Beyond the Medical Model: Can Discourse Analysis Provide Further Understanding of the Treatment of Eating Disorders?

Candidate: Isabel Sweetman

Module Title: Patterns of Action Dissertation

Module Tutor: Prof. David Clarke
Beyond the Medical Model: Can Discourse Analysis Provide Further Understanding of the Treatment of Eating Disorders?

Contents Page

| i.   | Introduction                               | 3 |
| ii.  | **Anorexia Nervosa and Bulimia Nervosa**  | 3 |
|      | Diagnoses, Risk factors, Prognosis and Treatment within the medical model |
| iii. | **Critique of the Medical Model**         | 4 |
| iv.  | **Discourse Analytic Methods**            | 5 |
|      | Discursive Psychology and Foucauldian Discourse Analysis |
| v.   | **Discourse Analysis and Eating Disorders** | 6 |
|      | a. The Social Construction of Eating Disorders | 6 |
|      | b. Discourses of Treatment Experiences    | 9 |
| vi.  | **Conclusions and Implications for Practice** | 12 |
| vii. | **References**                            | 15 |
Introduction

Anorexia nervosa and bulimia nervosa are increasingly prevalent in contemporary western societies, particularly amongst young women and girls. Crucially, eating disorders have the highest mortality rate of any psychiatric illness but despite this there is a lack of quality evidence-based practice. Traditional psychological research uses quantitative research methods, such as self-report questionnaires, to identify behaviours and attitudes towards eating. The limitations of the use of the medical model in diagnosing and treating eating disorders will be discussed. Discourse analysis offers an alternative, qualitative approach for studying eating disorders, and their treatment. Current research has investigated patients’ experience of treatment, nurses’ experiences of treating eating disorders and the role of family and cultural messages in the development of eating disorders. These findings from discourse analysis will be discussed primarily in terms of their implications for improving clinical interventions for eating disorders.

Anorexia Nervosa and Bulimia Nervosa

These disorders are both characterised by the prioritisation of body weight and shape, but anorexia and bulimia present different profiles of disordered eating. Anorexia nervosa is identified using the Diagnostic and Statistical Manual of mental disorders (DSM-IV-TR) (American Psychiatric Association, 2000). The DSM-IV-TR classifies anorexia as refusal to maintain a normal body weight (15% below normal weight for age and height), an intense fear of gaining weight, a distorted perceived body image, amenorrhoea (in post-pubertal females) and a self-identity reliant on body weight and shape. Anorexia is characterised by the exertion of discipline and control towards losing weight, either through self-starvation or through binge-purge cycles, resulting in being severely underweight.

In comparison, Bulimia nervosa is not defined by body weight. The DSM-IV-TR classifies Bulimia as recurrent episodes of binge eating and inappropriate compensatory behaviours, which occur at least twice a week for three months, and an undue influence of body weight and shape on self-evaluation. Many ‘recovered’ anorexic individuals often go on to display symptoms of bulimia, therefore maintaining a healthy weight, but not recovering from their disordered eating behaviours and attitudes.

In the treatment of eating disorders, weight gain is the initial focus in order that the patient is physically healthy. This focus carries on throughout the treatment process. Beyond this focus,
popular methods of treatment include cognitive behavioural therapy (Garner & Bemis, 1985; Anderson & Maloney, 2001), family therapy (Minuchin et al., 1978) and drug treatments (Kaye et al., 2001). However, treatment of anorexia and bulimia has largely been unsuccessful. The prognosis is generally unfavourable for eating disorders, in particular, for anorexia. With estimates of mortality ranging from 5 - 20% for anorectics due to either self-starvation or suicide (Crisp et al., 1992; Deter & Herzog, 1994). Approximately 30 - 40% (Richards et al., 2000) make a full recovery, but generally there is a problem of chronic relapse (Deter & Herzog, 1994) or as in the case of anorectics, they maintain a healthy weight, but adopt bulimic practices or other disordered eating patterns (Bennett, 2006). During treatment, there is also high drop-out rates for both anorexia and bulimia treatments, which is often around 20% (Mahon, 2000) and resistance of treatment while admitted in hospital is extremely common.

**Critique of the Medical Model of Eating Disorders**

The problem of using the DSM-IV-TR to define eating disorders is that it is rooted in the medical model of mental illness, which treats mental problems in much the same way as physical illness. This model therefore implies that there is a dichotomy between ‘normal’ and ‘abnormal’, or between mentally ‘healthy’ or ‘ill’. In reality, it is likely that all mental disorders, including eating disorders, lie on a continuum of mental experience. Eating disorders, as diagnosed by the DSM-IV-TR, can be thought of as an extension of the normal dieting patterns and feelings of body dissatisfaction experienced by a majority of females in Western cultures. For example, Bordo (1993) stated that 75% of women in the United States feel that they are “too fat”, and Polivy & Herman (1987) found typical eating behaviours are currently characterised by a dieting mentality (also, Tomarken & Kirschenbaum, 1984).

Secondly, the medical model presents the eating disorder as an individual pathology, rather than as a result of an individual’s complex, social ecology (Joseph et al., in press). For example, the role of family and culture has been heavily implicated in the development of anorexia and bulimia (Haworth-Hoeppner, 2000). This approach is favoured by feminist and post-structuralist theories of eating disorders, which provide a “politicized and culturally contextualized account of ‘anorexia nervosa’ as a discursive rather than an individual problem” (Malson & Ussher, 1996, p. 278). In addition, the research methods associated with the medical model, such as surveys, do not allow scope for the patient’s own interpretation of their experience as they are confined to a prescribed set of responses that are based upon a pre-defined model of eating
disorders. If we narrow the repertoire of methodologies to only quantitative methods, we also narrow the number of questions that can be answered. Therefore the focus of research needs to shift from quantifiable outcomes to qualitative research of how eating disorders are experienced and practiced.

Finally, and most importantly, the medical model does not consider the experience of the individual. Rather, a diagnosis is found, and the diagnosis is then treated, not the individual. This results in the patient becoming a “passive recipient of expert care” (Joseph et al., in press). Treatment success for eating disorders could be vastly improved by gaining an understanding of the patient’s experiences of treatment. A patient-driven strategy has recently been implemented in the National Health Service in an attempt to improve quality of service and satisfaction (Darzi, 2008). Support for this notion comes from Williams et al. (2000) who found that relationship-centred healthcare improved patient satisfaction and adherence to treatment plans.

**Discourse Analytic Methods**

Qualitative research methods offer a promising alternative to more traditional quantitative methods used in psychosocial research as the resultant data is richer in meaning, and allows for understanding of individual experiences. In particular, discourse analysis can inform us of how reality is constructed through language and how people use language purposefully in social situations, rather than making claims about the truths of eating disorders, as is the way of the medical perspective. There are two main types of discourse analysis that will be discussed for the purpose of this essay: discursive psychology and Foucauldian discourse analysis.

Both versions of discourse analysis share the view of language as constructing reality, and a general criticism of the methods of cognitive psychology. However, the two methods differ on the types of research question they can answer, on agency and on the concept of experience (Willig, 2008). Discursive Psychology is interested in how people use language purposefully in everyday interactions. This is in contrast to Foucauldian discourse analysis, which examines how language constitutes our social reality, in particular, subjectivity, power relations and self-identity. In essence, discursive psychology looks at the ‘how’, and Foucauldian discourse analysis looks at ‘what’.

With regards to agency, discursive psychology places the user of language as active in constructing discourses in order to achieve goals within their social interactions. Whereas
Foucauldian discourse analysis puts forwards that language creates its objects, including the users themselves.

Finally, the two methods differ over the concept of experience. Discursive Psychology describes experience as a discursive strategy that can be employed by users, but does not conceptualise experience. Unlike Foucauldian discourse analysis, which theorises that discourses constitute subjective experience.

Discourse analytic research methods are beneficial as they allow the study of subjective experience and language construction, and as a result, expand the research area available for exploration. However, these methods can be problematic because they are extremely time-consuming and therefore also very costly. Additionally, these methods require a greater level of expertise to carry out than quantitative, statistical methodologies and analyses.

**Discourse Analysis and Eating Disorders**

The rationale for the use of discourse analysis in studying eating disorders is that eating is a social phenomenon, and takes place within an interactive context (Wiggins *et al.*, 2001). Discourse analysis allows us to examine how eating disorders may be socially constructed through social and historical messages, family communication, and perpetuated through treatment practices. Discursive research has therefore looked at discourses of treatment experience, practitioner-patient relationships, and messages in the media and the social environment.

**The social construction of eating disorders**

Feminist post-structuralism advocates that eating disorders are constructed through culturally and historically-specific discourses (Gremillion, 2002; Hepworth, 1999), rather than being naturally-occurring disorders. In particular, that there are gendered, cultural ideals on femininity, slenderness and eating, that are the result of men and women experiencing different pressures from society. Traditionally, men are characterised by their achievements, individuality, control, autonomy and physical strength. Whereas female power has centred around physical appearance. By attempting to transform their appearance through diet restriction, women may feel they are resolving this imbalance of power:

“the fit body is an icon for achieving individualism, productivity, and "self-actualization" within late capitalist consumer culture in the contemporary United States.” (Gremillion, 2002, p. 385)
By re-exerting control through their body, women create a superficial identity of discipline and self-control as a substitute for the lack thereof that they experience in other domains of their life, such as work and relationships.

The feminist argument puts forward that eating disorders are the product of male-female power relations in patriarchal society. Particularly, that binaries exist in language, which serve to emphasise these power relations in society (Burns, 2004; Hepworth, 1999). Examples of these binaries are: masculine/feminine, good/evil, thin/fat, ‘the Madonna’/‘the Whore’, mind/body, self-control/indulgence. Within each of these binaries lies a positive/negative association, and a norm/deviant association. Such that the feminine is constituted as the deviant or the ‘other’ to masculinity. Moreover, the feminine cultural ideal can be understood especially through the dichotomies of the Madonna and the Whore, and self-control and indulgence (Malson & Ryan, 2008; Whitehead & Kurz, 2008).

Although there is some argument that men have increasing concerns about their appearance (Mishkind, et al., 1986), it is largely undisputed that cultural inequalities remain between males and females. Furthermore, the emphasis for men is on bulking up and increasing muscle tone, whereas for women it is slimming down and losing body fat. This is reinforced by anorexics expressed desire for “no body” (Malson & Ussher, 1996) as shown in figure 1.

**Figure 1** – Discourses of a desire for “no body” (Source: Malson & Ussher, 1996, p. 275)

“**H:** What did slimness mean to you when you started to become anorexic? (.)

**Luyla:** Uh (short laugh) um (.) first of all (.) having no tummies or no great bottoms /**HM:** mm/ and having nice (.) thighs, thin (.) thighs.”

This all encompassing aim of ‘eradicating’ the body is conceptualised as an attempt to transcend the power relations associated with a patriarchal society (Malson, 1999). Orbach (2006) indicates that anorexia, and also obesity, are “mechanisms for reclaiming ownership of the body”.

In contemporary Western society, dieting is a normal process for most women as slenderness is so highly valued (Polivy and Herman, 1987). With the rise of ‘heroin chic’ during the nineties and the ‘size zero’ model during the ‘noughties’, as well as an increase in articles detailing the latest fad in dieting, women have never been more concerned with their body weight and shape, and as a result, their relationship with food becomes increasingly problematic (Grogan & Wainwright, 1996; Derenne & Beresin, 2006, Grabe et al., 2008). Whitehead and Kurz (2008) compared articles on anorexia and obesity taken from women’s magazines. They found that
although both were constructed as severely unhealthy, obesity was characterised in these articles as self-indulgent and sinful, and anorexia was seen as an expression of power, control and femininity. Moreover, the notion of ‘healthy weight’ that is promoted in the media and by the government serves as a rationale for disordered eating, particularly, bulimic practices (Burns & Gavey, 2004).

Consumerist society provides conflicts with the predominant Anglo-American Christian work ethic (Crawford, 1984); with the slenderness ideal; and with natural animal instincts to seek out food for survival. Dieting and exercise attempt to resolve these conflicts through “productive management of consumption” (Gremillion, 2002). These cultural conflicts reiterate the binaries of self-control/indulgence, good/evil and thin/fat. The culture of abundance that predominates in Western societies is in strict contrast to culturally and historically embedded norms about self-control and femininity. Eating disorders are a reality only in cultures where there are no food shortages, which might reflect previous evolutionary pressures on humans to forage for food when it is scarce.

The socio-cultural perspective on eating disorders offers an explanation for why anorexia and bulimia are most prevalent amongst white, educated, middle-class females within Western consumerist society, as these social constructions and conflicts are more entrenched within this subculture. This demographic pattern is opposite to the majority of mental disorders, which are more prevalent among individuals of lower socioeconomic status. This is supported by Becker’s and colleagues’ (2002) influential naturalistic research into the introduction of television in Fiji, a previously “media-naïve population”, and examined the effect on eating attitudes and behaviours. Exposure to television media was found to have a negative influence on adolescent girls’ eating attitudes and behaviours.

It has been suggested that the role of culture is mediated by individual family cultures. Haworth-Hoeppner (2000) explored which particular familial factors may exacerbate cultural pressures for slenderness and regulatory eating behaviours. She suggested that there were four distinct characteristics of family life that seemed to influence the development of disordered eating: critical family environment, coercive parental control, an unloving parent-child relationship and a primary discourse on weight. Figure 2 gives examples of these typical family discourses. Many theorists have implicated the mother-daughter relationship in the development of disordered eating patterns (Orbach, 2006; Lattimore et al., 2000; Haworth-Hoeppner, 2000).
Studies cite problems such as maternal criticism, destructive communication and the maintenance of culturally embedded discourses regarding femininity, physical appearance and power relations. The influence of family factors is reinforced by the use of family therapies in treating anorexia nervosa (Minuchin et al., 1978). However, Presnell et al., (2004) indicate that weight and appearance pressures from families are not significant in the prediction of eating disorders, whereas pressures from peers were found to be significant.

**Figure 2** – Examples of family discourses on eating, weight and criticism. (Source: Haworth-Hoeppner, 2000, p. 6 - 7)

| “Not that I was fat or thin, but that I should always watch my figure. Watching my figure was something always said. Even my grandmother, she’d always, like, if we were at her house, she always had candy out and if I went to take a piece she was like, "No, you need to watch your figure." So I guess I grew up kind of hearing it” |
| “My mom was always on me about, "have you gained a little weight?" Or, "That doesn't look good on you. Why don't you go put some lip-stick on? I don't like your hair; go back upstairs and change your outfit." But my mom and her sisters all modeled and I think that was just a way of life for her.” |

**Discourses of Treatment Experiences**

Current inpatient treatment practices are grounded in the medical model and have at their heart the aim of weight gain. It is typically recommended that eating disordered patients should gain 1 – 1.5 kg per week (Vandereycken, 2003) and that typical eating patterns are re-established. Treatment efficacy is extremely limited, with many patients relapsing after discharge and being repeatedly admitted (Deter & Herzog, 1994). This failure can partly be attributed to patient’s dissatisfaction with treatment experiences, and therefore, research into patient’s perspectives is much needed in order to improve service for eating disordered patients (Mahon, 2000). Discourse analysis has been used to examine patient’s subjective experience of treatment, relationship with clinical practitioners and how the construction of eating disorders is reinforced within inpatient settings.

Malson et al. (2004) studied patient’s account of treatment experiences using discourse analysis. It was found that the patient’s main source of dissatisfaction stemmed from healthcare workers’ construction of the ‘eating disordered patient’. Figure 3 is an example of how the patients felt that their identities on the wards were entirely subsumed in their eating disorder and
that they were never considered as “a person” with “a personality”. This was supported by Malson and Ryan (2008), who found that nurses treating eating disorders constituted patients based on the pathologies of the eating disorder and an absence of any individual identity. According to Malson and Ryan, treatment thus reconstitutes the cultural construction of femininity as deviant and deficit. However, this differs vastly from an alternative construction of ‘the eating disordered patient’ given by nurses, as aggressive, deceptive and manipulative. This contrast in nurses’ constructions mirrors a split in the self-identities expressed by anorexic patients themselves: as “someone occupying and torn between a multiplicity of conflicting subjectivities and desires” (Malson et al., 2004, p. 480).

**Figure 3 – The ‘eating disordered patient’ (Source: Malson et al. (2004), p. 481)**

“Jacqui: It’s sort of like speaking to him [a doctor] is like bashing your head up against a wall. / Int: right / Because everything you say is part of the disease. No matter what it is, / Int: right / it’s part of the disease . . . And you’re like: I’m a person. There’s a personality in here you know? It’s not just, / int: mm/ you know I’m not just anorexic kind of thing / Int: right, yeah / which is really tough. (T6A)”

This construction of the patient results in an inequality within the power-relations between the healthcare worker and the patient. Patients described feeling powerless as everything they said was invalid because “it’s the disease talking” in the eyes of the doctors and nurses treating them (see figure 4). Power relations within treatment therefore propagate power relations that already exist within society.

**Figure 4 - Power relations in the treatment of eating disorders (Source: Malson et al., 2004, p. 482)**

“Jessica: And they don’t listen to you at all. And whenever you try and like rationalize anything with them they just, you get told to sort of shut up because it’s the illness talking and you can’t possibly know any better than them because otherwise you wouldn’t be in here in the first place. /Int: mm/ [sighs] And there’s like no compromise or anything. You’re not allowed to have like choices or preferences. (T14UK)”

As discussed, treatment regimes aim to establish normal eating patterns with the patients. However, mealtimes are an incredibly difficult experience for the patient with an eating disorder, because discourses at mealtimes and also mealtimes regimes conflict with real-life experiences of eating and also serve to reinforce their constructions of food and weight. Hospital mealtimes take on a very strict, inflexible approach to food due to the assumption that anorexic patients will try to deceive their healthcare workers on how much they’ve consumed. Boughtwood and Halse (2008)
discovered that patients found the restrictions on when and what they can eat unacceptable. In particular, the hospital regime provides a direct contrast with the flexibility and choice that is available when eating outside of the hospital setting. Figure 5 gives an example of how one individual feels about mealtimes during inpatient treatment.

**Figure 5** – Hospital inflexibility in mealtimes and choice of food (Source: Boughtwood & Halse, 2008, p. 274)

> “I’d come from a family where I’d always had control. Like it wasn’t like my mum made my lunch in the morning (D: Mm) or always made dinner because, I like a wider variety of foods than my Mum. . . Um, so I always had a lot of [ ] freedom in that respect [in the foods and the times that she ate].”

This forced routine does not adequately prepare patients for when they are discharged from hospital, and it tends to exacerbate patients’ perceived lack of control, which is an important factor in the development of eating disorders, as shown in figure 6. Outside of this regimented hospital environment there won’t be constant surveillance, furthermore, there is an unlimited choice of what food to eat and when to eat it. Hospital treatment therefore should focus more on allowing patients to choose when and what they would like to eat. To further prepare the patients for social life, treatment could involve cookery classes, in which they get to cook and then eat their own food. A further problem with hospital feeding is that it conflicts with messages in their home life, from peers and from the media, that individuals should be restricting what they eat instead of increasing it. As discussed previously, dieting in women and the promotion of dieting in magazines and popular media is a widespread phenomenon and difficult to escape.

A conflict also occurs between numbers in hospital and appearances in their social worlds. In hospital patients are judged purely in terms of numbers: the number of calories they have consumed, the number of kilos they have gained in weight, and admittance, exercise and discharge weights. Whereas, in the ‘real world’ people are judged by how they look, not by numbers, as shown in figures 7 and 8. The other problem with this focus on numbers and weight is that it only serves to recreate the anorexics’ prior practices of calorie counting and placing utmost importance on how much they weigh and eat (Gremillion, 2002).
**Figure 6** – Control within eating disorders (Source: Reid *et al.*, (2008), p. 958).

“‘Everybody else, like my parents or whoever, control everything ... right down to what I should or shouldn’t be thinking, ... I feel ... the eating is the only thing that I control.’”

“The reason that you do it in the first place is to have some bit of control. But then you realize when you do try and eat you can’t. You start getting real problems in your head when you realize you’ve got to stop doing it and you can’t stop.”

**Figure 7** – Conflict of identities: numbers in hospital, appearance in the social world. (Boughtwood & Halse, 2008, p. 277)

“Once I got out of hospital, she [mother] thought everything was back to normal and that I wasn’t purging and what not. And then I got depression. ‘Cause I hated the way I looked. Like, it [anorexia] might be the numbers [on the scale] but doesn’t the look also depend on the numbers as well?”

**Figure 8** – The struggle with numbers in hospital (Source: Gremillion, 2002, p. 29)

“'Well your weight today is. ..... ’ And if I don't like the weight, it’s like they’re ... insulting me, or hurting me in some way, stabbing me.... The focus on the numbers and everything here, it's very easy to turn it-every day I do, I turn it to myself, it kind of like, says something about myself. And I think it’s a real hard process here. Because I think in one way you have to use the numbers, you have to get the numbers. But since I've been here, the numbers have been very hard to take. Daily.”

Another final issue identified was that meals were repetitive and bland, and the relentless focus on food for the function of gaining weight, quelled their appetite for food (Boughtwood & Halse, 2008). Treatment should aim to make food desirable to the patients, rather than something forced upon them as medicine, hopefully resulting in internalisation of the behaviour.

**Conclusions and Implications for Practice**

Studies of treatment experiences and practices reveal that patients generally feel dissatisfied with the quality of service in eating disorder interventions, which would explain their low success rate in treating the underlying problem. In particular, patients felt that healthcare workers only viewed them through their eating disorder, and as a result, their own identities were ignored. The advantage of qualitative research is that it explores individual variations in experience, compared with quantitative research which finds generalisations across a sample population (Brown & Lloyd, 2001). This is reflected in the medical treatment of eating disorders, as practitioners tend to view patients as a generalised diagnosis, and therefore tend to focus on the symptoms to be treated, rather than the individual’s experience of the disordered eating and
beliefs. Discourse analysis investigates the individual experience, and as a result can explore how treatment might be improved.

Mental health practitioners need to expand how they construct ‘the eating disordered patient’ (Malson et al., 2004; Malson & Ryan, 2008), which requires a focus on the “wider psychosocial issues” implicated in eating disorders (National Institute for Clinical Excellence, 2004) beyond a focus on weight gain. The strict and regulated focus on weight gain within inpatient treatments of eating disorders mirrors the patients’ previous strict calorie controlled diets, only in the opposite direction and therefore perpetuates the already paramount importance that food and eating have in their life and for their identity (Gremillion, 2002). The focus could be shifted from food and calorie regulation by making mealtimes into a social occasion, when families and friends of the patients can come together and converse, outside of the discourse of eating and weight. This has the aim of detracting from the unrelenting surveillance experienced by the patients with regards to their food intake (Boughtwood and Halse, 2008). Malson et al. (2004) identified that this narrow focus on eating needs to be challenged by healthcare workers, and an identity beyond the eating disorder needs to be asserted. It is important that the patient feels that they can achieve something beyond control over their weight. From a feminist perspective, eating disorders are a result of lack of control, power and autonomy in patriarchal society (Bordo, 1993; Orbach, 2006), therefore it is implied that females need to feel empowered, in areas of their life other than eating, to be able to fully recover from their eating disorder.

Autonomy and power were also found to be issues within the therapeutic relationship (Malson et al., 2004: Gremillion, 2002). Discourses revealed that patients often felt powerless within the treatment process and unable to negotiate any details of the treatment. This is an especially important component of treatment for anorexia, as anorectics are characterised by their desire for self-control and discipline over their body shape and appearance. Therefore, self-determination theory research (Deci & Ryan, 1985, 2000) should be incorporated into treatment plans with the aim of increasing patient’s autonomy towards healthy eating practices in the hospital, and later within their social lives. Ryan et al. (2008) suggest that by increasing autonomy for health-related behaviours, then they will eventually become internalised, and thus maintenance of these behaviours will be stronger.

Much of the research indicated that eating disordered patients receive messages during treatment about food, weight and eating that conflict with and contradict messages within real-
life social settings (Boughtwood & Halse, 2008; Gremillion, 2002). In particular, there was a conflict of ‘numbers’ in hospital settings and appearances in social settings, a conflict of weight gain messages during treatment and media messages about slenderness and dieting, and a conflict of the rigidity of mealtimes in hospital and the freedom of choice in consumer, capitalist society. The problem of chronic relapse after discharge from hospital could be understood within the contrast of eating in hospital and eating in a social setting. Inpatient interventions for anorexia nervosa do not adequately prepare patients for eating in a real-world setting, in which constant surveillance and regulation is not present. It is within this dimension that increasing autonomy for healthy eating behaviours can improve treatment success. This problem with inpatient treatment can be extended to a general criticism of mainstream Psychology, in that it cannot relate to real-life settings because research often takes place within artificial settings, such as laboratories and institutions.

In conclusion, discourse analysis allows exploration of how eating disorders are ‘culturally-bound’ syndromes and the complex, dynamic systems that affect the development of these disorders. However there is a difficulty in combining the poststructuralist view of eating disorders and the medical model. A mixed approach is still fundamental in this area of research because without biological treatments of the malnutrition, the health of individuals with eating disorders would be at risk whilst therapists attempt to ‘un-bind’ them from these cultural constructions. Unfortunately, biological treatments of eating disorders also pose a risk to recovery as they are counterproductive to helping patients overcome cultural and historical discourses of eating and physicality, because treatment practices tend to reiterate these discourses (Gremillion, 2002).
References


