboriginal people is higher than among non-Aboriginals – two to four times higher and up to ten times higher. I then inquired: "How does the mainstream diabetes program differ from the Aboriginal program?," to which she replied that the main program is very busy and keeps a rigid schedule whereas the Aboriginal program is more accommodating, especially regarding no-shows and drop-ins due to peoples' limited access to transportation. Tracy said that the AHT is more flexible and accommodates Aboriginal culture.

When I asked Tracy about Aboriginal attitudes regarding body image and issues of weight, she said that Aboriginals tolerate a larger body size. Men want to be bigger; they don't like it when they lose weight; women perceive that it is good to be larger; and, big babies are healthier. With Canadiann cultural ideologies, she can see more eating disorders appearing in the near future. She commented that midriff fat is visible even on

youth and that this is genetic, originally to help them survive the climate, but now it is a detriment to their health. They are now seeing eight year olds with type 2 diabetes. Tracy also expressed concern that eating disorders exists among elders, who hide food so family doesn't get it when they visit. She said that they really fight with this concept as they want to help the young but realize that they need to look after their own health first.

Tracy stated that the lifestyle of modern Aboriginals varies, and that you can't compare them, for example those who live on the reserve, in town, and in the city are all different. Food issues include accessibility, availability, cost, and education. Tracy said that within the Aboriginal community there is a lot of conflict between families. She gave the examples of wealthy versus poor; and, those on reserve council versus those not on council.

This interview revealed that the division of Aboriginals diabetics from mainstream diabetics establishes inequality and stereotypes Aboriginals as diabetic, albeit this division is intended by the post colonial discourse to give extra attention to Aboriginal health issues. The modification of the CFG to accommodate Aboriginal foods is yet another example of post colonial discourse. Although, as a nutritionist she stresses that it is the responsibility of individual to maintain good health, her narrative was full of references to food in the context of social relationships. This marking of particular groups was also addressed by Rock (2005), who observed that "contemporary efforts to treat and prevent diabetes may actually deepen social inequalities" (467) because the "social and economic inequalities underlying incidence of the disease" (ibid) are not addressed. That is, the lived experience of diabetes is not the same for all individuals, it

can be "the embodiment of inequality" (ibid:474) The next interview further illustrates post colonial discourse, but from the perspective of Aboriginal professionals.

The Aboriginal Mental Health Team (AMHT) is comprised of two 'promotion-prevention' professionals, Judy and Candace, and Aboriginal. Like Emma, these two professionals assumed that disordered eating meant eating disorders and said that "eating disorders do not exist among Aboriginals," but they added that if they encountered anyone with an eating disorder that they would refer the case to the appropriate department.

When I explained my position on disordered eating they were more receptive. Candace and Judy perceived that the main problem for Aboriginals is twofold: the change in diet from one high in protein to one high in carbohydrates; and the change in lifestyle from one of activity (hunter/gatherer) to one that is sedentary. They also blamed residential schools for causing malnutrition among Aboriginal people.

This team said that statistically 50 – 60 percent of Aboriginal people in Canada and the United States are diabetic, which was not the case in the 1960s OR (their emphasis) it was under-diagnosed. Judy and Candace also said that north of the 60th parallel more traditional foods are available; therefore, there is less incidence of diabetes; south of the 60th parallel the Aboriginal people have worse health even though they have easier access to health facilities.

Judy and Candace disagree with Tracy that there has been a loss of Aboriginal culture. They believe that there are still many who have retained pre-contact information. They also disagreed that there was a difference in diet between the reserve, town, and city Aboriginals. According to Judy, "food security is an issue, but the same as for any

member of society, Aboriginal and non," and "the obesity 'panic' is caused by government, it's not real."

However, Candace and Judy did agree with Tracy that Aboriginals have a greater tolerance for the larger body size, and have seen infants that were seventeen months old with type 2 diabetes. Regarding the food habits and body size of children and adolescents, Judy said that "mothers don't 'harangue' them about being fat," they "don't diet," and they are "not influenced by the cultural ideal of thinness." When I asked about the perceived problem of type 2 diabetes and alcoholism among Aboriginal people, Judy and Candace agreed that these are problems. But, Judy remarked that she "is tired of Aboriginal people being stereotyped" as such. She added that this stereotype is prevalent at health workshops and that doctors also assume these are the problems rather than something else – "the stereotype is always there, even in epidemiology."

Judy, herself and Aboriginal, remarked that food is not a comfort for her; her memories are of residential schools, that the food was terrible, and that she only ate enough to survive. She said that when her father noticed that she and her sister were getting very thin he took them out of school, despite the chance of harsh consequences such as "excommunication, and legal repercussions." Judy added that alcohol issues include issues of poor food habits; again, a stereotype about the prevalence and affect of alcohol on Aboriginal families as Judy said that she was raised in a family where alcohol was not an issue. To Judy food is about celebrations and relationships; she remembers that her grandmother was a great cook. Candace agreed that food is about family, and celebration, but she did not attend residential school.

Although these two women were trained in the health profession, and as such were responsible for reinforcing the cultural proposition of individualism, the interview was all about food in the context of social relationships. The tone of the interview was that of resistance to the dominant discourse, or rejection of the cultural proposition.

This concluded the interviews conducted with GH professionals, although there were many others that I could have contacted. Interviews with professionals specializing in eating disorders are included in Chapter 5.

From these interviews, several themes appeared. First, the influential role of biomedicine in maintaining cultural values is very evident in healthcare system of Rivertown. The services are not easy to find, as the offices are scattered throughout the city in various agencies and facilities rather than centralized. To access professionals and their services you need an appointment, the physical space that these services occupy is large, overpowering, maze-like, and institutional. The feeling is of being swallowed up, powerlessness. The power of the individual is minimalized as the professional takes control; thus the individual loses their autonomy. Second, the health services default to a mainstream population (white and visible minorities); therefore this segment is not marked. Post colonial discourse that forefronts Aboriginal health issues, marks this segment. Third, the responsibility of the individual to achieve and maintain health and productivity is constantly reinforced at all levels of the healthcare system; however, the social aspects of food are present.

These interviews with Rivertown health professionals led me to examine disordered eating as a nutritional dilemma in the case of type 2 diabetes, as well as other social

issues that manifest themselves as disordered eating, with the main focus being on Aboriginals.

Disordered Eating: as a Nutritional Dilemma

Type 2 diabetes is "a disease in and of nutrition" or a "diet-related disease" (Ferzacca 2004: 2). It has been classified as a 'disease of civilization or modernity,' and appeared about 1920 in both the western world and those areas colonized by the west. Individuals with type 2 diabetes tend to be over weight, usually as a result of over-alimentation; this behavior has lead to the development of a bodily dysfunction, and as such has been medicalized.

According to the Canadian Diabetes Association (CDA) (2005) recommendations, "nutritional advice for people with diabetes is the same as that for all Canadians … follow the principles of *Canada's Food Guide for Healthy Eating*" (Lank 2000). The Canada Food Guide (CFG) suggests a diet high in complex carbohydrates (55 percent), low in simple carbohydrates (10 percent), low in protein, and low in fat (30 percent). The CDA outlines "healthy" or acceptable eating as consuming three meals a day at regular times, defines the time span between meals, as well as what constitutes a healthy snack between meals. Sugars, sweets, and fats are to be limited and the quantity of high fibre foods increased; the recommended beverage is water; and physical activity is highly encouraged to improve blood glucose control. Unacceptable or disordered eating is just the opposite of these guidelines – binging, irregular eating patterns, and the intake of 'discouraged' foods. The CDA "recommends that all people with diabetes should seek advice about nutrition from a registered dietician" (Just the Basics 2005, online). In other

words, according to nutritional science and national standards, diet and health are the responsibility of the individual.

For individuals diagnosed with type 2 diabetes, adhering to a particular regimen such as the CFG is difficult. Ethnicity, age, and socioeconomic status (SES) are important factors in food choices and patterns of consumption as they reflect both the cultural background and individual history of the person affected. Ferzacca (2004) described type 2 diabetes as "a specific manifestation of a relationship between food, eating, and the body" (6). Therefore, when a diet regimen based on the science of food and nutrition enters into the "lives of people who have long-established life histories of food and eating" (Ferzacca 2004:11); it is met with some measure of confusion and resistance. Diabetes then becomes not only a physiological disease but also a psychological disorder as food and eating are intricately intertwined with memory, emotions, and identity. Such is been the case with not only the general population (see Jennifer[xiv] and Ferzacca 2004), but also with Canada's Aboriginal peoples.

From a CMA perspective it is important to explore the historical, economic, and political background of a particular issue in order to understand it. Therefore, next I will give a brief overview of the Aboriginal experience in the Rivertown area.

Historical Overview: Aboriginal Eating

Food is a primary resource that is a basic concern for all human societies. Human diets reflect "the ecological and market availabilities of foods" and "the nutritional and medical consequences of particular cultural consumption patterns" (Messer 1984:205). In non-industrialized societies whose subsistence depended mainly on local resources, economics and social organization were based on the symbolic and emotional values of

foods. These values "were often used ritually to mark social status, intervals in time, and culturally important environmental resources" (ibid:207, 208).

In Canadian history, as in the history of many other colonized territories, it was the indigenous people who became the 'other;' labeled as primitive and in need of civilizing. Indian and European relations began under the guise of friendship and alliance between nations but gradually became one of hegemony, the Europeans being in a dominant position.[xv] The resulting hierarchy has remained one of persistent resistance, as the Indian people have desperately held to their identity and traditions, refusing to be assimilated.

Within Canada there were many 'nations' of indigenous people, thus the foodways of each group varied according to location. For the purpose of this research, I will use the Plains Indians in general and the River People in particular; all individuals, groups and agencies have been given pseudonyms to protect their anonymity.

In the time before European contact, the buffalo was a primary resource for the River People. Both men and women participated in the hunting and the butchering of the animals; however, it was the women who were considered as the most proficient butchers. All parts of the buffalo were used; nothing was wasted. Not only did the buffalo provide food, it was also a source of raw materials used for clothing, shelters, tools, and ornaments (Kehoe 1995; Kidd 1986).

There was also an abundance of edible vegetation that helped to maintain a balanced diet. Berries such as chokecherries, Saskatoon berries, the service-berry and the bull-berry were gathered seasonally and used fresh, or dried for future consumption. However, "the most important berry was the Saskatoon berry, which was mixed with fat

and dried meat to make the pemmican that literally fuelled the fur trade" (Lux 2001:11). Vegetable foods such as onions, blue camus, cow parsnip or 'Indian celery,' prairie turnip or 'Indian breadroot,' mint and other green were seasonally gathered, primarily by the women and children (Kehoe 1995; Lux 2001), and used fresh, or dried and stored. Food on the Plains was abundant but ultimately community life was crucial for survival in the harsh climate

The River People never took to trading with Europeans, as had the other Plains nations, as their needs were being adequately met through established Native trade networks. As long as the buffalo herds lasted, the Plains' cultures had expanded in expression and societal complexity. "They were even able to overcome to a large extent the demographic disasters precipitated by introduced diseases" (Dickason 2002:176).[xvi] However, the dramatic suddenness of the disappearance of the herds did not allow for the Indians to culturally adjust, which "catapulted events beyond their control" (ibid).

Under the guise of 'civilization' missionaries were deployed by the government and a full-scale assault had begun on Indian culture. "Their means of subsistence gone and their traditional leaders killed or undermined" (Pritzker 2000:295), Plains Indians went into a long period of extreme transition. Between 1871 and 1929, Crown officials negotiated with many of the Plains Indians nations regarding the acquisition of their land. As a result a series of treaties were negotiated and the "Plains Indians were forced to take up farming but were denied decent land, land ownership, credit, and even without permission of the government bureaucracy, the right to sell their produce" (Molloy 2000:8). Confined to reservations and most of their land taken, they became dependent on the colonial government for food supplies, which were slow in arriving and when they

did they were meager and also contaminated. Flour contained sulphur, and meat was laced with lye and bluestone (a salt used as insecticide or fungicide) (Lux 2001:59).

However, European contact was "not all negative" as "the introduction of guns, kettles and iron knives during the fur trade undoubtedly facilitated the taking of animals for food and assisted in preservation" (Kelm 1998:25). And, as long as the fur industry thrived little was done to alter Native subsistence strategies. Only those Native groups "closely associated with particular fur-trading forts" were "increasingly dependent on post food supplies" (ibid). European traders introduced new domestic plants and animals but relied to a great extent "on indigenous foods and encouraged local groups to continue their exploitation of food resources" (ibid).

Contemporary Issues of Aboriginal Eating

Contemporary discourse claims that among the Aboriginal population the incidence of type 2 diabetes is dramatically higher than that among the general Canadian population.[xvii] According to health professionals this disease can be handled through nutrition and exercise management. A contributing factor to the high rate of diabetes is the fact that obesity, attributed to over-alimentation as compared to energy expenditure, is a major health problem, especially found among women in their 40s or older (Div. of Comm. Ed. 1992:BI-4).

A 1972 survey regarding the nutrition of Canadians concluded that the risk of diabetes for this aging sector of Aboriginal women is twice the national average, despite the fact that these women consume generally less calories than the national population. There have been several theories for this phenomenon. One is the "thrifty gene theory"[xviii] wherein the body stores fat when food is abundant to be used during lean periods. In

contemporary society, food is continuously abundant, causing many people, including Aboriginals, to more easily become obese. Another theory attributes changes in dietary habits and lifestyle to Aboriginal obesity. The diet changed from that of wild meats, which are low in fat, as well as vegetation that was relatively low in carbohydrates to that of a high fat, high carbohydrate diet that is also often low in nutrition. The more sedentary lifestyle is also a contributing factor (Div. of Comm. Ed. 1992:BI-4).

Concerning food as it relates to the self, we either voluntarily conform to the discourses of the culture or construct a means of expressing our subjectivity. This subjective voice is often expressed through food. The way in which individuals respond to external institutions concerning the regulation of food and eating behaviors indicates whether cultural values are internalized or not. This conscious or unconscious decision is embodied and then interpreted by others (Lupton 1996:15), and in the extreme, labeled as deviant. Once labeled, the stigma is difficult to overcome. Such has been the case with Aboriginals, as Judy remarked that she "is tired of Aboriginal people being stereotyped" as alcoholics and diabetics, and that "the stereotype is always there, even in epidemiology."

Food has cultural meaning and as such is used to manipulate relationships, whether social, economical, or political. Of those I have interviewed the common meaning of food is that of positive family relations, celebrations, and festive occasions. To many it meant ethnic identity and family history, yet to a few it was an expression of autonomy, the only area of their life that they felt they had control of. In other words, the social rather than the nutritional aspects are central. Research among the Dakota revealed that "Diabetes is a potent symbol associated with the lost life of the traditional" (Quintero

2002:5). This revelation can be applied to other Aboriginal people, such as the River People, as commentaries with the professionals dealing with this ethnic group expressed that type 2 diabetes reflects historical events and concern with loss of culture and identity. Szathmary and Farrell (1990) and Schoenberg et al. (2005) have suggested that stress, particularly as it relates to acculturation and the disruption of established societies, has been embodied in diseases such as diabetes.

Schoenberg et al.'s (2005) research revealed that "regardless of ethnicity or residential background, that" (178) stress is a highly influential factor in the precipitation and management of diabetes. They concluded that "the nexus between diabetes and stress" is the difference in the perception of disease by biomedicine and the individual's experience (ibid:183-184). This difference in perspective was also observed by Ferzacca (2004) as within the clinical encounter individuals were categorized as 'non-compliant;' the underlying reason for their behavior, or their lived experience of disease, was ignored by health professionals.

Although I did not succeed in procuring any interviews with Aboriginals diagnosed with type 2 diabetes, concern for family members with this disease as well as their own vulnerability with regards to developing diabetes was expressed by several interviewees. (See Carolyn's story, which is included in the next segment.)

Other Manifestations of Disordered Eating

Disordered eating is commonly misdiagnosed by physicians as depression; males, and members of ethnic groups, and varying age groups are more commonly diagnosed with depression, thus, the occurrence of eating disorders among these groups goes under reported. As an example, let us look at the Aboriginal population of North America.

Depression must be considered in a particular context, relative to the culture that is being affected. O'Nell (1996) stated that depression is a highly diagnosed problem among the Flathead Indians of North America, but that this is an expression of other issues such as identity, loss of land and culture. She related that these issues are also manifested in the form of alcoholism and diet-related problems. The medical model classifies depression as a mental illness without considering the cultural setting or the experience of the individual or social group. O'Nell said that:

> from the ethnographer's perspective, what gets lost in the medicalized version of "depression" from the ground of the DSM is the ability to appreciate the cultural processes whereby unique phenomenologies of self, emotion, and disorder are constructed, to understand the social origins of disease and distress, or to ascertain the impact of history on personal experience. In other words, the psychiatric perspective about the universality, the "givenness," of "real depression" calls into question the primacy of cultural processes in human experiences of disorder, relegating culture to the marginal position of "influencing" the universally recognizable disease of depression (10).

In research conducted in the city of Rivertown among Aboriginal men and women, I observed many situations that paralleled the Flathead in O'Nell's work. To illustrate the similarity of life experiences among two the groups of Aboriginal people, I will use the lens of food rather than depression in the stories of three individuals: Chelsey, Carolyn, and Joe. Food expresses identity and social relations, which are valued in traditional Aboriginal culture. The acculturation process and the change of values from the social to the individual within a relatively short timeframe has ruptured this culture. This rupture is voiced in the form of depression, alcoholism and disordered eating, which is evident in the narratives of these individuals. Each interviewee was asked the lead-in question: "What are your memories of food as far back as you can remember?"

Chelsey's Story

Chelsey is female, age 32 years, divorced with 5 children, identifies herself as Aboriginal, lives in Rivertown, and is currently employed. During the conversation she expressed that she is overweight. Her earliest memories of food were porridge (oatmeal) and that she was forced to eat it. The family was very poor and a treat was raw oatmeal and sugar in a bag. She also had peanut butter and jam for lunch every day; therefore, now she does not like it.

Chelsey grew up on a reserve near Rivertown, the youngest of six children (five girls and one boy). She remembered that a privilege of being 'the baby' was that she was protected. Her sisters played a large part in her upbringing, but so did her father, step mother and grandmother (mother's mom). Chelsey's mother died when she was two years old, and the kids were all separated; Chelsey and one sister went to the grandmother's.

When her father remarried he wanted his kids, but Chelsey was the only one that chose to live with them, as she was a 'Daddy's girl.' She was later to regret this decision as the step mother was mean and abusive, both mentally and physically. She was jealous of Chelsey and "issued harsh punishment for wanting to be with Daddy." The step mother also had children: two older boys, one older daughter, and two Chelsey's age. Her oldest son molested Chelsey and she became an emotionally detached child; this went on for three years. Her father was an alcoholic and not around much.

Chelsey remembers bannock, fried bread, and pan bread. She said that the step mother was a good cook but whatever she dished out you had to eat, even if you were full. "She cooked lots of meat and potatoes to impress Daddy." The step mother was

kind to Chelsey when her father was around but as soon as he left she was abusive; she would drag Chelsey by her hair to her room and beat her. Chelsey begged her older sisters to take her away with them. The step mother also starved her and she "became very skinny…no material things such as food, love…ages two to eight were the bad years." When the father realized what was going on, he kicked the step mom out and Chelsey's sisters and grandmother moved in.

When she was in Grade 2, Chelsey moved back to the reserve to be with her brother and grandmother. She paused and apologized at this point, then added that she "has blocked out a lot." Chelsey repeated that her father was an alcoholic and always out drinking, but she added that he provided the basics: flour, bologna, eggs, and fruit once a month. Bologna was a delicacy for her father, but to her it was a comfort food. In moments when she needed relief she ate bologna and pan bread sandwiches, and also *Dad's* cookies. Chelsey remembered that they went berry picking and made berry soup.

Chelsey remembered that every Sunday her grandmother would make soup, bannock and fried bread; she also remembers cream corn and grandma's mashed potatoes made with mayonnaise. After her grandmother moved in, things were better – stable and settled – she got to say what she wanted in her lunch and got extra lunch money. However, alcohol was a big factor growing up. After she had her first child, at age 19, she started acquiring a taste for alcohol.

Chelsey said that she "was always slender, no problems with weight until age 28, after the birth of her son." She perceived that her weight gain problem was caused by depression because her marriage was in trouble (her husband was abusing drugs and alcohol; he was also jealous and insecure). Also, Chelsey commented that when she

became pregnant with the last child that she ate lots of junk food. Her husband (of eleven years) "made good money" so they ate out a lot but, Chelsey added, it was "unhealthy eating … fries, hamburgers, pop, chips." Chelsey started not to care about her appearance. For example, no one knew she was pregnant, they thought she was just fat. Chelsey and her husband separated, but then reconciled for the sake of the baby. She said that she ate for comfort, and moved away from family and friends because they didn't like her husband. "Junk food and fast food meant comfort." The couple later divorced.

Chelsey is now starting to deal with past life problems, and eating healthier by trying to cook at home and not eat out so much. She has lost 20 pounds since the divorce and feels comfortable with herself, but food is still comfort. She gave the example that when she is shopping and having a challenge finding clothes to fit that she says "Let's go eat," and off they go to *McDonalds*. Chelsey said that she has never dieted and always stayed fit by riding a bike and walking. She said that recently she has become a one-meal-a-day person; Saturday's she cooks bacon, eggs and hash browns for the kids; she doesn't crave sweets or chips any more.

At the moment Chelsey is still dealing with the divorce and the recent death of a daughter. She said that she can go a day without eating and not realize it and can't remember the last time she had water. She also said that she has started smoking and drinking more coffee, then added that she "has changed from food to smoking." When I asked if the health consequences of smoking bothered her, she answered "Just temporarily. When the stress level is high I can smoke one after the other, when stress levels are low I can't even smoke one."

Since the death of her daughter (three weeks prior to this interview) she is trying to eat healthy, but has not been able to cook as it reminds her of her daughter, especially mashed potatoes. Her daughter loved to cook and made pancakes for her brother.

At this point in our conversation two of Chelsey's friends dropped in to visit. Chelsey introduced us, we chatted for a few minutes and I left. I felt that it was a good interruption as the conversation was getting very emotional, and I suggested that if she needed to talk I was available.

Food has meant many things to Chelsey during her life: poverty as a child; life on the reserve; abusive relationships with her step mother and husband, love and family connections with her sisters, father, grandmother, and children; the affects of alcohol on a family; memories of a child recently lost; the continuation of social relationships in the future. Inasmuch as the values of the dominant discourse are acknowledged by Chelsey's concern with making good food choices, and losing weight to attain a healthy, productive body, the social aspects of food are the most dominant. Disordered eating in Chelsey's case is a resistance to the dominant cultural proposition.

Carolyn's story is similar in that it portrays ruptures in the social aspects of her life, but her life experiences are in an urban context rather than that of the reserve.

Carolyn's Story

Carolyn is female, age 37 years, married, has two children, identifies as 'Treaty' Aboriginal, lives in Rivertown, and is currently employed. She considers her weight just right, but "would like to lose a few pounds." Growing up, her family was very poor; food was basic: potatoes, bannock, fried bread, rice, macaroni, moose, deer, hamburger, and "lots of soup." She remembered that "Mom was a good cook, but Dad was better."

Carolyn said that she has never lived on the reserve; her family lived in a small town near Rivertown; her father worked for a Dutch farmer; and, they were the only Aboriginals in the community. She always wished that she had something else (food choices), and remembered that she liked to go to a particular friend's house. Carolyn's parents were on welfare, so they ate good for a while after the cheque arrived (once a month). In the summer she went to her grandparents' farm in northern Saskatchewan for 2-3 months; it was in the bush; therefore, there were no amenities or luxuries. She remembered that they ate lots of moose and rabbit; food tasted better because of family relations.

According to Carolyn she experienced a double stigma of being both Aboriginal and poor, and her response to this experience: "The first thing you learned to do was fight." She "had a rough childhood." Carolyn remembered porridge, and that they "ate it a lot… with lard, salt and pepper, later margarine, but got butter at Christmas." She has 12 siblings: 6 male, 6 female and in two age groups. Carolyn remembered that her baby brother got special foods such as boxed cereals, and better milk; it was kept in a special chest just for him. She added emphatically "lots of resentment there!"

As a kid Carolyn said that she ate too much; even though they were poor, they still ate. She did not remember "vegetables or fruits … eggs were cheap … moose meat and gravy … mostly potatoes and heavy foods … supper was a plate of mashed potatoes or French fries." She informed me that her father worked for farmers who sent home sacks of potatoes, and that her "mother didn't know how to cook these foods. She was used to bush food."

Carolyn stated that she became conscious of weight in Grade 6, and in Grade 7 she "was the first girl to have 'boobs'" (and she laughed). Her parents considered it healthy to be large; she was her Dad's favorite and he gave her pop and chocolate (which made her large). However, when Carolyn moved from home her food habits changed; she tended to 'overbuy' and watched fliers for specials.

"Diet? I was the 'queen of dieting'!" Carolyn exclaimed, but added that she did not diet until after she had children (at age 18). When her marriage broke up she "didn't eat … now when stressed, eats." She got very skinny, but also got into the 'law enforcement' program at the local college which helped regulate her diet and exercise. She said that she "used *Slim Fast*, diet pills, every diet." Also at this time she started drinking alcohol and smoking cigarettes; she couldn't eat and drink or she would be sick, so she chose to drink. She "stayed skinny til 29-30 years old when [she] had a partial hysterectomy and started to put on weight, got comfortable." Now Carolyn says that she is comfortable with herself; food is still a big thing; she still over-buys.

Both of Carolyn's parents are now overweight and diabetic, this worries her as she expressed: "They have problems with their eyes, medical problems. They don't understand how to control their health through food. The food they eat hasn't changed … still the same. Mom would rather spend their money on other things … grandchildren."

Carolyn said that her parents and siblings "don't get together as a family … dysfunctional, alcoholic … they ate and drank together." She didn't like this behavior so separated herself from the family. Her parents split up about 10 years ago; she added that her mother is still alcoholic, and that her dad is more stable. Carolyn commented that

"big gatherings always ended in a big fight … influence of alcohol. Today Dad comes to my house … no alcohol. Food is comfort, reward … Dad always offers food."

Carolyn commented that her grandparents were old-fashioned, that they "had defined gendered roles." She remembered that her father's parents had died when he was quite young; his father when Carolyn was about 12 years old, his mother when he was 15. Therefore, he was an only child.

Carolyn "vowed that things would be different" for her children. They would "have enough food," and it would be "nutritious (pop only for special occasions)." She said that her daughter (age 19) has always been small; her son (age 20) is tall and slim, but "he was fat as a child. This changed when he went to high school. Cultural norms set in and it was important to him to fit in." Both of Carolyn's children have moved away from home, her daughter just recently. She was close to her daughter and misses her very much; she remarked that she "cries a lot," and that she even had to take time off work because she was so sad.

As our interview came to a close, Carolyn stated that "kids today don't know what 'good food' is; they want hamburgers, French fries, pop … too much fast food; people don't cook at home. Aboriginal kids are big … lack of proper food."

My interview with Carolyn revealed that food has always been about social relations, whether good or bad. Her food narratives describe her relationships, both positive and negative, with parents, siblings, peers, sexual partner, and children. Through the lens of food Carolyn also related the inequality of being Aboriginal in a white community. While the discourse of individualism was acknowledged by Carolyn's concern with meeting cultural body norms, and being healthy and productive, it is the need of social

relationships that overwhelms her life experiences. Again, we see the rupture caused by the conflicting values of the social rather than the individual; as in Chelsey's story, disordered eating is a voice of resistance.

The narratives of both Chelsey and Carolyn express these women's concern with excess body weight, especially Carolyn as her parents both have type 2 diabetes. Statistics given in the first part of this chapter reveal that there is a high rate of type 2 diabetes among Aboriginal women, especially those in their 40s or older. These two women are approaching this age group, and therefore could be considered at risk.

At this point of the discussion, I believe that it is appropriate to give a male perspective of this problem, especially since Aboriginal males presenting with alcohol abuse are disproportionately represented at The Shelter and The Kitchen. Although Joe's story would have fit in Chapter 3 in my exploration of homelessness, I feel that it has more relevance in the context of Aboriginal acculturation and the resulting dysfunctions and ruptures in their traditional value of community before the individual. Narratives about drinking communicate underlying concerns about identity and moral values among Aboriginal people (Quintero 2002:6).

Joe's Story

Joe is male, age 56 years, divorced, has children, is homeless, and currently unemployed. Our conversation was at the Rivertown Shelter, at which he was a client. He approached me, asked what I did (at The Shelter), and I replied that I was a volunteer. Joe then asked what I did other than volunteer, to which I replied that I was a university student. He said that he wanted to tell me about his problem.

First, Joe identified himself as an alcoholic. He was upset. Looking at the memorials of clients who had died that were posted on a wall by the reception desk had kindled memories and he became emotional. Joe then added somberly that he should stop drinking, but couldn't. He then related to me that he was 56 years old, his nickname was 'Bruiser,' that he was in the rodeo circuit when he was young, and that he had also been a boxer (that is how he got his nickname). He proudly said that he had a 13 year old granddaughter who was training to be a boxer, and that he would like to take her to the U.S. to fight professionally.

Joe related to me that he was recently in 'detox,' but as soon as he got out friends convinced him to partake of alcohol and 'socialize' with them. They kept goading him, saying that part of being an 'Indian Cowboy' was the ability to drink (alcohol). So finally, he gave in. Joe then told me that he had previously quit drinking for a year and a half, which he attributed to AA (Alcoholics Anonymous). He tried to help an ex-girlfriend to recover too, but his wife disapproved and it eventually caused their separation.

Joe proudly stated that he had thirty grandchildren. He related that he has a daughter who lives close to the Shelter, but added that he "wouldn't go there if he had been drinking, out of respect and responsibility." Joe also said that he respected The Shelter and wouldn't bring alcohol there either.

On another occasion, again at The Shelter, Joe confided that he was losing weight and was not healthy, but that he couldn't stop the drinking behaviors (he was very thin). He also asked me if I would accept a gift, as a token of friendship, which I said that I would. Joe then went out of the recreation room and came back with a vest made of fabric

displaying an Aboriginal design, which he passed to me inconspicuously. I decided that I would give him a gift to reciprocate the gesture. I took it to The Shelter the next few times that I volunteered, but I did not see him again. At first I felt as though I had not fulfilled the obligation of reciprocity, but on reflection of the situation it occurred to me that Joe's gift to me was reciprocating the gift of food and time spent serving at The Shelter; the obligation was complete.

Many characteristics of Joe's narrative are reflected in research conducted in other Aboriginal groups. For example, among the Flathead of Montana (O'Nell 1996) as well as among many other social and ethnic groups, reciprocity is an important element of identity, both individual and collective. Such was the dialogue with Joe as he expressed his identity as a father, as a member of the River People, and as an 'Indian Cowboy.' The value of reciprocity was also evident by his gift to me as a gesture of proper Aboriginal protocol. Quintero (2002), in his research among the Navajo, noted that "narratives of drinking are seldom solely about alcohol but refer to a host of distinct yet interrelated concerns involving moral values, individual and collective identities" (3). In his narratives about drinking, Joe expressed respect for his daughter and The Shelter staff by not exposing them to his abusive drinking behaviors, yet among his peers this was an expected and accepted behavior. However, Joe also expressed that his disordered eating behavior in the form of alcoholism was also linked to the loss of youth and the ability to participate in the rodeo circuit, loss of identity as an 'Indian cowboy,' failure to fulfill the traditional male social role in his marriage and family relationships, frustration with poor health, and a general sense of hopelessness.

Social networks are crucial in the context of both friends and family. Using the example of Chelsey, in O'Nell's (1996) description of a traditional Flathead 'wake,' she stated that "singing songs conjures up memories of relatives past, other ceremonies and celebrations." Songs "speak[s] to the heart" (84); it is the importance of hearing or oral traditions that symbolizes identity. Also an accepted part of the grief process is that appetites are "stolen by grief," and affected individuals "did not eat at all" (86), as was revealed in my interview with Chelsey and the recent death of a daughter. Death rituals reinforce (transmit, reproduce) cultural values about the self, and about the self and others through relationships. They "transform[s] dangerous emotions of grief, fear and anger that may cause isolation, sickness and death, into proper cultural emotions of compassion and gratitude, that bind the individual to the group" (92); thus, the importance of visiting, which I observed when my interview with Chelsey was cut short by family members stopping in to visit.

O'Nell (1996) uses the term 'pitiful' to refer to those who are materially poor and/or lack a family network (99), which I heard in all three interviews. Joe related that alcoholic behaviors had led to disconnectedness with family, Carolyn expressed that poverty and alcohol had caused her family to be dysfunctional, and in Chelsey's case a bad marriage caused cut off relations with family, isolation, weight gain, and poor health both physically and mentally. The example given by O'Nell was a case study of Clara (ibid:112). Clara's mother had expressed depression after the loss of an infant son; she could not eat or sleep, she lost a lot of weight, and took up smoking to relieve grief. Food and tobacco abuse served as a coping mechanism for the loss of a loved one, just as I heard in Chelsey's case. This same phenomenon was also expressed in a conversation I

had with an elder (Bernice) who said that she was thin and healthy until the death of her mother a few years ago. Bernice said that she is now overweight and has many health problems, and expressed that eating was a comfort. Disordered eating, then, is the result of using food to cope with sadness and loss associated with severed or lack of social or familial relations. Social issues were somaticized as weight gain, the risk of disease, and type 2 diabetes.

Disordered food and eating behaviors as a reflection of unfulfilled reciprocity, such as the humiliation caused by the shirking of social responsibilities by family members, can result in depression (O'Nell 1996:121, 122). For example, a woman that I encountered at The Shelter told me that she had been on a drinking episode because she was distraught about her son's rebellious behaviors; that he was not fulfilling family and cultural obligations.

There are external signs of grief and loneliness (O"Nell 1996:121): tearfulness (Carolyn was very upset about her daughter moving away to go to school, she cried a lot and had to take time off work); disturbances in eating: too little (Chelsey after the death of daughter; Carolyn drank rather than ate to increase social relations; Joe drank rather than ate to maintain status as 'Indian cowboy'), or too much (Chelsey due to bad marriage; Carolyn as a reaction to socioeconomic status and stress). Depression can also be a result of feeling abandoned or worthless (ibid:122). Joe 'fell off the wagon' because his wife abandoned him; Joe drank to hold his status of Indian Cowboy but at the same time felt worthless. Because of his age (54 years), and years of neglect and abuse, Joe's body would no longer allow him to follow this profession, leaving him feeling worthless.

Conclusions

The three individuals I interviewed displayed disordered eating; some had turned to food or alcohol as a means of coping with issues in their life, primarily dysfunctional and disconnected social relationships; food and eating symbolically returned them to the social relationships that they desired. Humans are social beings and food is a voice to express identity and connections with other humans whether past present or future, real or imagined, which was revealed in the interviews conducted with both professionals and Aboriginals. Although 'fry-bread' is classified as a traditional food, it is in reality a food introduced post-contact which represents a lost history but at the same time a connection with the acculturation process of the present. This example is also representative of post-colonial discourse.

Type 2 diabetes, depression, and alcoholism are perceived by professionals as the predictable consequences of the civilization process as well as the abundance of resources in a globalizing economy;[xix] however, they do not account for the lived experiences of the individual (white or Aboriginal) – politically, economically or socially. Lang (2006) concluded from her research among the Dakota that "illness … emerged as an indicator of an individual's or the community's spiritual or moral lack of wellness" (61). Her research also revealed that food and illness are connected to or are metaphors of Aboriginal culture as they relate a time long past with the present; they define a group's identity (62). Diabetes, alcoholism, and depression are symbols that relate dysfunction within a group (63). Scheder (2006) in her research on diabetes among the Hawaiians, aptly stated that "contemporary chronic diseases are sometimes mislabeled "diseases of civilization." Rather, "they are diseases of colonialism – and that's a very big difference"

(338). My research similarly revealed that the etiology of diabetes, alcoholism, and depression according to professionals differs from the ethnographic reality; disordered food and eating behaviors are the voice that expresses rupture within a social group in an attempt to create stability and coherence in an otherwise unstable and fragmented existence; and that chronic disease among Aboriginals is an effect of colonization. Thus, it is through discourse that disordered eating is embedded in social relationships and cultural values; eating (or not eating) is not an independent act as promoted by professionals, but rather is a highly socially dependent act, whether real or imagined.

In the following chapter I will examine the eating disorders as outlined in the DSM IV (American Psychiatric Association 1994): anorexia nervosa, bulimia nervosa, and binge-eating disorder. This examination will include my participation in an eating disorder support group as well as interviews with various subjects: male and female, white and Aboriginal. Also in this chapter I give cross cultural examples and use Devereux's ethnic disorder theory to show that DE is culturally created and as such varies across cultures.

Chapter 5: The 'Eating Disorders'

In contemporary Canadian culture the emphasis is on individuality within a capitalist system, which places a high value on thinness, but an equally high value on consumption. Herein lies the double bind: humans are social beings and socialized from an early age that food and eating are integral parts of social relations, but the overarching cultural proposition is that food is an individual act. Within the human experience this double bind is managed in a variety of ways as we have discussed in Chapters 3 and 4. In this chapter I focus on the 'eating disorders' as they have been labeled by biomedicine. On the continuum of disordered eating, the 'eating disorders' (ED) of anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED) are considered 'extreme,' and labeled as psychological diseases in the DSM IV. Biomedical doctors refer the treatment of these disorders to psychiatrists, psychologists, and nutritionists.

Eating disorders are stereotypically depicted as culture bound disorders affecting white, middle- to upper-class, adolescent females; however, this group is not marked in the same way as Aboriginals are marked as diabetics and alcoholics. There is a complex interplay between culture and body size. The human body is biologically predisposed to weight gain, and to store fat in times of shortage, but this has become a liability in the abundance of western Canadian society today. As well stated by Smith (2002), "One of the most tragic aspects of this emphasis on thinness and dieting is the resulting increase in the numbers of individuals with eating disorders. The emphasis on thinness has negative consequences for both the obese and the thin" (121).

Excessive dieting, self-induced vomiting, and laxative use are but a few methods of weight reduction used by those affected with ED. AN in the extreme causes severe

emaciation, heart attack, and death. BN drastically depletes the body's potassium level, which causes electrolyte imbalance resulting in cardiac failure; vomiting may also cause a rupture of the esophagus or a hemorrhage of the stomach. BED individuals are characteristically overweight, which can result in type 2 diabetes, hypertension and heart disease. Statistics on ED are difficult to establish as individuals with ED deny their condition until it threatens their health, parents either are unaware of or are in denial that they have children with the disorder, and physicians are not trained to recognize the less obvious symptoms.

In order to understand these disorders, we must look at them from a historical and culturally relative position. We must also consider the individual affected and their subject position, whether this is consciously recognized by the individual or not.

The Stereotype

Eating disorders have been labeled as a psychological disorder found in western states; they affect Caucasian, middle- to upper-class female adolescents. In order to understand this phenomenon from a CMA perspective, we must deconstruct it historically, politically and socially.

According to Bell (1987),[xx] "the definition of anorexia as lack of appetite is a misnomer – many are hungry but will not eat" (1-2). In the past, Freud and his followers asserted a link between self-starvation and the sexual drive in anorexia. While holy anorexia (HA) of medieval times sought to tame or obliterate bodily urges such as appetite and sexual drive (ibid: 11) and to conquer and clear the path of holiness (ibid:15). Today, anorexia is about identity, autonomy and perfection – the "struggle against feeling enslaved, exploited, and not permitted to lead a life of their own"

(ibid:17). "The anorexic girl feels hopelessly inadequate and ineffective in dealing with others – parents, friends, teachers, psychiatrists. And yet she has become master of herself. Regardless of what others see and prefer, she sees her emaciated appearance as normal and likes it very much" (ibid:19).

There are many similarities between HA and AN. First, both have internalized the cultural ideology. For example, AN strives for bodily health, thinness, and self control; HA strives for spiritual health, fasting, and self-control. In both cases the anorexic "becomes an 'expert' or champion of the cultural ideologies," they become her identity, and the "self-starvation behavior continues beyond her conscious control" (Bell 1987:19). Second, "both suffer from visual distortion." For example, the AN individual "sees herself in the mirror as heavier than she actually is" just as the HA individual "sees Jesus' bridal ring on her finger and a place for herself in heaven;" the AN "feels fine and displays physical endurance" just as the HA "feels God's love and energetically lives on the host alone" (ibid:20).

However, there are also definite differences between HA and AN. First, AN is defined "as a nervous condition and professionals set out to cure and change this condition" (Bell 1987:21). Second, in the case of HA the cause of the disorder resulted in much confusion among authorities of the time – was it God or the devil? Many were charged and convicted of heresy and witchcraft (ibid).

If looked at from a historical perspective, both disorders were a means of dealing with gender hierarchy. Both AN and HA had to deal with male hierarchy – male clergy, and until recently male psychiatrists, and psychologists. In medieval times male patriarchy defined whether HA was demonic, sick or saintly; this still holds today as biomedicine, as

guardian of the entrance to the 'sick role,' remains a patriarchal institution (Bell 1987). Contemporary AN can only be compared to HA in that they are both culturally constituted, and historically relative.

Although anorexia nervosa "was known to physicians as early as the 1870s, the general public knew virtually nothing about it until the 1970s, when the popular press began to feature stories about young women who refused to eat despite available and plentiful food" (Brumberg 1988:8). Girls and women were forced to resort to drastic measures to comply with the slim body ideal that was expected in their more public involvement, and anorexia nervosa, which had remained relatively obscure for a century, returned with a vengeance. Newspapers, magazines and television took it upon themselves to educate the public, with a sense of urgency, about the 'epidemic' of anorexia that was sweeping the nation (ibid).

BN also emerged in the 1970s and has been compared to the Ancient Romans, but as with AN and HA, the eating patterns of two eras cannot be compared. The Romans had no drive for thinness; binging and purging behaviors were characteristic of a wealthy and decadent aristocracy. In fact, "periodic purgation or vomiting was prescribed by physicians of the time as 'healthy'" (Gordon 2000:38). BN as we know it today did not appear until 1980.

Unlike AN, BN evokes the feeling of pride in accomplishment, but also feelings of shame and embarrassment. It is more difficult to diagnose because the individual appears normal; therefore, the condition remains undetected and it may take several years (the average is seven) for the individual to admit that they need help (Gordon 2000:44). BN is also more common than AN. It often begins in high school, but the greatest prevalence

is at the college level; therefore, a later age of onset of 16-20 years of age whereas AN typically presents between 12-18 years of age. There are issues of identity as the young adult leaves home and learns to become a responsible adult (ibid:45).

BED "has been around for centuries" (Gordon 2000:50). However, until recently, it was not labeled as a disorder separate from BN. Unlike BN, there is an abstinence of vomiting or other methods of purging, therefore the individual tends to be obese (Gordon 2000; Yanosvski 2002). Research suggests that BED is "more prevalent in males than AN or BN" (3 females to 2 males), and "that BED is significantly more common than BN, even among students!" (ibid:52) With BED, there is a "preoccupation with weight but the individual does not overvalue thinness as do BN patients" (ibid:53). As well, the binging behavior of BN usually follows intense periods of dieting and food restriction, while in BED it precedes dieting (Gordon 2000; Yanosvski 2002).

G. Terence Wilson (2002) compared binge eating to substance abuse. As characteristic of addictive disorders, the individual with BED develops a craving to consume the substance (food) and a sense of loss of control, uses the substance to cope with stress, becomes pre-occupied with their problem and makes repeated attempts to stop, and seeks to keep it secret. Many individuals with BED experience both eating and either an alcohol or a drug problem, simultaneously. He concluded that "since ED and addiction disorders are essentially different expressions of the same underlying problem, the treatment of ED should not differ fundamentally from that of substance abuse" (199).

Until the 1970s, anorexia nervosa and bulimia were not well known because of the restrictive age, gender, and class of clientele that they affected. Researchers seeking to understand and alleviate the increase of eating disorders have had to "work aggressively

to convince the public of their seriousness, especially when the competitors are AIDS, cancer and Alzheimers" (Brumberg 1988:19). As a result of the involvement of health professionals such as internists, psychiatrists, neurobiologists, psychologists, family therapists and nutritionists, over the past three decades there has been "an explosion of clinically focused research on anorexia nervosa and bulimia" (ibid:20). Results of empirical and clinical research are then published, and up "to fifty different professional journals published articles and clinical research findings on anorexia nervosa" (ibid). The number and variance of professionals involved in studying and treating eating disorders is important as it reflects the interest in the current issues as well as "the increasing specialization of health-related knowledge and services" (ibid). In addition, in a consumer driven economy, where the dieting industry produces billions of dollars in profits each year, the "interest in eating disorders should come as no surprise" (ibid). Corporations providing medical or related services to patients with eating disorders, conceive of "an expansive market in the years ahead" (ibid:22).

Thus we see that eating disorders have been culturally created albeit in different historical contexts. How then are these disorders dealt with by cultural institutions? Again we must return to the healthcare system and the clinical encounter.

ED and the Healthcare System

Since ED are considered as psycho-pathologies, it followed that my initial contact for this research project was a psychologist, who is considered an expert in the area of disordered eating, and is part of the Mental Health Team (MHT). Surrounding this individual is a network of healthcare professionals and counselors including the RHS administration, physicians, nurses, and counselors in the education system, as well as private

practitioners. These professionals operate amongst each other through a system of referrals making the process for obtaining treatment at any level lengthy. For those in most need, there are three treatment centers in the greater area, which operate on a referral basis from the experts in this network of professionals.

In order to understand ED from the perspective of these professionals, from diagnosis to treatment, I sought access to this network. The following interviews illustrate the role of professionals in the reinforcement of the cultural proposition that ultimately food and eating are individual acts. They also justify the stereotype.

Many of the professionals that I interviewed expressed their concern for the number of individuals presenting with disordered eating problems - predominantly white, female adolescents between the ages of fourteen and eighteen. They revealed that survey research has indicated that 36 percent of this group has a problem with food and/or body image. According to experts, the first indication of a problem presents at about nine years of age, peaks at fourteen, and then drops off as the individual enters their 30s. They attribute the prevalence of disordered eating to demographics including the aging 'baby boomers,' economic status, the prevalence of health issues such as cardiac disease, lack of exercise, poor diet, and changes to the family structure.

These professionals also indicated that while disordered eating is more prevalent among females, it also presents itself in males, but in the form of an emphasis on bodybuilding. The use of steroids, chromium and protein supplements along with extensive weight training and exercise regimes stress the importance of "bulking up" instead of proper nutrition. Because there are different societal expectations for males and females, males are not as likely to seek counseling.

It was the opinion of some professionals that the stereotypical middle- and upper class status of individuals with this disorder no longer applies as it now affects all classes. As well, second and third generation females from visible minority immigrant groups are now presenting with the signs of disordered eating habits. According to these professionals, eating disorders are more an issue of control, and a high expectation of perfection, than of socioeconomic status or ethnicity.

An indication that assistance is needed usually comes from a roommate, friend or concerned family member, who contacts a professional for help on their behalf. The individuals concerned deny that there is a problem. One counselor expressed that when seeking counseling, the individual is not really distressed, but very controlled. They come in for either of two reasons: (1) they have scared themselves (e.g. stopped menstruating) and are afraid that they have taken their habit to the next level, and are out of control; or (2) someone has caught them and/or is hounding them to get help. Any person presenting with "I have a problem" is only the tip of the iceberg.

According to the counselors with whom I spoke, disordered eating, such as anorexia and bulimia present a big problem to females in Canadian culture. If they have existed for up to four years, these disorders are life threatening. When an individual contacts a counseling service about eating or health concerns, they are first referred to a physician to assess their overall health, and then to an 'eating disorder expert.' It is reported that there is a 60-70 percent cure rate, with the average length of treatment being four years. As well, there are several support groups in the city; however, most cater to adults and are considered by professionals as not appropriate for adolescents. The opinion of some

professionals is that there are no support groups for adolescents because there are not enough of them at the same stage of treatment at one time to merit such a group.

As well, among professionals there is a growing concern regarding the rising incidence of obesity in both males and females in Canadian culture. The professional consensus is that the cause of this phenomenon is the increasing sedentary lifestyle and issues of low self-esteem.

The medical and health professionals that I interviewed were very helpful and informative, but at the same time maintained the authoritative role. They defined disordered eating not as a diagnosis, but as a pattern of eating (or etiology) that can lead to an eating disorder. Professionals also acknowledged that eating disorders are complex in nature, stemming from a combination of physical, emotional, spiritual and cultural factors. They perceived that within Canadian culture it is the emphasis on thinness and physical beauty, the prevalence of dieting, nutrition misinformation and perfectionist expectations that contribute to disordered eating.

Part way through my research, the 'eating disorder specialist' position changed, both in job qualifications (from an MA to PHD in Psychology) and in physical space (from the local hospital to the space occupied by other MHT professionals), so I sought to interview this new professional. The purpose of this interview was: first, to introduce myself and the nature of my research to this new professional, Lauren; second, to see if the perspective of this position of authority changed as the gender of the professional changed, as the former ED specialist was male; third, to gain further access to 'the secret world of eating disorders.' Lauren agreed to this interview but in the capacity of an eating disorder professional only, not as part of the MHT. I had previously met Lauren at

a RHS workshop for family and friends of persons with eating disorders; and had also been to a public presentation at the hospital about eating disorders, at which Lauren was the guest speaker. She said that she became interested in eating disorders "because they are multifaceted with multiple clinical issues."

For Lauren there are two areas of interest. First, as a psychologist she is interested in the development of the self, how we are limited, and how we move on from there. Second, as a feminist she is interested in sociocultural messages-ideologies, and how they impact women's development, gender, and socialization. Lauren initially said that she has not experienced EDs in her personal life, but upon reflection she can see it on the periphery. She became interested through clients and workshops, and as a result has become very aware of body dissatisfaction among women in her family, and EDs.

According to Lauren, EDs have been impacted through social standards in three areas: body image, emotionality, and gender. First, there are clear indicators that culturally women have to be a certain size and shape to be accepted, which is one of the greatest challenges for women. There are also subtle indicators, for example, the sizes available in trendy clothing stores for young women are very small and these sizes promote ideal body image. The second and third areas overlap; emotionality and gender go together, as gender stereotyping through socialization teaches youth that generally emotions are not okay. However, by repressing feelings a mask is created.

Lauren said that the media impacts the subconscious, or what is going on in the psyche. EDs are not just about body size and shape ideals, but about what you need to do to get there. The diet, clothing, exercise, and food industries are billion dollar industries that promise to fulfill an illusion that is unattainable; to be happy we must meet the

socially accepted size and shape. She gave the example of actresses who get thinner as they get more successful. Nicole Richie starred with Paris Hilton (already thin and successful) on a television reality show, and as the show got more successful Richie got thinner. Another example is Kirstie Alley who was thin and successful; she retired and gained weight; now to regain success she has to become thin again, which she is doing as a *Jenny Craig* diet spokesperson and regaining her success while she is slimming.

Peer pressure, Lauren said, has a huge impact, especially for girls as they are more socially connected to the sense of self; social relations are important, especially from age eight years and up. Boys, she said, are more individual. As women get older peer pressure is not so much a factor as they have usually become more isolated.

Regarding treatment programs for EDs, Lauren would like to see a continuum of services and training for professionals – therapists, dieticians, coaches, and teachers. She said that we also need a continuum of services that include those just beginning to those who are severe; a public awareness and promotion program, targeting those at risk and those affected; and a self-help component – support for self-help groups. As well, therapists, team promotion-prevention, and training all need to be coordinated.

As far as what clients perceive as their problem, Lauren said that it depends on the stage of the disorder the individual is in. Most often the early stages are about food; other feelings, self, and relationships are discounted; and some don't think they have a problem. In order to access help for an ED the normal route is through physicians, and school counselors; however, this varies as the disorder is multifaceted. She stated that "in this community there is no coordination of services, no consistency of the perception of ED" (it varies across services); and the cost of private practice counselors is high. Lauren

said that access is difficult due to lack of resources; poor coordination of services (i.e. they are "piecemeal"). She is leaving the position to go into private practice and to do further research. Lauren was very enthusiastic about my research and we decided to keep in touch. As well, she gave me several other avenues and referrals to search.

Lauren's perspective as a biomedical professional upheld the cultural proposition of individualism but also clearly stated the double bind. She acknowledged that most often the early stages (of socialization) are about food, especially for girls as they are more socially connected to the sense of self; social relations are important, especially age eight years and up. At the onset of adolescence for females she said that other feelings, self, and relationships are discounted, that is, they are trying to accommodate the change from the social meaning of food in childhood to the meaning of food as and independent act of adulthood. Because this transition has become commonsense it is not talked about; therefore, some don't think they have a problem. Lauren also stated that as women get older peer pressure is not so much a factor as they have usually become more isolated. It is this isolation (from social connections) caused by the value of individualism that causes EDs in adult females. This same isolation could be indicative of the potential for EDs in males, as Lauren said that boys are more individual (again through socialization). Further evidence of these last two statements is included in interviews with Terri and Vickie, which follow.

The evidence that the goals of this interview were accomplished was realized: by Lauren's enthusiasm for my anthropological view of ED; the perspective of a female in this position closely paralleled that of the male, but I felt was more empathetic towards females. To gain further access to 'the secret world of eating disorders,' Lauren gave me

referrals to professionals working in the closest treatment center as well as endorsed my legitimacy to attend the local ED support group.

The next professional I sought out was the ED dietician, Terri. As with the ED specialist (psychologist), I wanted to see if the nutritionist that specialized in EDs had a different perspective than the other nutritionists in the RHS. Although I had been referred to this individual by other professionals, I decided to attempt contact as a member of the general public, not as a researcher. I found that the lay route of access is restricted. When I phoned the hospital to make an appointment with Terri I was told that they would take my name and phone number, and that someone would call me when the appointment was arranged; there was about a one to two month wait. However, when I changed my route of access to that of a graduate student doing research on DE, I was put right through to Terri, and made appointment with her. She said that she would meet me at the main reception desk in the atrium of the hospital on the designated day because her office is hard to find – and it was: down stairwells, through hallways – in the 'bowels' of the hospital – invisible.

Terri told me that she is a registered dietician, but had to be trained and endorsed to work with ED patients. She also said that her job is only part-time. When I asked Terri why she chose this area of work, she answered that she chose to deal with ED patients because she enjoyed the psychology tied in with food. She develops a relationship with the client long-term, and each client is unique.

I then asked Terri what channels a person needed to go through to see her. She said that a person can be referred through the community health professionals, doctors, MHT

eating disorder expert, and various counselors. I told her about the process that I had to go through to see her; she was surprised as she thought that she was quite accessible.

My next question for Terri was regarding the treatment process. She said that she first assesses the clients' perception of food, for example 'hunger' and the mind/body connection; is it from external cues, is it that they do not feel hunger, or do they suppress it? She sees all age groups – early teens, late 30s, early 40s, both male and female, but she has not had Aboriginal clients. The treatment sessions are not structured, but rather consist of lots of talking about good-bad foods. Terri likes to see what the clients' goals are: why are they looking for treatment; what do they know about diets; is their information true or false.

Terri is part of a multi-dimensional team: doctors that specialize in EDs, counselors and doctors in the closest treatment center, the ED expert, and the previous ED expert. She said that she meets once a month with the larger city's treatment team; meets once a week with the ED expert; does case conferencing with the previous ED expert. Terri said that there is a possibility that through the restructuring within the RHS, that her position may be coming under the umbrella of a new community health agency that encompasses 'chronic disease.'

From this interview it was revealed that the professionals dealing with EDs are not easily accessible to the general public; although Terri's perspective is more specialized, it has the same thrust of individualism as other nutritionists; and, that the position is only part-time suggests that not many are given access. Her admission that she has never had an Aboriginal client is further evidence of the division of services between mainstream and Aboriginals, and also suggests that EDs among Aboriginals may be under reported.

Terri's statement that she sees all age groups, both male and female suggests that perhaps the stereotype needs to be expanded.

The RHS also endorses various support groups to aid the individual in coping with their various disorders. The Disordered Eating Support Group (DESG) is one such group, which is open to individuals with ED, as well as their friends and family. Being the parent of an individual with an ED legitimized my access to this group; however, I decided to first interview the group facilitator who I had previously met at a public ED presentation.

Interview with the DESG Facilitator

To gain access to this support group, I first interviewed the facilitator. Although meetings are open to the public, attendance by outsiders is guarded. My interview with this individual illustrates the perspective of EDs from individuals affected with the disorder and reveals why there is so much secrecy.

After a few telephone calls, Vickie and I finally met late one evening in a local coffee shop for the purpose of an interview regarding her relationship with the local eating disorder support group. We had met some months earlier at a RHS workshop on EDs, she expressed interest in my research project, and said that she was open to an interview. During the conversation Vickie told me that she was 45 years of age and alluded to being part of a minority ethnic group, but did not expand on the topic. We exchanged 'small talk' for a few minutes, then I proceeded to ask her the same questions that I asked of the professionals (see Appendix C).

Vickie first became involved with the DESG as an observer at a regular weekly meeting. Vickie said that at first she was non-committal, did not participate, just

observed, and was wary of the professional therapist in attendance (the ED expert). Three months later the group was going to disband for the summer, but she remarked that "ED don't stop for the summer," so assumed leadership for the summer. In the fall, the leader's daughter was ill so Vickie continued, then the leader became ill and died shortly after as a result of ED complications. Vickie continued in the capacity of the DESG facilitator.

The influence of societal standards on ED behaviors depends on where the individual is at the particular moment; as Vickie phrases it "the way you see your world." She said that "there has been a change in the meaning of diet, it now means 'healthy choices,' and there are more options, regimens are not so rigid." Vickie also commented that there is competition within the group, that is, if someone is fatter than you it is okay, but if they are thinner, then, it is not okay. As a facilitator and a role model she is more aware of her own (ED) behaviors as there is a fine line that defines what she can reveal and what can be detrimental to the group; they need to know that the struggle is there (for her), but not the details.

Vickie remarked that peer group pressure in the case of the DESG is a good thing as it pulls people along to recovery whether they like it or not through positive role modeling. However, she added that it can also be a bad thing because if people are facing more challenges, it brings the whole group down. In Vickie's perception, "not many guys have ED – maybe only two or three" that she knows of. "Are men affected? Yes. They go to internet sites where they are not visible, safe." She added that even as a female she has said things on the internet that she would not say face-to-face, but she also said that she gets both positive and negative feedback.

Age is an important factor, and according to Vickie there are more middle-aged, divorced, and empty nest syndrome individuals who are affected by ED. She also remarked that "disordered eating is not a matter of income, but a matter of priorities – laziness, peer pressure, and a rushed life." Vickie said that "you can always cut back in some areas to provide fruits, vegetables, and an exercise program." Also, "if you're bulimic it doesn't matter – you're going to puke no matter what you eat." As far as the importance of ethnicity, Vickie commented that "there is a bigger pull for blonde, blue-eyed models to be thin. In order to compete with this stereotype, ethnic women must conform; the anorexic look is rewarded." All of these comments by Vickie are contrary to the stereotype.

What ED programs would Vickie like to see in this area? "A retreat that can encompass all people: in recovery, thinking about recovery, on the fringe … can see all those stages of the disorder … motivates people to change … helps maintain recovery. Need for group assertiveness … psycho-education, family support group. Different age support groups: teens; young adults; middle age; parents." She reinforced the need for a follow-up program that would facilitate connections within the community, such as a phone/buddy system like AA.

Vickie stated that group members perceive their problem as "They're fat; an ED is a coping mechanism to make their world work, a way of disappearing – become invisible – self-protection". She then gave me a personal example. Vickie said that she was sexually abused between the ages of 10-17 years. From this experience, she perceived that normal weight was dangerous; abnormal (too fat or too thin) was not dangerous.

Vickie also commented that some people want to be sick so they can be taken care of, others feel self-sufficient when they are isolated.

As far as help available and access to those services, Vickie commented that there is "not enough out there; the treatment program in a larger centre, near Rivertown has a high success rate (must have medical and counseling back-up) – anyone can phone them for help – must take 3 months off work for treatment." She also added that there is a 21-day treatment program in an adjoining province that anyone can go to – she has been often. Individuals can also get connections through the DESG as Vickie expanded, "I watched the ED expert for 3 months – now [I am] seeing [this expert] in the capacity of a private counselor."

Why so secretive? Her answer was straight forward "the stigma attached – mental illness, shame-based."

This interview with Vickie reflected the changing discourse of food when she stated that "there has been a change in the meaning of diet, it now means 'healthy choices,' and there are more options, regimens are not so rigid." Vickie's conformity to capitalist discourse is expressed by her acceptance of treatment through the biomedical model by her own clinical encounter with a psychologist, as well as her recommendations for the establishment of more such biomedical services, and acknowledging the effectiveness of programs such as AA. However, she also expresses the need for social connections within the family and the community at large.

Vickie aptly stated that the double bind between the individual and the social when she commented that some people want to be sick so they can be taken care of (using food

and eating behaviors to establish social connectedness), while others feel self-sufficient when they are isolated (conforming to the value of individualism).

As per interviews with Lauren and Terri, the interview with Vickie is further evidence that the stereotypes of ED do not fit the ethnographic reality as she stated, "not many guys have ED – maybe only two or three" that she knows of. "Are men affected – yes – they go to internet sites where they are not visible, safe." Age is an important factor, and according to Vickie there are more middle-aged, divorced, and empty nest syndrome individuals who are affected by ED.

Also contrary to the stereotype is Vickie's response to my question of EDs among ethnic groups: "there is a bigger pull for blonde, blue-eyed models to be thin. In order to compete with this stereotype, ethnic women must conform; the anorexic look is rewarded." This statement suggests that EDs among ethnic groups may be under reported.

Why so secretive? Vickie's straight forward reply "the stigma attached – mental illness; shame-based," illustrates the power of biomedical discourse to label human behaviors, which creates subject positions and inequalities. This inequality is exacerbated by control of and unequal access to treatment made evident in Vickie's statement: "not enough out there; the treatment program in a larger centre, near Rivertown has a high success rate (must have medical and counseling back-up) – anyone can phone them for help – must take 3 months off work for treatment."

As we ended our interview, Vickie confessed that she was interviewing me as well, and invited me to attend the next meeting of the DESG. This was the first level of acceptance into the group. Following are my experiences with this group.

My Experience with the DESG

The first meeting I attended was to be a special meeting with a local nutritionist as the guest speaker; however, she didn't show. I identified myself as 'the mother of a daughter with an ED' – the support group is advertised as including family and friends, so I qualified. Although I had also been invited by the facilitator, she did not acknowledge our relationship; I was able to be a part of the group on my own terms.

Weekly meetings are held in an auxiliary wing of the hospital. To get to the meeting room one enters the hospital through automatic-opening doors and crosses a waiting room, then traverses a short hallway past the 'outpatient lab' and waiting room, and finally reaches the designated DESG meeting room a few doors down. Sometimes across the hall there are prenatal classes, as evident by the couples coming in with their pillows. The ED meeting room is small, with tables set up in a 'T'; there is a chalk board on one wall and windows on the wall opposite. On the tables are small boxes of facial tissue, pads of scratch paper, pens, five colored pages with the AA 12 Steps on one side and the AA Promises on the other, two pages with the Serenity Prayer on them, and a small wicker pot for donations. Just inside the door is a table covered with a black cloth and on it are displayed an assortment of 'self-help' and educational books. These are available for members to sign out in a book provided. There are also business cards of the therapists available and other community resource materials. The local ED expert is usually in attendance on a consulting basis.

Each meeting has a ritual. The facilitator welcomes members and reads a script of the DESG mandate, those in attendance are set at ease by being advised that they can 'pass' if they do not want to participate in the evening's activities. Each member is asked to

introduce themselves (first name only or pseudonym), give their reason for attending (e.g. anorexic, bulimic, in recovery from …, parent or friend of someone with an ED), and what they hope to get out of the meeting (these are all optional, as the person can choose to 'pass'). An attendance/phone sheet is circulated; those not wanting to be phoned, can indicate this choice on the sheet (phone list is updated twice monthly, and members are encouraged to use this resource during the week to help them with their ED recovery journey). The 12 Steps of Alcoholics Anonymous (AA) are read alternately by members; then there is a general news and question period. During the 'sharing' portion, each member reflected on last weeks' events, good and bad. No one is allowed to discuss 'methods' or 'numbers' involving their ED problems. Because the DESG is a 'safe' place; all that is said is confidential. At the end of the meeting the AA Promises are read alternately by members and the Serenity Prayer is said aloud by all members; sometimes they stand and hold hands, sometimes not, depending on the mood of the evening. I was told this last behavior had to do with issues of personal space.

At the end of the first meeting, I was invited to come back. This was the next level of acceptance in my experience with the DESG. Following are descriptions and narratives of some of the weekly meetings. What I hoped to gain from this experience was insight into the experience of ED from the perspective of the individuals affected, or the lived experience of ED.

The following meetings incorporated two new rituals that followed the announcements. First, members were asked to select one card from each of two sets of 'inspirational thought cards,' and then comment on what they meant to her. Second, following the thought cards was an educational section on an agreed upon topic;

professional help. Vickie said that if she felt the person was not okay, that she would call the psych ward for help (since we meet in the hospital). She also said the emotional outburst could be a positive thing – maybe there was an 'awakening,' Patricia was overwhelmed, and needed space; she could also have left because she felt embarrassed about the emotional outburst and left to 'save face'.

One meeting by Sarah started the discussion on the topic of goal-setting. However, the ensuing discussion was a tangent that focused on the topic of food and the inability of certain individuals to talk about food. Tonight before the meeting one member admitted that she stopped at a local coffee shop that she frequents several times a day, but this time she bought a donut and ate it on the way to the meeting. The idea was to eat it in secret, but she was conscious of people seeing her eat, especially when at a stop-light, and she could feel her thighs getting larger. This admission led into the discussion topic of goal-setting: the goal to not feel guilty about food and eating, about being able to eat without losing control. The general consensus within the group was that when this feeling of guilt surfaces, the individual would probably restrict food intake for one or more days, but they also added this is not a positive response, and that the donut should be replaced with more healthy choices. Another member joined in the discussion by adding that she loves to play sports but might have to give it up because she has to eat to have enough energy to play properly, and she doesn't know if she is willing to do that. Comments in the group expressed that it was sad that someone would give up something she loved to maintain her ED.

During this session we also discussed grocery shopping and the fact that this daily-living activity is an ordeal; the ability to perform this activity is a goal for ED individuals.

members are given the chance to veto the topic if it hit too many 'nerves'. The purpose of these new rituals was to encourage discussion about feelings and bring these feeling into the open, perhaps even to resolve the negative ones. They accomplished just that.

Over the next few months I participated by telling of my own experiences with food – that I sometimes use food as a coping mechanism; and of my feelings and experiences with ED as a parent. I tried not to 'pass' in order to be part of the group, to gain their trust. At an appropriate time agreed on by the facilitator and myself, I discussed my research with the group. They were totally okay this revelation because they realized my commitment to both the cause of overcoming ED behaviors and the group.

Conversation within the group is confidential in order to maintain 'a safe place,' but the group has given me permission to discuss generalities of issues and educational exercises that have transpired. Individual stories are the domain of the individual and not to be revealed, therefore any names, places and events are pseudonyms. While the dialogue may be altered to protect individual identities, the underlying issues remain in context.

During the card interpretation, educational section, and sharing portions, some interesting issues arose. During one particular meeting, Patricia, who is affected by anorexia, was very emotional as several events were happening in her life that she wanted to resolve before the end of summer. At sharing time she 'passed' and left the meeting crying. Vickie, the facilitator, excused herself and followed Patricia out to make sure she was okay and would not harm herself. It was a good experience for other members as when Vickie returned we discussed our individual feelings about what had just transpired and how to handle it if this happens – when to know if the person is okay or if they need

Pam, for instance, said that she needed to take a friend with her for 'control;' she said that she will not take debit or credit cards to pay for her groceries as she feels that she "will buy too much, go home, eat and puke it all up." To prevent this behavior, Pam said that she does many 'mini-shops,' and then puts the food into portion-sized baggies so she won't overeat. Sarah shared that she doesn't shop; she would like to be able to for her husband, but she can't even go in a grocery store.

Being unable to talk about food or shop for groceries reflects that the denial or refusal of food, or disordered eating, creates relationships, positive or negative. Similar to 'food as gift' discussed in Chapter 3, it creates a dependency on others for food. However, it could be argued that whereas the acceptance of 'food as gift' is a recognition of a subject position, ED is a voice against a subject position.

Another week, the topic of discussion was about ED as an identity as members voiced that they "don't want to give it up – it is a friend – it makes you special." In response to this symbolic meaning of EDs, Pam related two situations in her life where her bulimic behaviors were a direct result of being angry with either work or personal issues. When Melanie suggested that there were underlying issues to the anger, Pam agreed but said that she did not know what these issues were yet.

One week there was a 'special meeting' for which we put up posters around the city to advertise that there would be a presentation by a member of the CDT on "food and how various nutrients help our body to function." Throughout her presentation the speaker promoted the Healthy Body/Healthy Life program. After her presentation, I asked her how I would go about finding her in the RHS as I had been looking on the website and did not see any links to dieticians. She said to look under 'nutrition.' The next day I

followed her instructions, but it took several layers of links to find dieticians – they were not obvious.

Following the presentation, the guest speaker was asked to leave (for the sharing portion). Discussion began about being obsessed with 'scales.' Several members said that having the right numbers (weight) at morning weigh-in controlled the mood for the day. They also added that it was a form of organizing the day – if the right number or less appeared, it was a good day; if the wrong number appeared, one must immediately make plans to change one's behavior regarding eating for the rest of the day so that the number would change tomorrow (their mind-set was "what can I do to get rid of excess calories ingested?"). Sarah denied that the scales affected her mood, and was immediately challenged by Amanda, who suggested that she decide the mood for the day before stepping on the scale, and then see if her mood changed after weigh-in. It was also questioned by Darlene "What does the number on a scale matter? Get rid of the scales." This brought up the issue of over-exercising to get rid of excess calories. Pam shared that as a runner she was interested in the nutrition presentation because she wanted to know what food she had to eat to make muscles and make her body perform well, in effect, to maximize the food she eats. She also stated that in order to control her weight, she takes her scales everywhere – even to business conventions and on holidays - so she can compensate for any over-consumption and not gain weight.

The topic of another week was 'goals' (again). The reason for this choice was because some members were given 'goals' as an assignment by their therapists. They were required to make long-term and short-term goals for their recovery process, and they did not know where to begin. One member began the discussion by expressing her

concern about not being able to control eating once she started; therefore, she chooses not to eat. For example, the previous Saturday she went to a craft party but before she went she had decided that at the party she would have a muffin (the hostess always serves them), but instead of eating just one muffin she ate one and one-half muffins and was not impressed with herself. Then she expounded that the same day she ate too much at mealtime and then had a large snack later in the evening. She expressed that she is afraid that her 'hunger' and 'full' switches are not working. Of course the next morning the numbers on the scale showed the eating behaviors of the day before, so she had to compensate.

At this point, Patricia turned the discussion to EDs as identity (another repeat topic). One member stated that she was concerned about her eating behaviors and the possibility that she was gaining weight because she no longer meets the criteria of anorexia. She is now considered 'ED not otherwise specified' (ENOS) – and she doesn't like it. She feels that she is now not small enough to be worthy of help. This brought up childhood and parents. She was from a large blended family; she felt that she didn't get the love and attention that she needed. She hates the small child (herself) who is weak, but also expressed that "it is the small and weak who get help." At this point I talked a bit about being a parent and Patricia said that she purposely brought up this subject because she knew that I was a parent, and that she wanted to know how I felt about what had been said.

Wanting to be a child by being physically small, through anorexic behaviors, and wanting 'parental' feedback suggests several possibilities. For the member involved it could symbolize a desire to return to familial relationships, positive or negative, the

physical disconnection from family by living at a distance. The refusal of food could also be the desire to be dependent, taken care of rather than a working adult that is promoted in the capitalist system. ED behaviors, diagnosis and treatment keep DESG members in the 'sick role' and in need of care, which satisfies this desire.

For the next few weeks we discussed and had educational exercises about 'The Ten Common Forms of Twisted Thinking' (see appendix D). One week we made collages – we chose a piece of colored paper, then tore pictures and words out of magazines that Vickie had brought for such a purpose. There was no talking allowed; and we were not to think too much about what where tearing out. We then pasted these pictures and words onto the colored paper however we liked. When all were finished, those who wanted to talked about what the collage meant to them. Sarah's collage was very disturbing – she chose black paper, and throughout the exercise she kept removing, adding, tearing so that when her collage was finished, the edges of her background paper were uneven. The most predominant images were of pigs and angels, the meaning of which was not disclosed (perhaps at another time).

Another exercise regarding the same topic involved using the large chalkboard in the meeting room. Vickie made five columns: ED gives, Changes to ED, How to try something different, Benefits of change, Specifics of that change. It was sort of a brain-storming session, everyone participated. For example: ED gives us a sense of identity, change ED by giving it up, try something different by eating twice a week instead of once, the benefit of this change would be to find/have a life, specifically it would mean better relationships, including with self. Another example: ED gives us a sense of acceptance/belonging (cultural ideal of thinness), changes to ED would be to examine

beliefs about self-worth, question who determines what is acceptable, try something different by using self-talk and reaching out to others, the benefit of this change would be increased feeling of self-worth, specifically a full range of emotions, experiencing life to the fullest. There were two more examples (see appendix E).

The next week we did another interactive exercise about the benefits and costs of ED (see appendix F); again it was done on the chalkboard. At this meeting, a member who has been through treatment but not able to attend regular meetings was in attendance. She commented: "I really miss my ED." It was during this exercise that another member, who was talking about going into treatment, commented: "If I had to give up my ED I think I would die;" yet she knows that if she does not get treatment, and soon, she may in fact die. I began to notice that ED was being personified by these women; it was a part of the their selves; if they gave up ED that it was like a death and Ed was grieved for. I also found it interesting that the acronym was a man's name and that members also referred to 'ED' as 'he.'

This personification of an ED suggests several possible meanings. It could symbolize an imaginary relationship through the medium of food as ED reflects a lost relationship in reality, past, present or future; it can be a positive or negative exchange. For example, it could represent a mother-daughter conflict, a sexually abusive relationship, a desired peer or sexual relationship, or a disconnection with family. ED may also be an attempt to create a stable relationship in what seems chaotic; therefore, ED symbolizes order through control of food.

The educational portion of the meetings (as depicted in Appendixes D, E and F) reflect that the current biomedical treatment models for ED emphasize the responsibility

on the part of the individual to conform to cultural standards of productivity. Individualistic values are reinforced through exercises on goal-setting, self-worth and self-esteem; these exercises are all about the individual, the self. Ironically, when done in a group setting the sharing and creating of these appendices is creating relationships through disordered eating. Group treatment is important because it is less hierarchical than therapist-client or physician-patient relationships.

Another week went by; we kept on with the self-esteem exercises – talking through statements in the scripts, and getting closer to feelings. I was informed that individuals with an ED avoid this topic. The member who was contemplating treatment added that she had decided to go into treatment and has been confronted with feelings. She commented: "my time with my ED is ending and I'm scared and sad." After a few moments she added: "I know there must be a life without my ED, I just don't know what it's like" (she has had an ED for over 25 years).

Conversation among members turned to confronting people in their lives about feelings of being wronged. Vickie said that that can be hard to do, especially if they are dead. She also questioned the truth of actual events that caused these feelings, using the example of the abuse she suffered as a child and that she can't remember the details. She questioned "Does that make my feelings less valid?" The group agreed that attending meetings once a week showed a sign of awareness, agency and confrontation, which was a good feeling. Vickie also remarked "Two hours at a meeting is two hours less with the ED."

Another issue that arose during the education portion of the meeting was not being as concerned about how others perceive you, as you don't have control of this. Sarah

remarked that she was not concerned with how she, or her body, looked to others. Amanda, who was in recovery, shared that she was 'falling off the wagon' more and more often, that she can't grasp the severity of her health; she doesn't trust the doctors. Even her therapist, whom she trusts, can't convince her. The group then discussed and reinforced the severity of EDs to health, and the possible consequences (death). Vickie and Melanie reminded the group that they all know the dangers of ED behaviors – each time could be the last.

During my involvement with the DESG, I perceived that there were some main issues in these women's lives. First, at some point in their life, whether during childhood, adolescence or adulthood, past or present, there had been a disconnection or rupture in a social relationship. Second, they had accepted the cultural proposition that food is an individual act rather than a social one. Therefore, they had also accepted the biomedical model of treatment, and as such had been labeled, which they strive to keep hidden; hence the secrecy. Evidence of this acceptance was illustrated by the fact that they all have a therapist and follow the AA program of recovery (which is endorsed by biomedicine). Third, all of the members of this group are older than the stereotype (23-70 years of age) and one is of a different ethnic background, but all are middle-class and female. During my participation with the DESG, there were never males or Aboriginals in attendance. Fourth, most of these women have had an ED for a long time and are at various stages of the disorder: some are still in denial of the severity of their behaviors, some are in therapy, some are contemplating treatment, and some are in recovery.

From my perspective, attendance at the DESG breaks the self-imposed isolation of these individuals by encouraging them to share their experience with someone other than

a professional, or creating social relationships. Because food is the language used by these women, and food is always social, it reinforces the socialization they learned during their childhood years. If the disconnection was during childhood, it allows the individual to learn from the group the importance of relationships. It appeared that those who had a social network, or re-established rupture relationships, were more apt to recover than those who were isolated. Also, members who attend DESG meetings on a regular basis form friendships within the group. Whether they realize it or not the group is reversing the internalization of the proposition that food is an individual act; thus, reducing its absolute power. The group empowers the individual by giving her or him a social connection in order to put the proposition in proper perspective.

I agree with Gremillion (2002) who in her research conducted in an eating disorder clinic in the United States observed that the medical discourse used in the treatment of eating disorders actually reproduces these disorders. In the clinical encounter, the patient's resistance to treatment, which is considered as a sign of autonomy and individualism, a valued cultural belief (ibid:391), is rewarded. For the anorexic, anti-consumption "indicates personal achievement" and is "the "solution" to the "seemingly unresolvable cultural tension between productivity and consumption" (ibid:400). Therefore, discourse has constructed but is also reproducing EDs. However, the dialogue between members of the DESG suggested that those individuals who had a female therapist were more apt to recover than those who had a male therapist. Perhaps this is because female therapists, like Lauren, have more empathy toward female clients, more of a psycho-social approach? There is need of research on this topic.

According to Counihan (1999:111) "the prodigious fasting of Western women over eight hundred years," can be attributed to some extent by the secondary position of women within a patriarchal society – food is "a voice" that expresses the "struggle against their subordination." This caused me to question: do some contemporary males also use food as a voice to express subject positions?

Beyond the Stereotype: Males (white)

Gordon (2000:57) suggested that the high number of ED among females is associated with women's subject position within the capitalist system. However, research of this phenomenon revealed that the incidence of ED among males is increasing (Gordon 2000; Woodside 2004). Several studies have noted that body size is important to males but from a different perspective than females; as with females, the male body is culturally constructed per stereotypes of 'maleness;' fewer males seek help because of the stigma of having a female disorder (Gordon 2000; Weltzin et al 2005;). Therefore, studies suggest that ED in males is under reported (Gordon 2000; Menaster 2002; Woodside 2004; Weltzin et al. 2005).

There is a consensus in the research that the age of onset, and characteristics of an ED are the same for both male and female patients (Burns and Crisp 1985; Fichter et al 1985; Hall et al. 1985; Woodside et al. 1990; Bramon-Bosch et al. 2000; Eliot and Baker 2001), but that ED among males is less prevalent than in females (Fichter et al. 1985; Burns and Crisp 1985; Andersen 1990; Wilps, Jr. 1990; Woodside 2004). While AN and BN in males has been a controversial issue in the fields of psychiatry and medicine for centuries, it is a well-know fact that one of the first two case reports (1689) of AN was a male (Andersen 1990, Silverman 1990). Research has shown that extreme weight loss in

males results in the same endocrinal shut-down as in females (Burns and Crisp 1985, Fichter et al. 1985), and that males do suffer hormone decrease but it is less visible than amenorrhea in females (Andersen 1990; Mickalide 1990; Andersen et al. 2000).

EDs are a coping mechanism used by the individual concerning a particular social issue: self-esteem, identity, meaning, quest for relief from painful mood states, conflicts in personal development, and struggles in family functioning (Burns and Crisp 1985; Andersen 1990; Herzog et al. 1990; Levine et al. 1990; Wilps, Jr. 1990). They begin as a 'diet,' sometimes prescribed by a doctor, sometimes as a result of medication prescribed by a doctor, and gain momentum during the preteen and teen years. ED can also present at times of crisis in marital or extra-marital relations (older onset). ED gives the individual a sense of control over the perfectionist personality, demands of school, work, parents, and friends. What began as a voluntary behavior gradually escalates to the sick role, creating a dependency on the continuation of the illness behaviors. ED "becomes part of the individual's identity, to give it up and be "cured" leads to a sense of anomie" (Andersen 1990:140).

Anorexic (and ED) males are just as confused about their gender identity as their female counterparts (Burns and Crisp 1985). ED is manifest in males (as in females) "to ward off adolescent maturation conflicts, specifically regarding sexual feelings and behaviors." Males are more negatively affected by "sexual anxiety, limited sexual experience, and ambivalence towards roles and identities as males," than are females (Herzog et al 1990:41); and, there is a high incidence of EDs among gay males (Fichter et al. 1985; Herzog et al. 1990; Mickalide 1990; Woodside 2004).

Biologically boys and girls have similar body shapes until puberty – ages 9-12 – during which time girls develop more fat in order for the menstrual cycle to begin. Today, puberty starts earlier due to the greater availability of food, especially fats and sweets. Girls' maturity stages are more definitive than boys. For example, doctors record a girls' first menses, and girls write it in their diaries; this is not so with boys – there are no definitive markers (Andersen et al. 2000:51). Male and female bodies store fat in different areas of the body; males most often above the waist, females below the waist, therefore the areas of criticism are allocated accordingly (Andersen 1990; Mickalide 1990; Andersen et al. 2000).

Boys are socialized to suppress emotion and express unconscious feelings through their bodily actions, such as aggression and violence; girls are socialized to use their body to please and attract others and to influence the way they are treated. Parents tend to withdraw physical affection, especially in public, toward boys past kindergarten age. Thus, boys are socialized to the physical, girls to the emotional (Andersen et al. 2000:63, 64). The socialization and enculturation of norms such as body image, appearance, and sexuality varies in males relative to their culture (Hall et al. 1985; Pope et al. 1998; Andersen et al. 2000).

As with women's bodies, the ideal male body form has varied historically (Mickalide 1990, Pope et al. 1998, Anderson et al. 2000). In medieval times men were warriors and leaders, and as such lean and muscular. Beginning in the Middle Ages and the Reformation, males with power and affluence were heavier as a symbol of their wealth and status. This ideal did not change drastically until the 1960s when the ideology of thinness, although targeting women, also began to have an affect on men. Today males

are expected to act like a 'real man' in protecting 'hearth and home' and creating sexual excitement, but are also expected to be intellectual and sensitive, tender and nurturing – a double bind (Andersen et al. 2000:41).

Food carries as much meaning for men as for women; however, Kiefer et al. (2005) suggested that the meaning is gender specific. For example, men's approach "to food is more pleasure oriented," while "women orientate themselves more strongly with social norms" (7). Men are stereotyped as eating heavier foods, and socialized that it is okay to 'pig out;' women stereotypically are expected to eat lighter foods and in smaller quantities. These expectations lead to conflicts about self-esteem, body image, and sexuality, and as a result men, like women, are becoming more 'diet' conscious (Andersen et al. 2000:64).

Men diet and have cosmetic surgery, count calories, are preoccupied with weight, and have ED. Just as for women, the media and clothing industry image of the ideal male body shape is unrealistic for the majority of men: "medium weight, 6 feet tall, prominent chest muscles, slim waist, and well-defined abdominal muscles, muscular butt, and strong legs" (Andersen et al 2000:30). Men dislike the physical presence of fat on their bodies, as do women, only in different places – e.g. 'beer bellies' and 'love handles' (ibid). In the 1980s, the diet industry realized that it was missing half of its potential consumers, and therefore began targeting men (ibid:xvi)

The need for exercise is for the same for both men and women as both are affected by the contemporary sedentary life style - computer work, cars, and television. By junior high school, the best athletes (jocks) have already been chosen, which provides them with privileges over other males. Such privileges include status, special class privileges such

as low class loads, and the tolerance of physical and verbal abuse behaviors. Jocks develop exercise habits that continued into adulthood, whereas the males not chosen are left to the mercy of the media and cultural norms (Andersen et al. 2000:38) - some become compulsive exercisers, like women (Fichter et al. 1985; Hall et al. 1985; Andersen et al. 2000).

EDs are more common in athletes, both male and female, especially those that demand weight control such as jockeys, wrestlers, runners, swimmers, models, and dancers (Andersen 1990; Mickalide 1990; Eliot and Baker 2001) because weight restrictions are enforced within their professions. Jockeys and wrestlers use dietary restriction and binging behaviors only during peak professional times, and it is during these times that they present with disordered eating behaviors. Males use different terminology than women to describe their unwanted girth. For example, they lose 'flab' not 'fat' and seek 'muscle definition' rather than 'body shape'. Men use 'dieting' as a defense mechanism to 'cover-up' hereditary heart disease or risk of diabetes (Andersen 1990:137).

Some males suffer reverse AN, or body dysmorphia, that is they need to be larger, not smaller (Andersen et al. 2000:36). Men are just as dissatisfied with their appearance as women except 40 percent would like to increase not decrease in weight whereas 70-80 percent of women want to decrease. Men are more shape than weight concerned – height, musculature, and strength. In boys, those who mature late are more likely to be stigmatized; this is the reverse in girls as they want to delay development (Andersen et al. 2000:55). Society's impossible body ideals for males are just as hard to attain as the body ideals for females (Pope et al. 1998; Andersen et al. 2000).

As an example of ED affecting males, Wilps, Jr. (1990) stated in a research article that he authored that he was bulimic and engaged in binge eating, over exercise, and prolonged fasting. For Wilps, Jr., low self-esteem issues began at the age of 13 years, he was small for his age and his "bookish" appearance evoked bullying from other boys. Food became a source of comfort for him; his parents, not knowing their son's dilemma, thought his appetite was normal as to them food meant family tradition and heritage. He became a 'secret' eater, eating alone with a book (13). Later, in college, food changed from being just a source of comfort to mean safety and affiliation with other male students. However, during graduate studies Wilps, Jr.'s social network decreased, and marital stress caused him to develop AN tendencies. He went on a calorie restrictive diet, and alternately binged and fasted (ibid:14-16). Later, divorced and a co-parent, he became bulimic, binging as a reward/release from pressures of parenting and work; he also abused alcohol and became suicidal (ibid:19). Wilps, Jr. claimed that his recovery from BN was due to the development of food allergies, which he perceived as an addiction because he suffered withdrawal when certain foods were eliminated (ibid:23). Wilps, Jr.'s experience with EDs, as with females, reinforces that there are pressures on deviant body types regardless of gender to conform to cultural norms.

EDs in males is under reported (Fichter et al. 1985; Andersen 1990; Andersen et al. 2000; Woodside 2004); however, research suggests that AN, BN, and BED are just as prevalent in males as in females. Psychological testing for ED is biased towards diagnosing women; there is a need for male testing (Woodside 2004). Health care professionals do not generally think EDs occur in males; insurance companies refuse to pay for AN treatment because they believe males do not have EDs, it must be something

else. "This stereotype may lead clinicians, especially those not accustomed to routinely treating ED, to miss the diagnosis when it does occur, as it so often does in older women, minorities, or males of any age" (Andersen 1990:136).

Yet another explanation for the low ED statistics for males offered by Woodside (2004) was that males do not see themselves at risk, and "therefore dismiss or ignore symptoms that might be indicative of an illness requiring treatment" (85). He gave the example of a young woman identifying that she was bulimic because of her binging and purging behaviors as compared to a young man with similar symptoms who dismisses the symptoms as excess alcohol consumption or bad eating habits (ibid).

Although I was not successful in interviewing a male with an ED, my interview with Gordon in Chapter 3 describes the life experience of a male who was overweight. If he was not labeled as 'homeless,' I perceive that Gordon would have fit into the male ED category. Gordon's food history narrative reflected the affects of food on his ethnic immigrant identity, family relationships with grandparents, parents, and siblings, peer relationships at school and at work. As a responsible adult in the capitalist system, food created and maintained his professional relationships. Through narratives about foods of the world and travel Gordon was attempting to validate his position in mainstream society as a successful businessman. Ironically, the food and eating behaviors used to create these relationships also destroyed them, reducing Gordon to a state of dependency. In this state he is unable to fulfill the cultural proposition.

The interview with Gordon as well as the extensive literature research revealed several underlying themes. The cultural proposition that food is an individual act is just as contradictory regardless of gender. The lack of research, prognosis and treatment of male

EDs could be viewed by some as an inequality in the health service for men. Food is symbolic of social relationships for males just as it is for females.

Aboriginals (Males and Females)

The research on eating disorders among mainstream population is extensive, especially among females. However, the same phenomenon among minority groups is less studied, especially among Native American girls (Rosen et al. 1988; Story et al. 1997; Story et al. 2001). There has been a steady increase of eating disorders among ethnic and minority groups, which needs to be addressed (Rosen et al. 1988; Mickalide 1990; Story et al. 1997; Marchessault 1999).

Across cultures ED symptoms seem similar; however, "the contexts in which eating disorders develop and what constitutes effective interventions may vary among ethnic groups. Few studies have focused on risk factors for disordered eating behaviors among ethnic minorities ... thus [the disorder is] less well understood than among white adolescents" (Story et al. 1997:2). Available research suggests that adolescents, whether white or Aboriginal, use dieting and purging to cope with issues of weight, low self-esteem, depression, peer pressure, family conflict and disconnectedness, as well as substance use and sexual abuse (ibid; Marchessault 1999). Other risky and "health-compromising behaviors such as alcohol and tobacco use have also been associated with dieting and purging behaviors" (ibid); in fact, the more risk factors present, the higher the rate of DE behaviors. The same holds true for both girls and boys (Story et al. 1997:6). The similarities between the two groups "suggests that the larger sociocultural environment, which emphasizes thinness as a beauty ideal and equates slenderness with

attractiveness in women, may be strong enough to affect ethnic and cultural subgroups" (ibid:7).

Researchers have concluded that while EDs and ED symptoms have been considered culture-bound syndromes, "it seems that the prevalence of these disorders is increasing among all social classes and ethnic groups in the United States, as well as in a number of other countries with diverse cultures" (Story et al. 1997:7). The cultural message to be slim is pervasive and constantly transmitted, especially to females through mass media. However, among Aboriginal youth there appears to be an added "prevailing sense of hopelessness" (ibid).

Of the studies done with Native American girls, it was found that "eating disturbances and unhealthy weight loss practices are common and that they "scored higher on disturbed eating behaviors and attitudes than white or Hispanic adolescents" (Story et al. 1997:2). These studies have also shown that there is a high rate of dieting (48 percent) and bulimia-like symptoms (38 percent) among this group (Story et al. 1997; Sherwood et al. 2000).

"It is well documented that Native Americans have a high prevalence of obesity in all age groups and among both sexes" (Story et al. 1997:8), and studies have shown that children, preadolescents, adolescents, and women are at risk for developing eating disorders (Story et al. 1997, Story et al. 2001). Among overweight children, exercise was the most common method of weight control; however, a high percentage of youth who considered themselves obese "reported that they had gone for a day without eating to lose weight. Extreme weight control practices such as fasting are inappropriate at any age and are especially undesirable in children" (Story et al. 2001:361).

Among women participants, "the vast majority (90.1%) of respondents had never participated in an organized weight-loss program. However, of the participants who believed they needed to lose weight (70.9%), 72% said they would like to join a weight-loss program if one were offered in their community" (Story et al. 2001:361). Deterrents to participating in these types of programs are unequal access, lack of child care, and high cost of entry (Sherwood et al. 2000:446).

According to Story et al (2001), "little is known regarding attitudes about weight among American Indians" (361). Studies have suggested that Aboriginal people are more tolerant of larger sized bodies, especially older adults, who "may believe that moderate overweight is normal and healthy" (ibid). Researchers have called for studies that focus "on factors associated with obesity" among Aboriginals in order to understand "how obesity is perceived and its potential impact on psychosocial concerns and weight control behaviors among this population" (Neumark-Sztainer et al. 1997:598). They perceive that such research "may have relevance for other populations who have experienced large lifestyle changes over relatively short time" (ibid:598).

The following is an interview I conducted with an Aboriginal female, who related to me that she had an ED. This interview along with the above noted literature research illustrates that there is a need to 'rethink' the stereotype.

Interview with Aboriginal Female with ED

Contrary to opinion of the two Aboriginal AMHT professionals that I interviewed and a study conducted by Rosen et al (1988), ED does exist within the Aboriginal population, to what extent has yet to be determined. The Rosen et al. study, which included a sample of 85 Chippewa women and girls from the ages of 12 to 55 years, concluded that

potentially hazardous weight-control techniques such as purging, diet pills and prolonged fasting were "not restricted to Caucasian American and Western European women" (811), but were also prevalent among Native American women. The following is an interview with an Aboriginal female who identified herself as having had an ED and was willing to share her experience. Here is Diane's story:

Diane is female, age 31 years, married with 2 children, identifies herself as Native, lives in Rivertown, and is currently employed. She considers herself overweight because there is always eating involved at work – at meetings, workshops, and staff birthdays.

Diane's initial response to my lead-in question about food memories was: "hospitality, holidays. Mom always had food and snacks – cheese, meat, crackers." She said that her childhood years were spent mostly in the city of Rivertown. Diane recalled that she always had breakfast before school, came home for lunch, and then had a big meal for supper. She commented that her step-father made a lot of the meals, which included salad, juice, milk, and vegetables.

At the age of 14 years, Diane became bulimic, but she does not know what 'sparked' it, as she was not too thin or too fat. She related that the behaviors started slowly; she thinks maybe she saw a movie about it, which escalated the behaviors. It got to the point where Diane's mother didn't want Diane to have supper because she was afraid Diane was going to vomit it up. Her parents saw what she was doing – she would load up her plate, go to the bathroom, have dessert, go to the bathroom. Diane said that she just used vomiting, not laxatives or pills.

Diane said that she was married very young (15 years of age), and went to live on the reserve. When she found out that she was pregnant, Diane was able to stop her bulimic

behaviors, but after the baby was born she started the behaviors again to lose the baby fat, remarking that she "lost it fast." Not long after, Diane said that she started having trouble in her marriage; she became depressed, sometimes not eating for three or four days, always making excuses for this behavior. She added that she "wouldn't even eat at restaurants." When Diane did eat, she remembered that she ate a lot, but ended up vomiting.

Diane felt that "not eating helped the depression." She said that she had low self-esteem, and that her marital relationship was falling apart; she felt that if she looked better (in appearance) it would help. Diane then found out that she was pregnant again (she weighed only 100 pounds), so again she had to wean herself off of bulimic habits because she had to feed her baby. After the baby was born, Diane resumed her bulimic behavior. She stated that she got to the point where she didn't have to force herself to vomit, her body just did it, so her husband found out (he did not know about her bulimia until then). Diane admitted that she was not aware of the danger that she had put herself in; and commented that "after two kids I was a size 4."

It was at this point that Diane's doctor sent her to counseling (a psychiatrist) on the reserve, as she was always crying. A cousin expressed concern for Diane's health because she had seen a movie about an ED person who had died at the age of 16-17. Diane became so depressed that she began writing her own obituary and "letters of good-bye to my children." She said that she had thoughts of suicide (Diane later confided that she made several suicide attempts and that "they didn't work out"). Both her doctor and psychiatrist wanted to hospitalize her, but she didn't want this. She remembered thinking "people would think I was crazy, an unfit mother, and take my kids away."

Diane said that she separated from her husband at age 24, started gaining weight, and by age 26 was feeling like the bulimic behaviors were under control. When she got to 115 pounds, the thoughts of being overweight returned and she started to want to lose weight again. However, she said that within the year she started to regain control over her eating behaviors.

Since then, Diane said that she has gained a lot of weight; when she goes to the mall, and when she sees magazines and television programs that depict thin women, she finds them ugly. But she also feels that now she is "too big, not huge, but I know that I am overweight and want to lose it in a healthy way." She added that "weight depends on how and what you eat;" that "weight was never the issue" (size was the issue). Diane concluded that she perceived bulimia as a way to keep her husband as she thought she didn't look good, but in the end it didn't make any difference; he was mentally and physically abusive.

So far Diane said that she has not experienced any health repercussions from her ED behavior; she just went back to eating the things she liked. She remembered that her goal as a child was to play volleyball for Canada; volleyball was her game, and she would like to get back to it. She also finds that family and friends lean on her for emotional support, which has led her to an interest in pursuing a psychology/psychiatry career.

Diane stated that she has good family relations and a good network of friends; speculating that perhaps this was because she was a middle child. She feels that she is nothing like her two sisters, they were more alike/similar, and preppie. In fact, she said that at one point in her adolescent years that she began to feel like she was adopted because she was so different as compared to her sisters. For example, she liked heavy

metal music, leather, lace spandex, boots, and black (in contrast to preppie). Diane commented that her sisters are a healthy size, not thin, and look healthy. She added, "Mom always baked cakes and pies; there was no shortage of food."

As we drew near the end of our conversation, Diane returned to her childhood memories. She reminisced that her parents separated when she was 5 years old; her father stayed on the reserve and her mother moved to Rivertown, which is where she grew up. She said that her parents did not pass down their culture and that she would like to regain her culture; she knows the traditional language now, but only speaks it when older relatives are around. Diane said that she misses her grandmother and great-grandmother on her Dad's side. They would tell her stories about the old days, about Napi (part of Aboriginal cultural). She is not close to grandparents on her mother's side. To Diane traditional foods include fried bread, bannock, and fried potatoes.

As far as EDs among Aboriginal people, Diane said that she has not heard of much, "mostly other races." She felt that keeping a diary helped her to deal with personal issues, a habit that she still continues.

This interview revealed that during early childhood socialization, food and eating were established as social acts. As Diane reached adolescence, the cultural proposition that food and eating are individual acts conflicted with these early meanings surrounding food, the result being an eating disorder. Food and eating behaviors are about social relations, and in Diane's case she used these behaviors manipulate relationships within the family, among peers, and in her marital relationship. For example, ED was used to gain relationships during adolescence, as evident in her marriage at a young age. However, ED also symbolized Diane's insecurity regarding her position in the family as

she felt she was adopted. Relationships with her children were complex as the initial bond of mother protecting children when they were young (i.e. she did not want them taken from her because of ED) was reversed as the children matured. As a single-parent family the children as they matured also protected Diane.

The end of the interview revealed underlying issues of identity as Diane connected the notion of traditional foods and memories of past times as conveyed thru oral tradition with Aboriginal culture. She has been successful in recovering from the ED because of social relationships, especially with her children, and a reconnection with her Aboriginal identity. The narrative also illustrates the discourse of post colonialism, and thus inequality for Aboriginals in the healthcare system in that Diane did not access the mainstream professionals but was treated by a professional on the reserve. As well, she expressed the fear that her children would be taken away. This consequence of being diagnosed with an ED was not expressed by any individuals I encountered from the mainstream sample. The reversal of the internalization of the cultural proposition is evident in that whereas her thinness as an adolescent and adult expressed conformity to Canadian capitalist ideals, her current state expressed as overweight is symbolic of resistance to the proposition as well as a reconnection with Aboriginal values.

Diane's experience with ED reflects that Aboriginal females present the same way, and are affected by and react to the disconnectedness of social relationships in the same way as the stereotype does – EDs are not bound by ethnicity. Although my research only identified one individual, it concurs with the Rosen et al. study that ED is not restricted to Euro-Canadians and that the research done in this area is limited.

The interview with Diane, as well as with others in this thesis, reiterates that all peoples have food histories, regardless of gender and ethnicity. Food is essential for human life but it also creates relationships through exchanges, positive or negative, in the past, present or future. Food structures society and creates inequalities. Does this phenomenon hold across cultures? To answer this question I will look at the cross-cultural examples of Java and Fiji.

Cross-cultural Comparisons

The cultural meaning of food and eating behaviors as they relate to identity are not static and vary across cultures. Health is not always perceived as the responsibility of the individual. Next I will examine two other cultures, Java and Fiji respectively, as to their perceptions of food, eating and diet-related disorders.

As has documented in other colonized states such as Canada, among the indigenous people, Java has a high incidence of type 2 diabetes, and biomedicine has become the primary health system. Javanese physicians "while not referring to diabetes as a 'western disease' or a disease of 'western lifestyle,' are nevertheless commenting on ... *makmur* (prosperity)" (Ferzacca 2001:93). The Javanese have lived through times of hardship and famine, such as the Japanese occupation of the 1940s, but through the process of globalization and modernity food has become relatively abundant. Much of the socialization and enculturation process within the Javanese culture involves the meaning of food as it relates to the Javanese self.

Makmur defines not only prosperity in terms of improved "economic conditions marked by increased caloric intake and improved nutrition," but also in terms of the "kinds of foods present, especially rice" (Ferzacca 2001:94). The state of *makmur* also

parallels the increased incidents of type 2 diabetes among the Javanese population, and according to physicians and mass media, those diagnosed with diabetes "should limit their consumption of *nasi* (rice)" (ibid). Rice is important not only for its nutritional value, but socially it is symbolic of the Javanese self and identity.[xxi] The *rasa* or taste of rice serves to mediate food and identity, and also serves as a link to their cultural values and beliefs.

In line with western treatment of diabetes, 'order' is needed in the patient's eating habits to regain a healthy life. This eating regimen in itself is problematic as "for the majority of Indonesians and Javanese... many eat when hungry, at all hours of day and night...many...did not have the resources to eat three meals a day, but would if they could" (Ferzacca 2001:133). This 'disordered eating' led to much confusion – "patients were told they were fat, but ... were asked to eat in a way they felt that could only lead to increased body weight, or *obesitas*" (ibid), a disordered body in Javanese terms.

The diagnosis of a western disease has led to a total revision of body types perceived by the Javanese. The ideal body type is the *gemuk* body, which is a balanced 'plumpness,' neither too thin nor too fat. This body type symbolizes the mature adult both physically and socially, and is a marker of one's social success; for such an individual to be diagnosed with or thought to have a western disease is to become *obesitas*. Therefore "under the scrutiny that diagnoses western disease, the *gemuk* body is rewritten in the terms of *obesitas*" (Ferzacca 2001:135). "What was once the symbol of Javanese prosperity and wealth based on orderly and cooperative behavior in the context of social hierarchy" (ibid:136) has now become 'disordered eating' in the context

of Javanese norms of consumption and body size. The label of '*obesitas*' is not to be Javanese, thus the loss of sense of identity.

Ordered eating is culturally defined; disorder can ensue when one culture imposes its values on another, a process called acculturation. As cultural changes occur, the conflict between value systems becomes normalized; thus, influencing the socialization and enculturation processes. In effect, disordered eating is socially and culturally produced and reproduced.

Fiji

According to Becker (1995) core cultural values are expressed through the body. The thin body is the epitome of capitalist values – disciplined, hard-working, self-motivated, and energetic; the obese body becomes the deviant model - undisciplined, lazy, no ambition, and slovenly. With the perpetuation of this ideal, there is an increasing gap between actual body size and what the individual perceives it should be (mind/body dualism). The rise of 'dieting' reinforces the idea by telling us that the body is something that needs to be worked on; that we must fight against hunger, thus objectifying the body. Capitalist discourse describes the body as something to escape from yet at the same time worked on, performed or structured to conform to societal norms and symbols (Becker 1995:33).

Different from capitalist core values, Fijian core values are based on community and are kinship related – work ethic but for others, sharing with and caring for others, survival of the community, and respect for others. In Fiji, people are not agents of their own body as the cultural emphasis is on community identity rather than your own; the body is a reflection of how well you are taken care of as well as how well you take care

of others. Food, and the sharing of food, symbolize the solidarity of the community, create and maintain social relationships, and organize the economic structure of the village (Becker 1995:66). Not that these values do not exist in Canadian culture, but they are just not as strong.

Fijians are just as obsessed with body size, food and eating as are Canadians, but in relation to others, not the self. They have no desire to control their consumption but carefully monitor the appetite of those charged to their care (especially children and the elderly). While the form most aesthetically pleasing is one similar to that of Canada (slim), those outside the norm are not stereotyped or medicalized. Disordered eating in Fiji is called *macake*, which is an appetite disturbance manifested in the loss of appetite or the desire for sweets; unlike AN, it is not deliberate. *Macake* is a symptom of the risk of ill-health, rather than a disease, which is restored through appetite (Becker 1995:81). Care is written on the body. For example, a body that is properly cared for will be normal to overweight, and healthy; one that is improperly cared for will be underweight and sickly. A healthy body is also fertile and productive, reproducing descendents (ibid:101).

Self-identity is actualized by how well the individual conforms to and performs the social protocol of care; thus we can see that in Fiji that the body is a reflection of the collective. The self is connected to the body as in Canadian culture, but the individual does not have sole agency (Becker 1995:129). Thus, it is evident that 'disordered eating' exists in Fiji, but within the context of its culture. If the body is symbolic of social relations, then food and eating are likewise. Food and eating are not independent acts but socially dependent.

Conclusions

Stice (2002) stated that EDs, generally speaking, are the result of social reinforcement, "the process whereby people internalize attitudes and exhibit behaviors approved of by others" (103). Stice uses the term 'modeling' rather than the processes of socialization and enculturation to explain the reproduction of the thin body ideal, especially for women, which is reinforced by peer pressure, the family, and the media. For example, if an individual sees a peer using laxatives for weight control, they do the same; if they observe others engaging in disordered eating behaviors, such as a parent dieting they perceive it as acceptable. As seen in the media, body dimensions of female models, actresses and other icons are becoming smaller – "one quarter of models in some magazines satisfy the weight criteria for AN" and there is "greater emphasis on dieting and weight management in media targeting females" (ibid:104). It has also been hypothesized that individuals learn ED behaviors from the media through documentaries, biographies, autobiographies, and self-help gurus (ibid).

Devereux's ethnic disorder theory,[xxii] adds a cross-cultural perspective to Stice's generality regarding EDs. Devereux stated that whether eighteenth or twentieth century, relativism was important and that "certain disorders become a core expression of the stresses and tensions of a particular culture or historical period" (Gordon 2000:6). Disorders of nutrition occur frequently in Canadian culture and in a wide spectrum of intensity from under-or improper eating as in the cases of low SES and AN, to dieting, to over-alimentation and obesity as in the cases of BN, BED and type 2 diabetes. This continuum of disordered eating ranges from satisfying particular cultural norms, to borderline non-conformity, to deviance, to medicalization.

In Java, type 2 diabetes is very prevalent causing great anxiety and expressed in terms of the body, from the *gemuk* body to the disordered body that is *obesitas*. For Fijians, caring for the bodies of loved ones is of prime cultural importance; a body that is improperly nourished, or disordered causes anxiety. Whether expressed as *obesitas*, *macake*, homelessness, dieting, type 2 diabetes, or EDs, nutritional disorders express core conflicts pervasive within the culture.

Disorders of nutrition draw on cultural values, but at the same time express deviance. Capitalist values of consumption and thinness evoke dieting, AN and BN behaviors, and obesity (leading to type 2 diabetes). Dieting is rewarded to some extent for the individual's adherence to the values of self-discipline, self-motivation, and hard work but it is criticized and labeled if this behavior becomes extreme, such as in AN and BN. Obesity and type 2 diabetes, while conforming to consumption, have negative stigmas attached to them, which allude to laziness, lack of discipline, and slovenliness.

Disordered eating as a coping mechanism for cultural norms is frequent within Canadian culture and is often classified as a psychiatric disorder. As a coping mechanism, disordered eating can be manifest in a wide spectrum of conditions. Some individuals eat to cope with feelings of stress, unhappiness, depression, and boredom; this behavior can be problematic if it results in an ED, obesity, heart disease or type 2 diabetes. On the other hand, some individuals cannot eat in the aforementioned situations; this too can be problematic, especially if it results in AN. In Fiji, *macake* is a coping mechanism for feelings of being unattached to one's social network; when symptoms arise, it is a call for the attention of caretakers, much like ED.

Coping mechanisms express core conflicts and psychological tensions that are pervasive within the culture. Over- and under-alimentation conflict with Canadian cultural values of self-discipline, which can cause the individual anxiety and lead to psychological illnesses such as ED. In Fiji, a body that expresses lack of care is of great concern both to the caregiver and the community at large, but ultimately it is the caregiver that is most affected. The state of *macake* in Fiji like EDs in Canada are expressions of social disconnectedness; thus, reinforcing that disordered eating is not an independent act.

EDs, while highly stigmatized as psychological disorders, have also been a source of awe and respect. These disorders have gained notoriety in the media as celebrities come forward as being affected. As well, many affected females have written autobiographies in the form of self-help books, and many television documentaries have been produced highlighting these disorders. While the intent is to demystify the disorder, it can do the reverse by reinforcing or even reproducing it because someone famous has the disorder – ED becomes a template of deviant eating behaviors. In Java, *obesitas* is a template of modernization, which causes anxiety because while it is valued, it also threatens national identity.

These same criteria can be applied to the Aboriginals of North America, as an acculturated population. Aboriginal people have been stereotyped as being highly affected by alcoholism, depression, obesity, and type 2 diabetes, which can be considered as both nutritional disorders and coping mechanisms. According to research, these disorders are disproportionately represented within this sub-culture as compared to their presence in the dominant culture.

Disordered eating among Aboriginals expresses core conflicts and psychological tensions that are pervasive within the culture. Sutton (2001) stated that "the ability of foods to produce memories is intimately tied to the possibility of reproduction of social identities (in the collective)" (61). As related to Aboriginals, a buffalo economy was replaced by a grain economy; buffalo meat has been replaced by "new traditional foods" such as fry bread, bannock, pan bread, and fried potatoes. More recently, highly processed foods have been incorporated as staples of the Aboriginal diet (as per interviews in my research). The standardization of food and the implementation of a health regime (e.g the CFG) "strips people of food's sensory experience ... not consuming and exchanging locally produced food ... foods imported from other countries ... takes away cultural identity ... the ability to replicate cultural practices which are embedded in reciprocity, aestheticism and the sensory strata of material objects" (Sutton 2001:61). This has been experienced by Aboriginal people through the loss of the buffalo, which was more than a change in diet; it was a change in their society which was structured around community interdependence. Particular foods such as the buffalo were symbolic of a way of life that was produced and reproduced through the hunt and memories of past hunts – the planning, enactment, rituals, gendered duties, exchange, and social relationships. The acculturation process has caused severe anxiety and the onset of psychological defenses among Aboriginal people.

As stated above, disordered eating is expressed in a variety of ways but they are also stereotyped or considered the normal forms of problematic behaviors among Aboriginal people, and range from mild to severe. These disorders are "direct extensions and exaggerations of normal behaviors and attitudes within the culture, often including

behaviors that are highly valued" (Gordon 2000:8). The ability to consume, which includes both food and alcohol, is highly valued in capitalist cultures; however, the extremes are stigmatized. That these disorders have been stereotyped as "Aboriginal disorders," has created a politics of its own. As with the example of Joe, the status of "Indian Cowboy" is a highly valued status; however, according to Joe the ability to drink large quantities of alcohol is part of the status. The consumption of alcohol, which is also disordered eating, then, becomes a template of deviant eating behaviors.

The data presented in Chapters 3, 4, and 5 caused me to 'rethink' disordered eating in the following chapter using Melford E. Spiro's (1997) Psychological Preadaptation Theory. The final chapter will also summarize the ways in which food, power, and identity are enmeshed and embedded within culture.

Chapter 6: Rethinking Disordered Eating

This chapter will summarize the ways in which food, power and identity are enmeshed and embedded in culture and are mutually constitutive. Because the discourse surrounding these issues is culturally produced and reproduced, Spiro's (1997) theories of preadaptation and the internalization of cultural propositions are helpful in further deconstructing and understanding disordered eating in Canadian culture.

Spiro's Theory

According to Spiro (1997), any theory about culture must include a theory of the mind. He theorized that cultural ideologies "are reproduced by being transmitted from enculturated actors (usually adults) to cultural novices (usually children and subadults)" (3). This is a process that is both social (between actors, and external), and psychological (within the actors, and internal). If cultural systems affect practice only when internalized, then it is important to consider not only the cultural symbols, but also the mind of the social actors (Spiro 1997).

In order for a cultural proposition (a traditional idea, norm or value that is held to be right and true) to become culturally constituted or internalized, "it must first be acquired" (Spiro 1997:8). There are four levels of acquisition: 1) the novice is acquainted with the proposition but may be indifferent to or reject it; 2) the proposition is acquired as a cliché, the novice agrees with it but only through lip service. This may function to promote solidarity or it could be spurious; 3) the proposition is acquired and internalized as right and true; 4) the proposition is acquired and internalized as right and true, plus has a strong emotional attachment to it, to the extent that they would resort to personal sacrifice (ibid:8,9).

Spiro's psychological preadaptation theory stresses the importance of childhood experience for cultural internalization to occur (1997:72). It is through both conscious and unconscious desires and beliefs that the novice is motivated into action. He did not believe that humans begin as 'empty slates' per Locke, but rather as active agents with needs, desires and beliefs; what he called "precultural." He argued that a cultural system can be transmitted and reproduced as a cliché, but in order for it to be reproduced as a cognitive salient belief it must also be internalized (ibid:177).

There is usually more than one cultural system in operation within a culture, which run parallel to each other causing disordered behavior depending on the level of acquisition and internalization. This disordered behavior, if reproduced as a cliché or a cognitive salient belief may be socialized and enculturated. For example, in Canadian culture the cultural propositions of consumption (capitalism), which include the thin body ideal, and gender roles have caused much conflict and confusion regarding self-identity. What does this tell us about the level of their acquisition?

Using Spiro's theory I will further deconstruct disordered eating in Canadian culture. Let us first look at the process (acquisition) whereby traditions, norms and values (cultural propositions) become culturally constituted or internalized. The preadaptation level of early childhood or the beginning of the socialization process, usually within the family milieu, focuses on food and the development of social relations; there is a definite connection between the two. At the first level of acquisition, after the preadaptation stage, the novice is acquainted with the proposition but may be indifferent to or reject it. The cultural proposition in this case is that food consumption is an independent individual act. This proposition of individualism is transmitted to cultural novices from

enculturated actors, to some extent through the family as the child matures, but especially through the education system; however, this proposition is contrary to what was learned in the preadaptation stage. If the proposition is rejected, and food as a social act learned in the preadaptation stage is retained, it can lead to disordered eating such as BED, obesity, and type 2 diabetes. If it is acquired as indifferent, the novice accommodates both ideologies, thus has ordered eating behaviors.

At the second level of acquisition, the cultural proposition is acquired as a cliché and the novice agrees with it, but only through lip service. This may function to promote solidarity or it could be spurious. As a cliché, the novice may reject food choices in order to identify themselves as belonging particular groups, which may be different according to gender, age, ethnicity, or class. It is at this level that food consumption can become problematic; we see yoyo dieting and the risk of bulimia as the novice controls the consumption of food to meet the criteria of the proposition, but also consumes to create or maintain social relationships.

From interviews I conducted, those individuals with type 2 diabetes and alcoholism have acquired the cultural proposition as merely a cliché. For example, Joe, as an alcoholic, has internalized the proposition in so far as he tries to take responsibility for his behaviors by going to detox and AA, but he also values familial and peer relations. Joe's disordered eating behaviors are an example of the conflict of individualism versus sociality. He is torn between his family and his status of 'Indian cowboy;' the social consumption of alcohol being a symbol of solidarity among a particular group of Aboriginal males. Another example is Carolyn who restricted food in order to belong to a peer group, but at the same time had to consume alcohol to create social relations

within this group. She sacrificed food for alcohol, which became disordered eating. When Carolyn considers herself overweight she is agreeing with the proposition but not practicing it, again disordered eating. Gordon is another example of the proposition acquired as a cliché as he accepted it by being aware that his weight was problematic, but in reality the use of food (including alcohol) to create social relations (especially in his occupation) was more important. The conflict between individual and social resulted in Gordon being overweight and alcoholic; hence, disordered eating.

In the case of type 2 diabetes, Jennifer's story revealed that she has internalized the proposition as a cliché. Her attempt at dieting first to lose weight and second to control diabetes showed acceptance of the proposition and that food consumption is an individual act, but it is in conflict with food consumption as a social act that maintained social relationships in her life such as daughter, wife and mother. This conflict has resulted in her being overweight, diagnosed with type 2 diabetes, and bulimia, or having disordered eating.

Those individuals with BN are undecided and confused as to the internalized of this proposition; several behavioral patterns emerge. On the one hand they reject it and use food to develop social relationships, but on the other hand they internalize it by taking the responsibility of getting rid of the food consumed. Or, they may appear to internalize the proposition by not eating; then gorge themselves with food in private. Thus there is a conflict between food as a social act and food as individual act. Individuals at this level of internalization may become overweight and at risk for type 2 diabetes.

Chelsey acquired the proposition initially as indifference, then rejected it to create social relations (with husband), and now has acquired it as a cliché in that she admits that

she is trying to lose weight by controlling food consumption. This example shows that interpretation of cultural propositions is not static, but can change according to life experience and subject positions.

The third level of acquisition suggests that the proposition is acquired and internalized as right and true. Individuals affected with AN have internalized that food consumption is an individual rather than social act and pride themselves in being the perfect model of the cultural proposition. Anorexics withdraw from social relationships of all kinds: family, peers, and friends; they lead a secret life. For example, one DESG who is married said that this relationship is 'rocky;' by not participating in the household grocery shopping, the cooking of meals or eating with her spouse, the social relationship of husband-wife is ruptured. Although this person rejects food, in her imagination she is using food to create social relations; a relationship of dependence on parents (and husband) that she remembers from childhood. This desired relationship is revealed through comments like "only those who are small are looked after (like a child)."

At the fourth level of acquisition, the proposition is acquired and internalized as right and true, plus has a strong emotional attachment to it to the extent that the individual would resort to personal sacrifice. Most of the general population does not internalize to this level; however, those who have had anorexia for an extended period of time (past adolescence) have internalized the cultural proposition ideology to the extent of self-destruction. For example, some of the women in DESG have had an ED for as long as twenty-five years, to the extent that it is personified, therefore, long-term EDs are internalized with an emotional attachment. Ironically, AN at this level of acquisition is

the ideal of the cultural proposition, but at the same time this achievement ultimately leads to the destruction of the self.

Spiro's theory further states that a proposition can be transferred to and reproduced by a cultural novice as a cliché, but in order for it to be reproduced as a cognitive salient belief it must also be internalized. Therefore, food and eating behaviors, whether ordered or disordered, can be transferred to and reproduced by a cultural novice as a cliché, but they can also be internalized and reproduced as cognitive salient beliefs.

Thus far I have used Spiro's theory at the micro or individual level; however, it can also be applied at the macro or broader level. Culture also acquires cultural propositions at these four levels; when internalized, the worldview of the culture is shaped around this proposition. For example, capitalism and the thin body ideal are the cultural metaphors of individualism. Cultural institutions such as biomedicine, nutritional science, and food welfare have internalized the cultural proposition that food consumption is an individual act. The professionals I interviewed in these institutions reflected this acceptance and internalization of the proposition; however, Spiro's theory reveals that this discourse produces both ordered and disordered eating.

According to Spiro, there are many cultural systems operating at the same time; these often overlap and can cause conflict. For example, in Canadian culture the cultural proposition that food is an individual act (capitalism and the thin body ideal) versus food as a social act has caused much conflict and confusion regarding issues of power and identity. However, the family (for the most part) has only acquired the proposition as a cliché. From early childhood experiences within the family milieu we are socialized that food develops social relations, and likewise know the importance of cooperation and

sharing in the production and reproduction of social relations. At the cultural level disordered behavior, like ordered behavior, can be reproduced as a cliché or a cognitive salient belief that may be socialized and enculturated. Are we in Canadian culture socializing and enculturating disordered eating?

Conclusions

As revealed in this research, food and eating are tools with which to structure society and food consumption has its roots in culturally defined social roles. Consumption activities and tastes are produced and reproduced, are not static, and vary across families, societies and cultures as food classifications, eating practices and taboos change; through exchange they negotiate relationships and shape identity within society politically, economically and socially. These exchanges create social structure through power relations that produce and reproduce inequalities both between and within groups (e.g. class and gender), and consequently subject positions.

Historically, eating customs and taboos dictated when and where (private or public) and with whom food could be eaten; eating disorders have been stereotyped as white, female, upper SES, and adolescent disorders for centuries; associated with women's issues of subjectivity, or the totality of their awareness of the self and the person in a variety of subject positions. As Renato Rosaldo (1989) stated:

> Cultures and their "positioned subjects" are laced with power, and power in turn is shaped by cultural forms. Like form and feeling, culture and power are inextricably intertwined. In discussing forms of social knowledge, both of analysts and of human actors, one must consider their social positions (169).

The primary role and source of power for women has been through their association with food. Consequently, food has been used as a tool by women to create, maintain, or alienate relationships within the family and the greater society as related to their subject

position in these institutions. However, disordered eating is the result of a multitude of strategies used by individuals to cope with and adapt to cultural propositions; it affects both men and women, white and Aboriginal, as well as all age groups.

This diversity of experience is especially evident in Chapter 4, which also revealed that although the professional interviewed evoked the "acculturation" model as the etiology of aboriginal diabetes, in actuality the acculturation story of the River People (and other Canadian Aboriginals) is much less progressive, linear, or predictable. The lived stories of Aboriginal people whether on the reserve or in the city of Rivertown evoked the rupture of a culture, which has resulted in shattered lives, and a fragmented existence. The interviews I conducted reveal the effects of colonial and post-colonial discourse in terms of social relations of which food and eating are a part of, as is the main argument of this thesis. However; this phenomenon must be placed in a particular cultural logic and in a particular cultural moment. At this historical moment in Canadian culture the cultural proposition is that food is an individual act rather than a social one, to which cultural members must adapted.

Humans are innately social beings; food as a tool to mediate social relationships has been used at all times and by all people. We are socialized from birth that food is about social relations, whether these relations are positive or negative. Problems with food appear especially at adolescence because we change the teaching from food as a social act to food as an independent or the individual act; this is a contradiction of values. Food is a language that expresses meaning - irregardless of the dominant discourse. DE rises as a voice to express this dysfunction through the language of food. When life experiences are perceived as 'out of control,' unmanageable,' or 'out of balance' we

revert back to the social teachings of our childhood and seek to change this dysfunction through food because we were taught that food creates social relations. Whether we eat too much or not enough, we are seeking to create relationships. Whether the relationships are memories, current ones, or ones we hope to have in the future, they are voiced through food.

As the discourse of capitalist individualism increasingly invades the lives of humans through the media, industry, and biomedicine it ruptures social relations; therefore, we see DE in many forms as illustrated in this thesis. The more this discourse tries to cure this problem through their own means (reinforcing individualism) the greater the problem. Humans will sacrifice nutrition and even life itself for social relationships, for without social relationships humans cannot thrive.

This change in discourse is difficult for many as we see the rise in disordered eating across the general population; however, it is especially traumatic in the case of Aboriginal people as they have experienced not only a relatively recent change in diet but also a rupture in the social fabric of their lives. Consequently their society is fragmented rather than cohesive leaving the individual to create their own reality, which is not always positive as evidenced by the high rate of disordered eating behaviors. Emphasizing hybridity in the health system, such as the modifications by the AHT of the CFG, for the most part does not alter, or is perhaps at the expense of, the material reality of the Aboriginal people. The discourse of biomedicine and nutritional science is one of individualism which conflicts with the importance of social relations in Aboriginal society (and mainstream society, but to a lesser degree).

The documentation of eating behaviors across cultures helps us to deconstruct and demystify these disorders within our own culture. We see from the examples of Java and Fiji that this proposition of individualism is not universal. Disordered eating is an affect of adaptation for all cultural groups, as all humans have food histories. Therefore, anthropologically speaking, disordered eating is an expression of exchange and social identity within a particular culture, which is experienced and manipulated through the consumption of food. Disordered eating is not bound, as commonly accepted, to individual psycho-pathology only, but is affected and shaped by social determinants and cultural norms, some of which are specific to difference by age, gender, class, or ethnicity, while others operate in society at large. The stories of the individuals depicted in this research project were stimulated by their memories of food, but evoked other issues and relationships in their lives. Whether manifested physically or psychologically, disordered eating is about relationships (past, present, and future); therefore, it is a reflection of the social rather than the individual. It is this social aspect of food and eating that is ignored by biomedicine and nutritional science.

Through the lived experiences of the individuals we see that their emotions, cognitions, perceptions and motivations surrounding their eating behaviors are enmeshed and embedded within cultural value systems that have been created through discourse, or 'power-knowledge.' Therefore, it is through discourse, such as the critical approach of medical anthropology, that the lived experience can be changed.[xxiii] Whether through socialization, enculturation, or acculturation food is a powerful tool. Food is more than just a means of sustenance; it is a major component in the structuring of society. Food,

power and identity are mutually constitutive, intertwined in cultural propositions, and inseparable.

Endnotes

[i] Also see Miriam Kahn (1986), Edward L. Schieffelin (1976), and William Shack (1997).

[ii] See Mead, Levi-Strauss, Barthes, and Douglas (1997).

[iii] See A. Kleinman (1980) *Patients and Healers in the Context of Culture* for an in-depth exploration of the Explanatory Model.

[iv] Baer, Singer and Susser (1997) Internationally, "the World Bank is a key player in the establishment of health policies and the making of financial loans to health care endeavors" (29) emphasizing capitalist solutions. Other key players are the World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF). It is also to be acknowledged that in the developing countries, biomedicine is part of the colonial inheritance, wherein the elite collaborate with and promote biomedicine's curative rather than preventative doctrines. Large corporations, including pharmaceutical companies, hospital construction and supply companies, and technology companies are very influential in developing countries, often trading employment opportunities for political favors.

[v] For an in-depth review of the history of sugar see Sidney Mintz (1986).

[vi] Also see further discussion in Grosz (1990).

[vii] For a more in-depth history of biomedicine see M. Foucault (1975) *The Birth of the Clinic.*

[viii] Baer et al (1997), Chapter 4, gives a good summary of the creation of discourse about the 'homeless.'

[ix] Baer et al. (1997) outline the historical political and economic events that underlie sickness and disease among the homeless at particular times and within particular cultures.

[x] Also see Arline Mathieu's (1993) and Kim Hopper's (1988) research among the homeless in New York city.

[xi] Also see Robert Desjarlais' (1994) research in a Massachusetts shelter.

[xii] For an in-depth review of the history of sugar see Sidney Mintz (1986) *Sweetness and Power: the Place of Sugar in Modern History.*

[xiii] The literature review by Eberle et al. (2001:16-19) indicated that: "homeless people are less likely than the general population to have a regular family doctor." As a result of this reality, the norm of access to health care is the hospital emergency room, which are "generally open 24 hours a day, seven days a week, and no appointment is required." Despite the fact that drop-in medical clinics are available for emergency concerns, emergency rooms remain the primary source of routine care for the homeless.

Several barriers to the health care system were noted by doctors including: the inability to locate patients regarding test results, thus the inability to provide treatment; the lack of health-insurance documents deters doctors from providing care and requesting special tests as there can be no monetary compensation for their time; the concerns that homeless patients will cause a disrupt in waiting rooms; the unequal access to treatment; the lack of financial resources and permanent shelter makes it difficult for homeless people to follow treatment advice. For example, "filling prescriptions, following special diets, and storing medication at the recommended temperature."

Several studies of the homeless in both the U.S. and Canada, reported that homeless persons generally seek medical attention only when their symptoms can no longer be ignored. Also, hospitalization is relative to the socioeconomic status (SES) of the individual, for example, low-income individuals have a higher rate of hospital admissions than those with middle-income; middle-income individuals have a higher rate of admissions than do those with a high-income. Therefore, the cost to social health care systems is higher for homeless than any other. As well, the lower SES patients lean more towards being chronically ill, which requires more healthcare system resources than other patients.

[xiv] Another participant in this research, Jennifer, is white, in her early 30s, married to an Aboriginal, has four children, works part-time from home, and considers herself to be of low socioeconomic status. She also perceives herself as overweight, bulimic, and addicted to food. Jennifer has tried every diet, and is at a point of desperation. She has been diagnosed by medical professionals as having type 2 diabetes.

Her immediate response to my lead-in question was: She (Mom) put us on all sorts of diets. I remember this one – it was some sort of liquid diet where you cooked vegetables and then blended them up in the water you cooked it in so you don't lose the minerals and you'd have to drink this stuff.

Jennifer's mother was diagnosed with juvenile diabetes at the age of eleven years, but always had trouble conforming to a diet that would control her condition. This problem carried over into her adult years, and Jennifer remembers her mother having stashes of chocolate bars and other junk food around the house, which Jennifer would find and sneak to eat later in private. Jennifer now finds that this same pattern is repeating with her children – she keeps stashes of chocolate bars and her children find them and secretly eat them. Jennifer's bedroom when she was a child was in the basement, close to the freezer where her mother kept homemade ice cream, which is Jennifer's weakness or 'trigger food'. She would take the ice cream into her room and secretly eat it. One specific incident that really made this duplication process hit home for Jennifer was when she caught her 4 year old daughter eating ice cream that she had taken from the freezer and hidden in the drawer under the stove.

Jennifer reflected that she was always bigger than a lot of the other girls in school but it was in junior high that she realized that she was chubbier and more overweight than the other kids in school. It was during the first teen years that her mother inflicted all sorts of unusual diets on the family. Jennifer recalled going to a friend's house, being on a diet and knowing that she was not supposed to eat certain foods. When she was offered chocolate cake she was so happy to get something 'forbidden' to eat. Other girls that she walked to school with always stopped at a particular store to buy chocolate bars and other treats, but she did not get an allowance. To participate in this peer activity, Jennifer admitted that during high school she would take the change out her father's pockets to buy junk food at the convenience store on the way to school in order to 'belong'. Also, these types of junk food were not available to the children of Jennifer's family, just to the mother, so when she did manage to acquire them, she ate too much.

Jennifer found that of the few friends that she did have, they were all overweight except one girl, who was very thin. It was to this girl's house that the others would go at lunchtime because her mother baked delicious butter tarts, and they were allowed to eat

as many as they wanted. At Jennifer's house there was control over, as well as competition for, food. She reminisced that at mealtimes "you had to eat fast to get your share" because her father would start eating off the children's plates when he finished his own.

Now in her 30s, Jennifer has found herself focused on providing for her four children, which has been a struggle. She was diagnosed with gestational diabetes with the first three pregnancies, and after the fourth one, it became type 2 diabetes. Also at this time Jennifer was overweight and suffered with depression. After conferring with her family physician, who referred her to a dietician to control the diabetes and suggested that she walk two miles per day, Jennifer continued with her regular eating habits. She remembered telling the doctor that she felt that she was addicted to food because she just ate all the time even though she knew that her behavior was killing her. So back to the dieticians she went. This time rather than just putting her on a diet, they referred Jennifer to a course offered at the local college called "Connections", which she said was very informative but did not provide the continued support that she felt she needed when the course ended.

It was after this course and further searching that Jennifer found a local support group that promoted the 12-step addiction model of treatment for disordered eating. She did very well on this program and lost 45 pounds in 9 months. Following this program, Jennifer's blood sugars leveled off, and she said that although the dieticians were impressed with the results, they disagreed that the diet was successful. Feeling totally deflated Jennifer left the dietician's office in tears. She lapsed into a deep depression and quit the support group.

Jennifer communicated to me that although the 12-step model really worked, helped her to deal with past issues, and made her feel good about herself, it consumed too much of her time and interfered with her life. Also, after she had lost a significant amount of weight and was beginning to receive attention from men, her father's words of warning from earlier years that "slim women were 'cocky' and unfaithful to their husbands", came back to haunt her. Jennifer recalled that she became scared and perceived that possibly her father was right, that maybe her weight loss would damage her marriage, and concluded that "fat was a shield against sexual advances". At 30 years of age Jennifer was overweight, trying to cope with her diabetes, and very frustrated.

After one year without a support group, Jennifer has regained most of the weight that she lost, her diabetes is still not under control, and the ensuing frustration has caused her to develop bulimic eating behaviors. Also, because Jennifer's family is in a relatively low socioeconomic status, she cannot afford to purchase the amount of fruits and vegetables required for her to stay on a diet program. She related that they rely on hampers from the local food bank on a regular basis, which does consist of a high quantity of carbohydrate-rich foods; however, Jennifer admits that she should "try to do the fruits and vegetables more". She has 'stacks' of books about diets and nutrition, and has been to various health professionals and counselors, but is still looking for that perfect program. Jennifer has just recently purchased a treadmill to try to get more exercise because she has realized that for physical as well as mental health reasons she must get her weight under control.

[xv] Colonization, Aboriginals and Health Care:The establishment of a 'reserve' system for natives is a familiar pattern in many colonial countries. However, "unlike examples in Africa and Latin America, most Canadian and American reserves were not labor pools for white industry, mining, and agriculture, but simply a means of removing Indians from desired land" (Patterson 1971: 7). Faced with assimilation, some Indian leaders perceived that reserves could serve as a refuge where their people could continue their communal lifestyle and at the same time adjust "to the ways of the white man" (ibid: 8).

According to Kleinman (1980) "in every culture, illness, the responses to it, individuals experiencing it, and the social institutions relating to it are all systematically interconnected" (24). Experiences related to the belief about sickness etiology, rules of treatment, and legitimization of social hierarchies and institutions are culturally constituted; patients and healer, illness and healing cannot be understood apart from their cultural context (ibid).

For Aboriginal peoples of Canada, disease and healing were bound up with the religious aspects of each nation. The Indian regarded disease as a visitation of evil spirits that had gained access to the body and which had to be eliminated. This process was called medicine, the discourse of specialists such as the medicine man or shaman (Corlett 1935: 65).

With colonialism came the conflict between the Aboriginal and biomedical health care systems. The construction of 'Aboriginal bodies' was the result of imperial Canadian government, "the medical profession, the churches, and the provincial" governments (Kelm 1998: xvi). As discussed in Chapter 2, discourse constructs the human experience: what we know, what we can know, and ultimately who we can know. In the eighteenth century, discourses of both medicine and taxonomies of race, as well as "the idea of the body as a subject of study closely coincided with the growth of imperialism" (ibid: xviii). The presence of subject populations in the colonial context served medical scientists "as laboratory samples of the pathological other, which could both stimulate and justify a reputedly humane imperialism" (ibid). Through the process of colonization, Aboriginal health was socially and culturally constructed "not just by faceless pathogens but by the colonial policies and practices of the Canadian government" (Kelm1998: xix). Euro-Canadian medicine was perceived as superior to Aboriginal medicine, however Native healers and traditional medicines "continued to play important roles among the First Nations" (ibid).

As with the establishment of reserves and the transition to farming, "government money was allocated to the assimilation of Aboriginal bodies and medical care" (Kelm 1998: 129), however, the Native people were seldom well served. Kelm (1998) described the health care issues of British Columbia Aboriginals in general rather than individual 'nations' because health care was a governmental jurisdiction. Likewise, Lux (2001) portrayed the same scenario for Native people in Alberta at the turn of the twentieth century; therefore, in referring to medical practices among Aboriginals across Canada, I posit that there are many similarities.

Colonial medical discourse within each province had as its prime objective the "establishment of a medical system for settlers" (Kelm 1998: 131), Aboriginal peoples were of secondary importance. Medical care provided to Aboriginals reflected "the

perception that Native people were primitive and in need of fundamental change," which "buttressed the department's policy to civilize and Christianize" (Lux 2001: 165).

Hospitals were avoided by Aboriginals due to the fact that only English or French were spoken, not their own language; and the custom of accompanying sick relatives as a source of comfort, was discouraged. 'Missionary medicine,' because of its spiritual overtones, was more in keeping with Aboriginal beliefs, and therefore more likely to be accepted. By emphasizing non-Native as the only 'true' medicine and dismissing traditional medicine as primitive, "missionaries and lay medical workers cast the First Nations as an afflicted people without the ability to heal themselves. Medically, then, they were ultimately dependent on the goodwill of the state and the proselytizing zeal of the missionaries" (Lux 2001: 151). However, not only did Aboriginals persist in practicing their own health system, they integrated the Euro-Canadian system with their own.

Kelm (1998) noted that "through the first decades of contact the potential existed for a hybrid of the two systems to emerge" as "settlers did avail themselves of the substances and practices of Aboriginal medicine. They used devil's club to treat tuberculosis, visited healers in Aboriginal communities, and relied on midwives to help them bear their children" (Kelm 1998: 153). Aboriginal medicine was discredited as quackery or superstition and European biomedicine was endorsed as the dominant discourse. However, this did not prevent the Aboriginal people from maintaining their own medical beliefs, but by combining the two belief systems a pluralistic rather than hybrid system emerged.

With contact came new diseases and "Aboriginals might select non-Native medicine to get the treatment for disease they considered a 'white' disease, to expand their range of treatment options" (Kelm 1998:154). Consequently, they were able to incorporate new diseases and cures into their health system but also distance the European medical profession; thus, maintained some aspects of autonomy.

The dispensary at the hospital was perceived as a valuable medical service. Officials perceived the tendency for the Natives to prefer their traditional medicine "as proof of their backwardness and 'savagery;' yet at the same time, they were perceived as shrewd and scheming because they accepted the doctor's drugs," which were free, "but not the doctor" (Lux 2001:166). Hospital medical reports of this period have enabled us to gain insight "not so much of the types of illness the [River People] were suffering from, but rather of the types of illnesses they perceived could be treated by non-Native medicine" (ibid:168). The most common disease treated at the dispensary was digestive tract problems "caused by inadequate food, contaminated water, and poorly ventilated and overcrowded houses" (ibid: 169). Other diseases such as respiratory conditions and bacterial infections were similarly related to social living conditions.

Hospital records, however, are "nearly silent on the 'greatest foe' of Aboriginal people, tuberculosis" (Lux 2001:170). In the early 1900s, it was "estimated that 90 per cent of all deaths on the reserve were caused by some form of tuberculosis" (ibid:171). However, it was the changing symptoms of the disease that made it hard to diagnose, and the fact that "most reserve medical officers, could not speak the language, and the communication necessary for diagnosis and treatment was entirely lacking unless an

interpreter was at hand" (ibid:172). Aboriginals resorted to their own medical practices and only resorted to white medicine as a last resort.

Missionaries fervently believed that the practices invoked by indigenous doctors was satanic, and urged native people to reject these traditional healers. As well, for those Aboriginal "people who accepted Christianity, the rejection of Aboriginal healers was integral to their profession of faith" (Kelm 1998:157). Missionaries lobbied for legal measures to be taken against those Aboriginal doctors found practicing traditional medicine. It was reported that the medicine man appeared to be a 'witch doctor,' dancing and chanting wildly over his victim, and this stereotype carried over into European literature, along with the misconception that Indians were primitive and uncivilized. In actual fact, the medicine man was usually a trained physician, priest, prophesier, council and/or a powerful, charismatic leader. Famous medicine men of early Indian history include Sitting Bull, Geronimo and Cochise. They were also great Chiefs and served as spokesmen concerning Indian-White relations (Vogel 1970: 26). Because of their power and charisma as leaders, the medicine men were perceived as a threat to European settlers and many were discredited or killed (ibid: 35).

Reserve hospitals functioned as both proselytizing tool for missionaries and a means of disease surveillance for colonial authorities. For the Aboriginals these institutions quickly became associated with death and the harboring of ghosts, and thus they were avoided (Lux 2001: 179). The introduction of new medical information, in particular the germ theory of disease changed the government's perception of the Aboriginal people from victims of "the biological rigours of civilization" (ibid) to a threat to the health of non-Native communities. Aboriginal ill health was attributed to their behavior; "excessive crowding into small, poorly ventilated houses" as well as "their ignorance of the value of nursing, their inattention to the directions of medical advisors, poorly prepared food, and premature marriages" (ibid:181). In effect, reserves were 'medicalized' as medical officers strove to confine communicable disease; but ultimately "it was the interest of the non-Native groups that were being served, often at the expense of the people in whose name the services had been created" (ibid: 188).

From this historical perspective we can see that sickness, including diet-related disease and disordered eating, is socially constructed and stereotyped through discourse.

[xvi] Pritzker (2000) and Carter (1999) further expand on the reasons for the disappearance of the buffalo.

[xvii] Also in Szathmary and Ferrell (1990), Schoenberg et al. (2005), Rock (2005).

[xviii] Also Schoenberg et al. (2005).

[xix] Aboriginal issues can also be discussed in the context of 'post-coloniality' as per Jervis et al (2003) and 'essentialism' per Brian Cliff (1996).

[xx] Also see Bynum (1997) for further discussion of food and medieval women.

[xxi] For further discussion on Rice and identity, see Ohnuki-Tierney, Emiko (1993). Rice as Self: Japanese Identities through Time.

[xxii] **Devereaux**'s criteria for an 'ethnic disorder' (Gordon 2000:8)

1. occurs frequently in a culture relative to other psychiatric disorders.
2. is expressed in a range of intensity, including a spectrum of borderline, sub-clinical forms.

3. expresses core conflicts and psychological tensions that are pervasive with the culture – so acute that it causes severe anxiety and the onset of psychological defenses.
4. are a common pathway for the expression of a wide variety of idiosyncratic personal and psychological problems, ranging from mild to severe.
5. symptoms "are direct extensions and exaggerations of normal behaviors and attitudes within the culture, often including behaviors that are usually highly valued" (8).
6. "is a highly patterned and widely imitated model for the expression of distress; it is a template of deviance, a "pattern of misconduct," providing the individual with an acceptable means of being irrational, deviant, or crazy" (8).
7. "because the disorder draws upon valued behaviors, but on the other hand is an expression of deviance, it elicits highly ambivalent responses from others: awe and respect, perhaps, but also punitive and controlling reactions to deviance. The disorder gains notoriety in the culture; it generates its own "politics"" (8).
8. occurs frequently in a culture relative to other psychiatric disorders.
9. is expressed in a range of intensity, including a spectrum of borderline, sub-clinical forms.
10. expresses core conflicts and psychological tensions that are pervasive with the culture – so acute that it causes severe anxiety and the onset of psychological defenses.
11. are a common pathway for the expression of a wide variety of idiosyncratic personal and psychological problems, ranging from mild to severe.
12. symptoms "are direct extensions and exaggerations of normal behaviors and attitudes within the culture, often including behaviors that are usually highly valued" (8).
13. "is a highly patterned and widely imitated model for the expression of distress; it is a template of deviance, a "pattern of misconduct," providing the individual with an acceptable means of being irrational, deviant, or crazy" (8).

[xxiii] Emily Martin (1987) also called for a change of discourse regarding the medicalization of women's bodies. Pp 27-67.

Bibliography

American Psychiatric Association
1994 Diagnostic and Statistical Manual of Mental Disorders. 4th edition. Washington, DC: American Psychiatric Association.

Andersen, Arnold E.
1990 Diagnosis and Treatment of Males with Eating Disorders. *In* Arnold E. Andersen, ed. Males With Eating Disorders. New York: Bruner/Mazel.

Andersen, Arnold, Leigh Cohn and Thomas Holbrook
2000 Making Weight: Men's Conflicts with Food, Weight, Shape and Appearance. Carlsbad, California: Gurze Books.

Baer, Hans A., Merrill Singer, and Ida Susser
1997 Medical Anthropology and the World System: A Critical Perspective. Westport, Connecticut: Bergen and Garvey.

Barthes, Roland
1997 Toward a Psychosociology of Contemporary Food Consumption. *In* Carole Counihan and Penny Van Esterik, eds. Pp. 20-27. Food and Culture: A Reader. New York: Routledge.

Bauwens, Eleanor E.
1978 The Anthropology of Health. Saint Louis: The C.V. Mosby Company.

Becker, Anne E.
1995 Body, Self, and Society: A View From Fiji. Philadelphia: University of Pennsylvania Press.

Bell, Rudolph M.
1987 Holy Anorexia. Chicago, London: The University of Chicago Press.

Bramon-Bosch, Elvira, Nicholas A. Troop, and Janet L. Treasure
2000 Eating Disorders in Males: A Comparison with Female Patients. European Eating Disorders Review 8(4):321-328.

Brown, Catrina and Karin Jasper
1993 Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders. Toronto: Second Story Press.

Brown, Peter
2001 Culture and the Evolution of Obesity. *In* Aaron Podolefsky and Peter J. Brown, eds. Applying Cultural Anthropolgy: An Introductory Reader. California: Mayfield Publishing Company.

Brumberg, J.J.
1988 Fasting Girls: The History of Anorexia Nervosa. Toronto: Penguin.

Burns, M.D., David
1980 Feeling Good: The New Mood Therapy. William Morrow & Co.

Burns, Tom and A.H. Crisp
1985 Factors Affecting Prognosis in Male Anorexics. Journal of Psychiatric Research 19 (2/3):323-328.

Bynum, Caroline Walker
1997 Fast, Feast, and Flesh: The Religious Significance of Food to the Medieval Woman. In Carole Counihan and Penny Van Esterik, eds. Pp. 138-158. Food and Culture: A Reader. New York: Routledge.

Canadian Diabetes Association
2005 Just the Basics: Tips for Healthy Eating, Diabetes Prevention and Management. Electronic document, http://www.diabetes.ca/files/JTB17x_11_CPG03_1103.pdf
Carter, Sarah
1999 Aboriginal People and Colonizers of Western Canada to 1900. Toronto: University of Toronto Press.
Cliff, Brian
1996 Essentialism. Electronic document, http://www.english.emory.edu/Bahri/Essentialism.html
Corlett, William Thomas
1935 The Medicine Man of the American Indian and his Cultural Background. New York: AMS Press.
Counihan, Carole M.
1999 The Anthropology of Food and Body: Gender, Meaning and Power. New York: Routledge.
Desjarlais, Robert
1994 Struggling Along: The Possibilities for Experience Among the Homeless Mentally Ill. American Anthropologist, New Series 96(4):886-901.
Dickason, Olive Patricia
2002 Canada's First Nations: A History of Founding Peoples from Earliest Times. Don Mills: Oxford University Press.
Division of Community Education and Instructional Development
1992 A Healthy Body If We Eat Well: A Nutritional Workshop for Blackfoot Natives. Lethbridge: Lethbridge Community College.
Douglas, Mary
1966 Purity and Danger: An Analysis of the Concepts of Pollution and Taboo. New York: Routledge.
1997 Deciphering a Meal. *In* Carole Counihan and Penny Van Esterik, eds. Pp. 36-54. Food and Culture: A Reader. New York: Routledge.
Eberle, Margaret, Deborah Kraus, Luba Serge, and David Hulchanski
2001 Homelessness, causes and effects, vol. 1: the relationship between homelessness and the health, social services and criminal justice systems: review of the literature. Victoria, B.C.: Ministry of Social Development and Economic Security.
Eliot, Alexandra O., and Christina Wood Baker
2001 Eating Disordered Adolescent Males. Adolescence 36(143):535-543.
Estroff, Sue E.
1997 A Cultural Perspective of Experiences of Illness, Disability, and Deviance. *In* Gail E. Henderson, Nancy M.P. King, Ronald P. Strauss and Sue E. Estroff, et al., eds. The Social Medicine Reader. Durham: Duke University Press.
Ferzacca, Steve
2001 Healing the Modern in a Central Javanese City. Durham, North Carolina: Carolina Academic Press.
2004 Lived Food and Judgments of Taste at a Time of Disease. Medical Anthropology 23:1-27.

Fichter, M.M., C. Daser and F. Postpischil
1985 Anorexic Syndromes in the Male. Journal of Psychiatric Research 19 (2/3):305 313.
Fitchen, Janet M.
2000 Hunger, Malnutrition, and Poverty in the Contemporary United States: Some Observations on Their Social and Cultural Context. *In* Nutritional Anthropology: Biocultural Perspectives on Food and Nutrition. Alan Goodman, Darna L. Dufour, and Gretel H. Pelto, eds. Pp. 235-347. California: Mayfield Publishing Company.
Foucault, Michel
1975 The Birth of the Clinic: An Archaeology of Medical Perception. A.M. Sheridan Smith, trans. New York: Vintage Books.
Gailey, Christine Ward
1987 Kinship to Kingship. Austin: University of Texas Press.
Globe and Mail
2005 Food guide feeding frenzy: Updating Canada's high-powered food guide has become a real grub match. Globe and Mail, March 12.
Gordon, Richard A.
2000 Eating Disorders: Anatomy of a Social Epidemic. Oxford U.K.: Blackwell Publishers.
Gremillion, Helen
2002 In Fitness and in Health: Crafting Bodies in the Treatment of Anorexia Nervosa. Signs 27(2):381-414.
Grosz, Elizabeth
1990 Contemporary Theories of Power and Subjectivity. *In* Sneja Gunew, ed. Pp. 59-120. Feminist Knowledge: Critique and Construct. London: Routledge.
Hahn, Robert A.
1995 Sickness and Healing: An Athropological Perspective. New Haven: Yale University Press.
Hall, Anne, John W. Delahunt and Peter M. Ellis
1985 Anorexia Nervosa in the Male: Clinical Features and Follow-up of Nine Patients. Journal Psychiatric Research 19 (2/3):315-321.
Herzog, David B., Isabel S. Bradburn, and Kerry Newman
1990 Sexuality in Males With Eating Disorders. *In* Males With Eating Disorders. Arnold E. Andersen, M.D., ed. New York: Brunner/Mazel.
Hopper, Kim
1988 More than Passing Strange: Homelessness and Mental Illness in New York City. American Ethnologist 15(1):155-167.
Huth, Mary Jo, and Talmadge Wright
1997 International Critical Perspectives on Homelessness. Westport, Connecticut: Praeger.
Jervis, Lori L., Paul Spicer, Spero M. Manson, and the A1-SUPERPFT Team
2003 Bordom, "Trouble," and the Realities of Postcolonial Reservation Life. Ethos (31) 1:38-58.
Kahn, Miriam
1986 Always Hungry, Never Greedy: Food and the expression of gender in a Melanesian society. Illinois: Waveland Press, Inc..

Kehoe, Alice B.
1996 Blackfoot Persons. *In* Laura F. Klein and Lillian A. Ackerman, eds. Women and Power in Native North America. Norman: University of Oklahoma Press.
Kelm, Mary-Ellen
1998 Colonizing Bodies: Aboriginal Health and Healing in British Columbia. Vancouver: UBC Press.
Kidd, Kenneth E.
1986 Blackfoot Ethnography. Edmonton: Alberta Culture, Historical Resources Division.
Kiefer, Ingrid, Theres Rathmanner, and Michael Kunze
2005 Eating and dieting differences in men and women. Journal of Men's Health & Gender 2(2):194-198.
Kleinman, Arthur
1980 Patients and Healers in the Context of Culture. Berkley: University of California Press.
Lang, Gretchen Chesley
2006 'In Their Tellings': Dakota Narratives about History and the Body. *In* Mariana Leal Ferreira and Gretchen Chesley Lang, eds. Pp. 53-71. Indigenous Peoples and Diabetes: Community Empowerment and Wellness. Durham, North Carolina: Carolina Academic Press.
2006 Talking about a New Illness with the Dakota: Reflections on Diabetes, Foods, and Culture. *In* Mariana Leal Ferriera and Gretchen Chesley Lang, eds. Pp. 203-230. Indigenous Peoples and Diabetes: Community Empowerment and Wellness. Durham, North Carolina: Carolina Academic Press.
Lank, Cynthia
2000 Depriving yourself just because you have diabetes is a thing of the past; instead, think 'flexibility'. Electronic document, http://www.diabetes.ca/common/PrintVersion.asp?ID=45488
Levenstein, Harvey
1993 Paradox of Plenty: A Social History of Eating in Modern America. New York: Oxford University Press.
Levine, Michael P., Trent A. Petrie, Jerome Gotthardt, and Todd D. Sevig
1990 A Professional-led Support Group for Males with Eating Disorders. *In* Arnold E. Andersen (ed.). Males With Eating Disorders. New York: Bruner/Mazel.
Levi-Strauss, Claude
1997 The Culinary Triangle. *In* Carole Counihan and Penny Van Esterik, eds. Pp. 28-35. Food and Culture: A Reader. New York/Routledge.
Lupton, Deborah
1996 Food, the Body and the Self. London: Sage Publications.
Lux, Maureen K.
2001 Medicine That Walks. Toronto: University of Toronto Press.
Lyon-Callo, Vincent
2000 Medicalizing Homelessness: The Production of Self-Blame and Self-Governing Within Homeless Shelters. Medical Anthropology Quarterly 14(3);328-345.

Martin, Emily
1987 The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.
Mathieu, Arline
1993 The Medicalization of Homelessness and the Theater of Repression. Medical Medical Anthropology Quarterly, New Series 7(2):170-184.
Mauss, Marcel
1967 The Gift. Ian Cunnison, trans. London: Routledge and Kegan Paul.
Mead, Margaret
1998 The Changing Significance of Food. *In* Carole Counihan and Penny Van Esterik, eds. Pp. 11-19. Food and Culture: A Reader. New York: Routledge.
Menaster, Michael
2002 Controversies in Eating Disorders Among Men. Psychiatric Times. Oct. 1, Pp. 83. Electronic document, http://0-web3.infotrac.galegroup.com.darius.uleth.ca/itw/infomark/...
Marchessault, Gail
1999 Weight in Native Peoples: Calling for a Comprehensive Approach. Editorial. Healthy Weight Journal 13(5):65, 80.
Messer, Ellen
1984 Anthropological Perspectives on Diet. Annual Review of Anthropology 13:205-249.
Mickalide, Angela D.
1990 Sociocultural Factors Influencing Weight Among Males. *In* Males With Eating Disorders. Arnold E. Anderson, M.D. (ed.). New York: Brunner/Mazel.
Mintz, Sidney W.
1986 Sweetness and Power: The Place of Sugar in Modern History. London: Penguin Books.
Molloy, Tom
2000 The World is Our Witness. Calgary: Fifth House Ltd.
Neumark-Sztainer, Dianne, Mary Story, Michael D. Resnick and Robert Blum
1997 Psychosocial concerns and weight control behaviors among overweight and nonoverweight Native American adolescents. Research 97 (6):598-604.
Ohnuki-Tierney, Emiko
1993 Rice as Self: Japanese Identities through Time. Princeton, New Jersey: Princeton University Press.
O'Nell, Theresa DeLeane
1996 Disciplined Hearts: History, Identity, and Depression in an American Indian Community. Berkley, Los Angeles: University of California Press.
Patterson, Palmer
1971 Colonial Parallel: A View of Indian History. Ethnohistory 18 (1): 1-17.
Pope, Jr., Harrison G., Roberto Olivardia, Amanda Gruber, and John Borowiecki
1998 Evolving Ideals of Male Body Image as Seen Through Action Toys. International Journal of Eating Disorders. Accepted May 19, 1998.

Powdermaker, Hortense
1997 The Anthropological Approach to the Problem of Obesity. *In* Carole Counihan and Penny Van Esterik, eds. Pp. 203-210. Food and Culture: A Reader. New York: Routledge.
Pritzker, Barry M.
2000 Native American Encyclopedia: History, Culture, and Peoples. New York: Oxford University Press.
Quintero, Gilbert
2002 Nostalgia and Degeneration: The Moral Economy of Drinking in Navajo Society. Medical Anthropology Quarterly 16(1):3-21.
Rock, Melanie
2006 Clarifying Diabetes; or, Commensurating Bodies of Unequal Experience. Public Culture 17(3):467-486.
Rosaldo, Renato
1989 Culture and Truth: The Remaking of Social Analysis. Boston: Beacon Press.
Rosen, Lionel W., Christine L. Schafer, Gail M. Dummer, Linda K. Cross, Gary W. Deuman, Steven R. Malmberg
1988 Prevalence of Pathogenic Weight-control Behaviors among Native American Women and Girls. International Journal of Eating Disorders 7(6):807-811.
Russell, Catherine
1999 Autoethnography: Journeys of the Self. Experimental Ethnography, Duke University Press. Electronic document, http://www.HAUSSITE.net
Scheder, Jo C.
2007 The Spirit's Cell: Reflections on Diabetes and Political Meaning. *In* Mariana Leal Ferreira and Gretchen Chesley Lang, eds. Pp. 335-355. Indigenous Peoples and Diabetes: Community Empowerment and Wellness. Durham, North Carolina: Carolina Academic Press.
Schieffelin, Edward L.
1976 The Sorrow of the Lonely and the Burning of the Dancers. New York: Martin's Press.
Schoenberg, Nancy E., Elaine M. Drew, Eleanor Palo Stoller, and Cary S. Kart
2005 Situating Diabetes: Lessons from Lay Discourses on Diabetes. Medical Anthropology Quarterly 19(2):171-193.
Shack, William A.
1997 Hunger, Anxiety, and Ritual: Deprivation and Spirit Possession among the Gurage of Ethiopia. *In* Carole Counihan and Penny Van Esterik, eds. Pp. 125-137. Food and Culture: A Reader. New York: Routledge.
Sherwood, Nancy E., Lisa Harnack and Mary Story
2000 Weight-loss practices, nutrition beliefs, and weight-loss program preferences of urban American Indian women. Research 100 (4):422-446.
Silverman, Joseph A.
1990 Anorexia Nervosa in the Male: Early Historic Cases. *In* Arnold E. Andersen, ed. Males with Eating Disorders. New York: Brunner/Mazel.

Smith, E. O.
2002 When Culture and Biology Collide: Why We Are Stressed, Depressed, and Self-Obsessed. New Brunswick: Rutgers University Press.
Spiro, Melford E.
1997 Gender Ideology and Psychological Reality. New Haven, London: Yale University Press.
Stein, Michael
1989 Gratitude and Attitude: A Note on Emotional Welfare. Social Psychology Quarterly 52(3):242-248.
Stice, Eric
2002 Sociocultural Influences on Body Image and Eating Disturbance. *In* Eating Disorders and Obesity: a Comprehensive Handbook. Christopher G. Fairburn and Kelly D. Brownell, eds. Pp. 103. New York: The Guilford Press.
Story, Mary, Simone A. French, Diane Neumark-Sztainer, Blake Downes, Michael D. Resnick, and Robert W. Blum
1997 Psychosocial and Behavioral Correlates of Dieting and Purging in Native American Adolescents. Pediatrics 99 (4): e8.
Story, Mary, June Stevens, Marguerite Evans, Carol E. Cornell, Juhaeri, Joel Gittelsohn, Scott B. Going, Theresa E. Clay, and David M. Murray
2001 Weight Loss Attempts and Attitudes toward Body Size, Eating, and Physical Activity in American Indian Children: Relationship to Weight Status and Gender. Obesity Research 9 (6): 356-363.
Sutton, David E.
2001 Remembrance of Repasts: An Anthropology of Food and Memory. Oxford, New York: Berg.
Szathmary, Emoke J. E., and R. E. Ferrell
1990 Glucose Level, Acculturation, and Glycosylated Hemoglobin: An Example of Biocultural Interaction. Medical Anthropology Quarterly, New Series 4(3):315-341.
Valois, Robert F., Keith Zullig, E. Scott Huebner and J. Wanzer Drane
2003 Dieting Behaviors, and Life Satisfaction Among Public High School Adolescents. Eating Disorders 11:271-288.
Vogel, Virgil J.
1970 American Indian Medicine. Norman: University of Oklahoma Press.
Waitzkin, Howard
1991 The Politics of Medical Encounters: How Patients and Doctors Deal With Social Problems. New Haven and London: Yale University Press.
Weltzin, Theodore E., Nicolette Weisensel, David Franczyk, Kevin Burnett, Christine Klitz, and Pamela Bean
2005 Eating disorders in men: update. Journal of Men's Health & Gender 2(2):186-188.
Wilps, Jr., Ralph F.
1990 Male Bulimia Nervosa: An Autobiographical Case. *In* Males With Eating Disorders. Arnold E. Andersen, M.D., ed. New York: Brunner/Mazel.

Wilson, G. Terence
2002 Eating Disorders and Addictive Disorders. *In* Eating Disorders and Obesity: a Comprehensive Handbook. Christopher G. Fairburn and Kelly D. Brownell, eds. Pp. 199. New York: The Guilford Press.
Woodman, Marion
1982 Addiction to Perfection: The Still Unravished Bride. Toronto: Inner City Books.
Woodside, Blake D.
2004 Assessing and Treating Men With Eating Disorders. Psychiatric Times. March 1, Pp. 85. Electronic document, http://0-web3.infotrac.galegroup.com.darius.uleth.ca/itw/infomark/...
Woodside, Blake D., David M. Garner, Wendi Rockert, and Paul E. Garfinkel
1990 Eating Disorders in Males: Insights from a Clinical and Psychometric Comparison with Female Patients. *In* Arnold E. Andersen, ed. Males with Eating Disorders. New York: Brunner/Mazel.
Yanovski, Susan Z.
2002 Binge Eating in Obese Persons. *In* Eating Disorders and Obesity: Comprehensive Handbook. Christopher G. Fairburn and Kelly D. Brownell, eds. Pp. 403. New York: The Guilford Press.

Appendix A

Patient Explanatory Model

Explanatory models differ from 'general' beliefs about sickness and health care. Kleinman (1980) found these questions helpful in assessing the perceptions and expectations of patients and their families:

1. What do you call your problem? What name does it have?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a long or short course?
6. What do you fear most about your sickness?
7. What are the chief problems your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

In conducting interviews for this research project I used these questions as a point of referral, especially when the conversation was lagging.

Appendix B

The Brief Multidimensional Student's Life Satisfaction Scale

These questions were used by Valois, Zullig, Heubner and Drane (2003). A random sample of public high school students in grades 9 through 12 were given an anonymous survey questionnaire, intended to measure the satisfaction with family, friends, school, self, living environment and overall life. The six questions were:

1. I would describe my satisfaction with my family life as …
2. I would describe my satisfaction with my friendships as …
3. I would describe my satisfaction with my school experience as …
4. I would describe my satisfaction with myself as …
5. I would describe my satisfaction with where I live as …
6. I would describe my satisfaction with my overall life as …

The seven response options from the *Terrible-Delighted Scale* were:

a. terrible

b. unhappy

c. mostly dissatisfied

d. mixed (equally satisfied and dissatisfied)

e. mostly satisfied

f. pleased

g. delighted

Also used were questions from the South Carolina Youth Risk Behavior Survey (Valois et al 2003):

1. How do you describe your weight (very underweight to very overweight)?
2. Which of the following are you trying to do about your weight (lose, gain, stay the same, do nothing)?
3. During the past 30 days, did you diet to lose weight to keep from gaining weight (yes/no)?
4. During the past 30 days, did you exercise to lose weight or to keep from gaining weight (yes/no)?
5. During the past 30 days, did you vomit or take laxatives to lose weight or to keep from gaining weight (yes/no)?
6. During the past 30 days, did you take diet pills to lose weight or to keep from gaining weight (yes/no)?

Appendix C

Questions for Professionals and Support Group Leaders

1. Why did you choose this area of work? Why ED?
2. How do you assess the impact of social standards on your clients/group members? E.g. Ideologies of youth, beauty, and thinness.
3. How do you assess the impact of the media on your clients/group members?
4. How do you assess the impact of peer group pressure on your clients/group members?
5. How important a factor is gender? age? SES? ethnicity?
6. What would you like to see in the way of programs to alleviate the problems of disordered eating?
7. How has treatment changed since the 1970s – genetic predisposition, mental illness, addiction – or all of these - what do you think?
8. What role do you think history, politics, economics, and culture play?
9. What do client/group members perceive as their problem?
10. What channels does one have to go through to get help?
11. Why does access appear so secretive?

Appendix D

Ten Common Forms of Twisted Thinking (Burns 1980)

1. All or Nothing Thinking: no shades of gray exist – it is either one way or the other.
2. Overgeneralization: one single negative event is seen as the continual pattern of defeat.
3. Mental Filter: the tendency is to dwell on a single detail which clouds all other perceptions.
4. Disqualifying the Positive: you negate or downplay all positive experiences.
5. Jumping to Conclusions: negative interpretations are made which are not factually supported, often leading to catastrophic judgments.
6. Magnification or Minimization: a weakness or importance of an error is exaggerated, a strength or achievement is underrated.
7. Emotional Reasoning: misinterpreting the reality of the situation because of your emotional state, i.e., you think your emotions mirror reality.
8. Woulds, Coulds, and Shoulds: second guessing one's own behavior leads to guilt; when directed at others (expecting people to be mind readers) leads to feelings of anger, frustration and resentment.
9. Labeling and Mislabeling: labeling yourself on the basis of one incident or mislabeling someone else which makes it difficult to have a positive encounter.
10. Personalization: taking the blame for some external event where there is no real responsibility leading to guilt, or you blame someone else for something that is your responsibility, which makes you angry.

Appendix E

ED gives	Changes to ED	Benefits	How to try something different	Specific of change
control	cut down on puking	money		go to the theatre
Identity	giving up ED	find a life	try to eat twice	better relationships
Sense of comfort	find something else to comfort	managing feelings	fulfill feeling with other than food	feel better about myself
Sense of acceptance	watch self-talk reaching out	self worth	examine beliefs self-worth but by whose definition?	full range of emotions experience life to fullest

Appendix F

ED Costs Us

- Causes helplessness in those who care about you.
- Robs you of your sanity.
- Prevents you from taking risks.
- Crash emotionally or physically.
- It gets old.
- Embarrassment.
- Basing looks on what others see on the outside.
- Being able to maintain healthy relationships.
- Money.
- Health.
- Life – suicide.
- Isolation costs social life.
- Time – planning.
- Costs you the ability to feel and deal.
- Sleep.
- Loss of self-control.
- Concentration.
- Job.
- Your integrity.
- Commitment or keeping your word.
- Compromise morals and values through unhealthy choices – decreased self-worth.
- Our identity robs us of parts that form our identity – forgot who you are – if you ever knew that.

ED Benefits

- Keeps life simple.
- Structure.
- I can do anything and not be affected – bring it on!
- Numbness – not having to feel.
- Avoid living life.
- Gives something to work at.
- Get to be skinny.
- Fight boredom.
- Control.
- Comfort zone.
- Isolation – to keep it a secret or secrets.
- Wallow in misery.
- Help to forget.
- Protection.
- Identity.