

ANORECTIC NARRATIVES
THE POSSIBLE AGENCY OF ANORECTIC WOMEN IN THE HUNGARIAN
PSYCHIATRIC TREATMENT

By

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Abstract

This thesis examines women with anorexia involved in Hungarian psychiatric treatment. The research is based on interviews, both with women who were hospitalized and doctors who treat anorexia in practice. The study makes an attempt to challenge the current medical approach on anorexia from an anthropological and gender-based perspective. Therefore, my analysis contests the actual country-specific medical discourse with the lived experiences of these women.

The purpose of the analysis is the representation of those subordinations, specific sets of suppressive practices, and institutional regulations that concern to an anorectic under the Hungarian medical care. The expectation of normal life, regular citizenship, proper womanhood, reproductivity, and well-functioning family, just a few of those decisive elements that the state or nation requires from a person who suffers from eating disorder. I assume that these factors are the parts of a bigger establishment of the Biopower.

In order to the contextualization of these elements, the research touches upon the Foucauldian theory on Biopolitics and disciplinary power. Foucault emphasizes that power is not mere repression since it has creative potential too. I would like to argue that, however, the subordinations above influence the subject's position and restrict her rights, the anorexia has already performed a sort of agency. Anorectic practices serve as a mean for the subject to flee from her crucial position to another. If the subject could not express herself verbally, she has to turn to other practices to perform herself in everyday life. I suppose that the anorexia is a bodily performed suffering by the cultural and symbolic constructions of the normative ideals, such as gender, race, class. Judith Butler thoughts on performativity and agency serve as a basis for the description of this agency.

The problem of the anorectic is that through her life-threatening acts she becomes the object of medicalization that deprives her right of reason. Therefore, the agency of the anorectic necessary has failed in the present psychiatric complex. The thesis argues for a therapeutic process that could open a space for the anorectic to accomplish her agency and modifies her previous position.

The research briefly touches upon the agency of the professionals too. According to my interviewee, their attitude is also determined by the circumstances of the psychiatry which hang on country-specific political and economic factors. This assumption drives out from the specific topic of the anorexia to the embeddedness of the psychiatry in wider Hungarian power relations.

I hope that the discourse of the research can maintain a space for anorectic women to express their feelings and thoughts on their psychiatric therapy, that the Hungarian medical treatment could not provide them. I expect that this discursive space can extend the country-specific medical discourse on anorexia with some more sensitive and in-depth gender-specific perspectives for the more successful treatment.

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Introduction

The present thesis intends to study women with anorexia involved in Hungarian psychiatric treatment. The research based on interviews, both with women who were hospitalized and doctors who treat anorexia in practice. The study makes an attempt to challenge the current medical approach on anorexia from an anthropological and gender-based perspective. Therefore, my analysis contests the actual country-specific medical discourse with the lived experiences of these women. The purpose of the analysis is the representation of that specific form of agency that plays in the practices of anorexia and the exposition of those institutional processes that provide or restricts the potential agency of the anorectic.

I hope that the thesis can maintain a discursive space for those anorectic women who shared their stories with me, to express their feelings and thoughts on their psychiatric treatment. I expect that this discursive space can extend the Hungarian medical discourse on anorexia with a sensitive and in-depth gender-specific perspectives for the more successful treatment.

Before the research, I assumed that I can centralize the research around the figure of the anorectic, however, I had to realize through my readings and interviews that this centralization could not be expressive enough to the responsible description of the phenomena. For a subtler picture, I also had to give attention to that complicated web of power that acts upon these women and map out the constellation of the apparatuses of the power, nation bounded ideals of femaleness, middle-class nuclear family, and scientific discourse on anorexia. Consequentially, before I examine the possibility of the anorectic agency, a part of the thesis analyses those power related processes that produce the anorectic's subjectivity and determine these subjects' space for action. I believe that the examination of these factors is fundamental to unfold the crucial position of those anorectic people who had to attend in treatment in Hungarian psychiatric institutions.

Brief background

In the past few decades, multiple scientific publications have reported the drastic rise of anorexia chiefly among Western young women. It has driven increased attention to eating disorders. Anorexia nervosa became a classified mental disorder and diagnostic category during the 70's. (Túry 2004) According to the Hungarian version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) which contains the internationally accepted criteria for the classification of mental diseases

The fundamental symptoms of the anorexia nervosa are the weight phobia, body image disorder, low weight, and amenorrhea. [...] Eating disorders are the disease of the higher and middle-class, however, in the last few years, it proliferates to the lower classes, aging population, and men too. Among specific groups, such as students (mostly college students), those whose professional requires slenderness (as dancers, models, athletes, and jockeys) or homosexuals, the risk of the anorexia is higher. There are transcultural differences too: among white people, it is more recent than black people [sic!]. It means that in the developing countries, the disorder is very rare. (440)

This medical description problematic from multiple aspects. It exposes anorexia as a singular phenomenon and a homogeneous category. In addition, the article deals with gender, class, or race as natural and universal categories, while it attaches preconceptions and culturally determined associations to them (such as the premises on professions or homosexuality). The other crucial problem of the article is the schematic and unreflexively manner towards cultural differences. For instance, it divides the population of black and white people as homogenous groups of the human kind.

I had some interviews with professionals who applied the same schematic language for their patient. One of them told me: In a psychiatric institution, everybody is the same, like they wear a prisoner's uniform. In the case of anorexia, it can be known exactly that they are thinking in the same way. They are typical.

Through my interviewees with ex-patients, I would like to emphasize the opposite of the statement above. I believe that every anorectic case is different. The problem of the Hungarian treatment is exactly that it gives no space to the multiple motivations behind the

seemingly same symptoms. Therefore, I think, the universalizing manner of the diagnostic handbooks could have a harmful effect in practice too. A part of the thesis makes an attempt to go behind these unreflexively medical assumptions and contests them with the particular, socio-cultural traits of Hungary. In order to this contestation, I had to examine the country-specific psychiatric treatment of anorexia. My interviews with professionals responsible for this critical analysis.

According to my findings, the psychiatric treatment focuses only to with the stabilization of the patient's biological body and the normalization of its eating behaviours without any communicative therapy and follow-up sessions. However, most of my interviewees lacked the personal therapy and after the psychiatric treatment, they fell to other psychiatric problems and later they had to attend further therapies. Therefore, I believe that, while the treatment does not pay attention to the deeper meanings of the anorectic practices, it could not heal them successfully.

My further assumption, after Susan Bordo and Judith Butler, is that anorectic practices stand for a specific set of performative practices for women who could not articulate their subjugated position under the structural oppressions in other ways. (Bordo 1990) As Butler emphasizes, our continuously reiterated everyday actions shape our identity. (Butler 1990) In this sense, the act of self-starvation and the practices around it are performative acts, that responsible for the coherence of the identity of the anorectic. Anorectic practices are always already efforts to the demonstration of the subject's agency, even before the medicalization. I suggest that the anorexic makes an attempt to create her own identity independently from its environment through the practice of starvation, and seek for other spheres, such as the psychiatry, in order to complete the process of subjectification.

The problem is that the actual psychiatric treatment makes this agency questionable, invalid and incomplete through its attempt to normalization. Therefore, in the thesis I arguing

that psychiatry has to realize its role in the subjectification and the therapy has to provide a space for complete the subject's modification, instead of the re-socialization of the patient. With the help of my interviewees' insights and the Butlerian notion of agency, (1990) the end of the thesis, makes an effort to offer an alternative form of therapy, for a more suitable treatment of anorexia.

Methods and Research Design

The thesis based on interviewees both with ex-patients and the experts of anorexia. I followed the insights of Joey Sprague and Mary K. Zimmerman during my research. The authors formulate a feminist critique of positivist claims to objectivity. (Sprague, Zimmerman 1989) Accordingly, they promoting the usage of qualitative methods in the case of critical examination, because, as they claim, there is no neutral, objective and absolute standpoint. Therefore, the authors emphasize the importance of the qualitative methods, besides the quantitative mode of gaining data. (76)

Under this consideration, I endeavored to work with my interviewees as partners and I tried to avoid the separation of myself from my informants in order to create an intersubjective space with them. I think, the ideal method for the research of this topic is more like a group work than a creation of an outsider narrative from an 'objective' researcher standpoint, since this attitude easily reproduces the scientist-scientific object relation, that the institution of psychiatry already exercised over them. Therefore, my interviews were more like conversations than an interrogation. Hence, I reduced the direct question to a minimum amount, because I was interested in the way how they design the narrative of their disease, how they express their feeling on it, and how they reflect on their past position on their own. Consequently, I followed Marjorie DeVault insights, and I 'let the women talk' to see how they construct themselves through their speech acts and emotional responses. (DeVault 1999) I followed nearly the same

manner with professionals as well. Besides, I retroactively requested my partners to ask for their opinion about my insights and I built their latter observations to the thesis.

I had 12 narrative interviews, 5 with anorectics and 7 with professionals. In the case of anorectics, my focus group was women who had been diagnosed with anorexia nervosa in the past and had to attend forced medical treatment in Hungarian medical institutions. I conducted interviews with ex-patients because I assumed that these women have a reflexive distance from their medical treatment. The other reason why I tried to avoid the discussion with patients who has still attended in treatment is because I suggest that this reflexive claim towards them can be harmful to their therapy as long as my questions could easily hurt or influence them.

For the collection of my interviewees, used snowball sampling with a few key informants. One of my sources was a friend of mine. She had previously spoken about her anorectic stage and hospitalization, and when I asked her to give me an interviewee and help me to find other anorectics she was really helpful. The problem of this method of gaining interviewees is that the strongly restricted field of the research to some specific institutions in Budapest. In order to make my sample broader, I also asked the help of the Institution of Behavioural Science in Budapest to find more interviewees.

Simultaneously, I conducted interviews with psychiatrist too. I found them mainly through those institutions there my interviewees spent their treatment. Although, I had some interviewees outside these institutions, because of my earlier interest and research on the topic of anorexia and the Hungarian psychiatry, I knew some of them personally and some of them by their publications, for instance, a Ph.D. student who wrote his thesis on the autonomy of the anorectic patients, or a psychoanalyst who tries to build critical theory and feminism into her praxis.

My questions towards the doctors focused on the medical treatment, to get to know more about the official medical practices and how the doctors perceive their patients in this

institutional frame. However, my questions also touched upon the professional's personal opinions and feelings, and how they see their own possibilities and limitations in the Hungarian medical system. These reports raised my attention to the importance of the examination the agency of the doctors too, besides the patients. The last part of the thesis refers to this agency in connection with the country-specific conditions of the healthcare system.

Limitations

Since the snowball sampling was the only way to reach the specific group of ex-anorectics, this method more or less determined my subject's age, class, and ethnicity. Therefore, my anorectic interviewees were women Hungarian-middle class women in their thirties. This sample could not contest the diagnostic handbooks schematic picture on the anorectic background, hence, I have to emphasize that this research needs a further extension to other underrepresented social groups, such as Roma people or men. The present research also could not be representative for all over the country, however, the specific group of my interviewees provided me a good starting point for the research of the topic and allowed me to map out more precisely some particular institutions in Budapest.

Another limit of my research arose from my own researcher position. As I am not a professional doctor, I had to face with several ethical problems. The Hungarian Ethical Committee of Medical Researches strictly saves the patients' safety, therefore, they are strongly restricting the researchers' rights to use their gained data on psychiatric institutions. This is the reason why I did not use the findings of my participant observation in the present thesis.

However, my position as an outsider served with advantages too. It helped me to create a more personal atmosphere during the interviews both with doctors and patients. My ex-anorectic partners spoke more familiar with me, because, I think, they regard me as a young outsider student, not as an authority who stands for the preservation of the medical discourse. Sometimes, I was even amazed by how openly they spoke with me about their crucial situation

in their past. Most of the doctors were very communicable with me too, not counting one or two cases when I felt antipathy towards me, exactly because I of my outsider position. Instead of these few cases, professionals were very helpful, as they did not regard me as a concurrence in their professional discourse space.

Because of the limited time and length of the research, I had to leave out of consideration several important aspects of anorexia too, such as its relations with other eating disorders, the online pro-anorexia communities or the history of the Hungarian psychiatry. One of the most crucial deficiencies of the research, therefore, the avoidance of the topic of male anorexia. I do not think that male anorexia is not the part of this complex phenomenon, however, the present research has no space to touch upon this topic. My aim is to use anorexia as a lens to contest the Hungarian medical discourse, common opinions, and power relations that specifically affects female subjects. Therefore, as a tactical decision, I left out of consideration male anorexia.

Besides these deficiencies above, I hope that the thesis can give a glimpse to the specific structures and patterns in the patient-doctor-institution dynamic in Hungary and the data can highlight the importance of this topic and the necessity of further researches.

The thesis consists of two main chapters: one about the subordination and one about the agency of the anorectic subject. The first chapter represents those oppressive structures that shape the anorectic's positionality in the present Hungarian medical establishment. The first section details how medical and juridical discourse intertwines each other in the psychiatric treatment and how their apparatuses design the subjectivity of the anorectic patients by the restriction of their rights. This part briefly explains the Foucauldian approach on the current system of biopower and the way how this establishment transforms the diagnostic process into a disciplinary mean.

The second section focuses on those reproductive expectations that the biopower requires from female subjects. Through this part, I intend to show how anorectic women became abnormal since they fail proper femaleness through the unintentional refusing of their reproductive capacities. The third section explains reproductive requirements from a nationalistic and racist standpoint, based on George Mosse's and Attila Melegh's theoretical works. The ideals of population, bodies, reproduction and future come together in the modern notion of nation. In this sense, the anorectic means constant danger for the future of the society by the refuse of reproduction. The section shows how the higher goals of the nation justify the power's intervention either to the private sphere of the anorectic either to the life of its family.

After I described some of those conditions that restrict the anorectic's rights to action, the second main chapter discusses the possible agency of the anorectic. The first section draws upon a theoretical frame of agency according to Foucault's and Butler's insights. Then the next section applies these insights to concrete anorectic narratives. I present three cases and I interpret them along the Butlerian criteria of the agency and the thesis previous findings. Followed by the case studies, the research makes an attempt to expose anorectic agency from a new perspective.

In the light of my interviews, in the third section, I recommend an alternative therapeutic method, based on communication, that can help to the anorectic to modify her previous crucial position. At last, I would like to point out the limitations of the professionals too by economic and political factors. This insight drives out from the analysis of anorexia to a further examination of wider power relations in the present Hungarian medical discourse.

Literature Review

The present thesis intends to compare the lived experiences of anorectic women with the country-specific medical discourse to find out what forms of agency are possible for these women under these institutional practices. In this literature review part, I would like to position

my research among the already existing scientific literature on anorexia and those critical theoretical insights that concern to this corpus. The main difference between the medical discourse and the gender-based discussion on the anorexia is the contextualization of the disease. While the medical discourse does not go deeper into the cultural and social causes of the diseases, critical readings emphasize the importance of the underlying power relations that shapes it.

As I have already mentioned, my present research reduces the category of anorexia to those who were diagnosed with anorexia nervosa. Consequently, my inevitable starting point to define anorexia is the *International Statistical Classification of Diseases and Related Health Problems* (2010), the *Diagnostic and Statistical Manual of Mental Disorders* (2013) and their Hungarian translation, made by an anorexia expert Ferenc Túry (2004). These manuals provide diagnostic criteria, case detection methods and unified classification system of the mental diseases for medical professionals all around the world. However, these handbooks based on quantitative data, that supposedly causes many distortions in the recognition of anorexia. While ICD-10 and DSM-5 see anorexia nervosa only as a disturbance of body image and eating behaviours, it does not count with those wider power relations and cultural differences that necessary influences the person's life and subjectivity.

Garner and Garfinkel, Canadian professors of psychiatry, in their article from 1980 made an attempt to go deeper into the socio-cultural background of anorexia. The *Socio-cultural Factors in the Development of Anorexia Nervosa* (Garner and Garfinkel 1980) examine the population with eating disorders by quantitative questionnaires to define abnormal eating attitudes. While the article's chief objective is to show the socio-cultural aspects of eating disorders, the authors gained their data only in English-speaking areas such as Canada or Great Britain. At the same time, they reduce the meaning of culture to the aesthetic ideal of the West. Therefore, the authors make the same mistakes as the ICD-10: their explanation centralized

around women's body, but it does not go further to explain the socio-cultural meanings of the body, and the desire for thinness in this wider context.

My research, therefore, makes an attempt to the critical reading of the vague diagnostic notions around the definition of anorexia, such as culture, body, or reproduction and place them in a biopolitical context. To maintain this, I use Michel Foucault's approaches on power mainly through his insights in *The Subject and Power*, *History of Sexuality Vol. 1*, and *The Birth of Biopolitics*. (Foucault 1982; 1998; 2008)

Many critical gender reading of the anorexia centralizes around the Foucauldian approach of biopower. Julie Hepworth's work, *The Social Construction of Anorexia Nervosa*, concentrates to those wider social conditions that shape the disease. (1979) Susan Bordo critical feminist analyses on anorexia also follow Foucault's insights, such as the *Reading the Slender Body* and the *Unbearable Weight: Feminism, Western Culture, and the Body*. (Bordo 1990; 1993) These works make attempts to read the underlying meanings of the female body ideal and its cultural role. Bordo emphasizes the gendered nature of anorexia (and other eating disorders) to make visible the connections between the social-cultural-economic changes of the 19th century that call forth these diseases.

„[...]contemporary preoccupation with slenderness as it functions within a modern, „normalizing” machinery of power in general, and, in particular, as it functions to reproduce gender relations.” (1990: 85)

According to Bordo, the anorectic body is a gendered body, trapped between two interests: the women's own desire to control herself and the political control of her body.

Naomi Wolf in her book, the *Beauty Myth*, (Wolf 1991) also emphasizes the political importance of anorexia. She maintains a connection between the 1st wave of feminism and the birth of the slender body ideal. Her argument is that the dominant aesthetic ideal of the present developed exactly when the women's emancipatory movements had started. Slenderness, therefore, an implicit tool for the power to maintain control over women's body. Wolf's assumption is that while women have to focus to suit the unreachable female ideal their political

aims become secondary. (210) As these examples show, the gender perspective in the reading of anorexia can point out the wider relationships between bodies and power, therefore, for the present research, it provides a fruitful perspective for the in-depth analysis of this phenomena. Marilyn Lawrence also emphasizes in the *Anorexia Nervosa—The Control Paradox* the anorectic's contradictory relation to control. While the subject makes an attempt to gain control over her body, it serves political and economic interests. Therefore, the experience of control in anorexia only an illusion. (1979)

However, gender readings make an attempt to step beyond the medical description of anorexia and make visible the complex gendered and political angles of it, they still remain in the Western theoretical frame. Multiple articles, such as *Prevalence of Eating Disorders: a Comparison of Western and non-Western Countries* (Makino, Tsuboi, Dennerstein 2004) emphasize that limited numbers of studies have been conducted in non-Western countries on anorexia, such as in East and Central-Europe. According to the authors, the main problem is that '[h]owever, eating disorders may present differently in different cultures, the diagnostic criteria based on Western norms may not always be appropriate.' (2004)

Because of the effects of Westernisation, both doctors and researchers have to take into account those cultural differences that shape the country-specific causes of anorexia, for the more successful treatment, prevention and education. Susan Bordo also reflects on this problem. In the *Not Just a 'White Girl's Thing* (2013) she revises her earlier works and starts to emphasize the importance of cultural differences in anorexia and gender. Her point is that while earlier studies, such as hers, focused on Western, white, middle-class, young girls in the examination of this topic, anorexia existing in multiple other social spheres, other races, classes, and ages.

In order to synthesize my findings with the already existing literature on anorexia, I use George Mosse's and Attila Melegh's studies on nation and demography. Mosse in *Nationalism and Respectability: Normal and Abnormal Sexuality in the Nineteenth Century* (1982) analyses

how the modern nationalistic norms developed a system of values based on the respectability of the body, and how this ethical arrangement proliferated to other discourses such as healthcare. Melegh in his book from 2006, *On the East-west Slope: Globalization, Nationalism, Racism and Discourses on Eastern Europe*, get to a similar insight as Mosse. He analyses the science of demography that appears in the 17th-18th century. Melegh sees this discourse as the consequences of the discourse on the population and as a new disciplinary mean of the nation. This new attitude towards the people gradually reorganized the macro-political relations of the nation and the micro-political hierarchy of the family which set the new standards of life. (50) Mosse's and Melegh's theoretical insights provide me a tool to connect earlier Western insights on the anorexia with the Hungarian expectations towards the family, female body, and population that influences the country-specific medical discourse and practices on anorexia. I believe that the post-socialist political establishment of Hungary decisive in the present attitudes towards the notions above, that we could see for example as in the case of the family structure. Therefore, on the basis of Mosse and Melegh, I would like to revise the already existing Western theoretical insights on the anorexia and compare them with some country-specific issues.

Ferenc Túry, the head of the Institute of Behavioural Science in Budapest reinforces that, besides the rising attention to the cultural differences in the psychiatric practice and the classification of diseases, there is relatively a few research on the anorexia in Central and Eastern-Europe. (Túry 2010: 79) His historical and medical overview, the *History of Eating Disorders in Hungary* (Túry, Babusa, Varga 2010) explains the occurrence of the disease in the Hungarian history. The research has shown that patients with anorectic behaviours existed either in the Austro-Hungarian Monarchy, either in the State Socialism, consequently, it could not be the outcome only of the Westernization after 1990, as some medical literature suppose. Túry emphasizes that there is a lack of the English language studies on the Eastern-European forms of eating disorders, and this “linguistic isolation” (7) is a barrier between the region and

the international discourses on this topic. However, Túry conducted several medical research on anorexia in the last 20 years, there are relatively few sociological or anthropological studies on the topic and the critical gender aspect has frequently been neglected.

Although there has no specific gender research on anorexia in Hungary there are some remarkable gender-based studies on psychiatry in the last 10 years. One of them is Anna Borgos' book, the *Nemek Között* [In-Between Genders]. (2013) The book represents the Hungarian psychiatry in the fin-le-Sec through case studies of hysteric women. Borgos used 30 case studies to reconstruct the stories of these women, not from a medical but a gender perspective. These narratives can provide a glimpse of the psychiatric practice of this time, and also to the social position of women in the Austro-Hungarian Monarchy. I see her research as an important methodological turn in the sphere of Hungarian psychiatry from a medical and quantitative discourse to a qualitative and subtler investigation at the intersection of medicine, anthropology and gender discourse. In my research, I would like to create a similar discursive space to give a patient focused description on anorexia.

Emese Lafferton's study from 2002, *Hysteria and Hypnosis as Ongoing Processes of Negotiation. Ilma's Case from the Austro- Hungarian Monarchy*, serves as another important methodological example for my research. In her essay, Lafferton analyses a case study of a hysteric woman. The study analyses the relationship between doctor and patient and the way how the discursive space of psychotherapy modifies both participants' subjectivity. The case highlights the importance of that communicative space of analysis that can provide the possibility of action both for the patients and the doctors. The present research also emphasizes the importance of this potential of the therapy.

To define the notion of agency in the particular issue of anorexia, I lean on Judith Butler's works, mainly on the *Gender Trouble* and *The Psychic Life of Power: Theories in Subjection*. (1990; 1997) These studies emphasize that the subject itself is the outcome of the

current power relations, therefore, all action is embedded in this web of relations. Subjectivity maintains its continuity through the everyday reiterations of the norms. These are those performative acts that make the individuality. Therefore, our actions are domesticated to power, however, according to Butler, the agency could be possible through the variation of the culturally recognized reiterations of the norm. This alternative performative practice makes the subject's agency possible, but only if it is recognizable for the power in some way. (1990) When I apply the notion of the agency to the issue of the anorexia, I follow these Butlerian insights, because I think that anorectic practices consist of the alternative variation of the socially respectable norms.

1. The Subordinations of the Anorectic Subject

1.1 *Anorectic Subjectification*

In the first month of my research, I made a participant observation in a group therapy. The group came together on every Monday afternoon for 12 weeks in the Institution of Behaviour Science in Budapest. The group had two leaders: a young Ph.D. student, and a professor, who was the expert of bioethics. As an observer, I had to introduce myself and explain to the group why was there, then the members had to give their consent to my presence. All of them agreed to it. When the therapy started I noticed that the professor constantly stared at me, therefore, I was not surprised when he stepped up to me at the end of the session. ‘If I properly understand, you do a research right there’ he said. ‘Well, you have to know that you are not allowed to publish your findings without the permission of our ethical committee. Please, make an official request for the permission and if you need any help, just ask me, I am the member of the committee.’

When I went home, I started eagerly reading the regulation of this ethical committee, but I got lost among the regulations, as 90% of them concerned experiments on people, such as medicine tests. The regulations also informed me that the committee meets every second month and it has a two-month process to make decisions. The next session took place at the end of the following month, but I did not have that much time, I had to finish my research in two months. Therefore, I made an appointment with the expert of bioethics. I explained to him that I am under a time pressure, but he was not too helpful and he did not give me any concession while he constantly repeated that I could not use my data retroactively. I also explained that I do interviews only with people who were receiving medical treatment, but now were over it, exactly because I would like to avoid ethical problems. He started to shake his head with

disapproval. 'You know, it does not matter that somebody is receiving treatment in the present or in the past, you also have to get our ethical permission.'

I was surprised, so I could not resist asking why. 'These people are adults. Yes, they were under psychiatric treatment, but decades ago and they gave me their written consent to work with them. Since then they have made a family, they also have to pay taxes, and they can vote. Aren't they full right citizens who can make their own decision about what they would like to speak about and to whom?' 'Well, the thing is,' he said, 'you can influence those people much easier than others.' However, I argued that my research makes an attempt to avoid those direct questions that could possibly harm their interviewees he replied: 'That is exactly why you need our committee because we can help you to formulate your questions in a proper way.' I could not pretend sympathy anymore and politely but quickly left his office. Later that day I wrote to another member of the committee about my issue. After a few days, I got an answer. Surprisingly, it turned out that I could make the process of the request faster. Moreover, I could use the data retroactively.

1.1.1 Diagnosis in the Past, Restrictions in the Present

According to the *Universal Declaration of Human Rights*, the right to speech is one of the inalienable human rights of all the countries of the United Nations. (The United Nations art. 19) Therefore, it might seem paradoxical that the country's local Medical and Scientific Committee can override this in the case of the limitation of the rights of adult ex-patients. In this section, therefore, I would like to point out that the contradiction between the medical and juridical discourse is an illusion, as both of them are displays of the power structure of the present.

Michel Foucault in the first volume of the *History of Sexuality* reports, that the very new development of the Enlightenment is that deeds are not mere acts anymore but the markers of

the subject as a whole.¹ (31) The totalization of particular deeds for the entire subjectivity enables both the medical and the juridical discourse to restrict the subject's rights. According to this, the medical and the legal discourse have already connected to each other in the web of state apparatuses, where these discourses are means for maintaining the social norm. They support and confirm each other in the process of subject production, therefore, they have the power to give and restrict rights in the name of the preservation of the culturally recognized borders of the norm.

The same dynamism plays out in Hungary. If somebody was a medical patient once, he or she remains a medical patient forever. If not in medical, then in legal terms as we see in the restriction of their right to speech by the Ethical Committee.² In other words, a medical patient became an eternally ill subject. The medicalization process, whenever it happened in the subjects' personal history, influences the person's whole life. The juridical discourse gifts the psychiatric state apparatus with rights for the penetration into the private sphere of the patients whenever it wants, as these people could mean potential danger to the social body. Therefore, the past medical status keeps its stamp on the subject forever, such as the stamp of a crime. (Foucault et al. 2003: 6)³

The diagnosis, thus, interconnects the person's past circumstances and future possibilities in a never passing moment and keeps the medicalized subjectivity coherent. (Jain

¹ Foucault tells a story from 1867 about a "simple-minded" village boy as an example. This boy used to play sexual games with the girls of the village. However, from a certain historical moment, his act was not a game anymore but a crime. The parents of one girl turned to the jurisdiction to punish the boy for his illicit activity. As Foucault expresses, the 'inconsequential bucolic pleasure' turned into the object of the collective intolerance, judicial action, medical intervention, and careful clinical examination. (Foucault 1998: 31)

² These apparatuses create the web of institutions, and in this web, psychiatry is a discursive space that responsible for the knowledge production on the human psyche. (Foucault 2008) Only this institution has the legal right to define who, why and how can access to this knowledge and who has the right to speak inside the psychiatric discourse. (Foucault 1981) In this sense, the professor as the member of the Ethical Committee is a gatekeeper of this discursive space and his duty is the protection and reinforcement of the borders of scientific discourse. Therefore, the restriction played a symbolic role to make me transparent the territory of psychiatry, maintains its hierarchical order, and reproduces its rules through their reiteration.

³ The pathological behaviour in this process can be traced back in the person's childhood, habits, lifestyle. Consequently, abnormality had to exist in the past and it can possibly come up at any time in the future. The established abnormality, after the diagnosis, became an essential component of the patient's entire subjectivity.

2007) The example of the Hungarian Ethical Committee shows that this psychiatric discourse could not imagine the possibility of the change of a patient, as the diagnosis made illness to the essence of those people. By this medical gaze, the subject becomes his or her own disease. The diagnosis, therefore, serves as a tool to fix abnormality in bodies and justify overall surveillance in the name of protection. The essentialization of the abnormality by the scientific discourse restricts the subject's agency and takes away their seemingly unalienable human rights.⁴

The guilt of the anorectic is the failure in the process of self-development. Medical handbooks, like the ICD-10 or DSM-5, emphasize that anorexia nervosa is the disease of young middle-class girls who at a certain point of their maturation start to refuse nourishment and they seemingly choose the slow death of their biological body. (ICD-10 2010; DSM-5 2013; Túry 2002) One of the most medically important effects of self-starvation is the disappearance of the capacity for fertility.⁵ Therefore, the body of an anorectic is inappropriate to accomplish the biological necessity of childbearing. (Shomento, Kreipe 1994; Túry 2004; 2002) From the perspective of the society, the regression of the anorectic is not merely a personal problem, but the obstruction of the continuity of the population, inasmuch as the anorectic voluntarily refuses the re-production of life.

The anorectic became dangerous and guilty, because she could not bear responsibility for their own life and for the life of the community, as well. Consequentially, they could not live in accordance with the natural law of self-preservation and the cultural norms of the society. These irregular bodies do not deserve the symbolic privileges of the social that goes hand in hand with full legal citizenship. Oppositely, they deserve to be disciplined and restricted,

⁴ Foucault, in his lecture series, *The Abnormal*, discuss the process how juridical and medical discourses had gradually intertwined each other in the jurisdiction from the 17th century. (Foucault 1975) Medicine and law produce knowledge about human beings and define the norms of the social reality. Foucault, therefore, calls them the 'discourses of the truth' because they have the right to qualify people thus modify their status inside the social hierarchy. These institutions have the right to make decisions about life and death just as the king had in earlier power constellations in the Western history. But while the decision of the king executed the corporeal body of the condemned, juridical and medical decisions executes the person's legal body in the society. (Foucault 2003)

⁵ The drastic loss of weight has an endocrine-disrupting effect that causes amenorrhea, the absence of menstrual period that in the worst case would lead to infertility. (Shomento, Kreipe 1994)

although it can only happen in the name of protection, because modern and democratic states cannot criminalize ill people explicitly, but diagnose and treat them in psychiatric institutions. According to Foucault, criminalization and medicalization structurally works and modifies the subject's position in a nearly same way, the only difference is those means that they are applied. (Foucault 2003) This is how protection can justify the restriction of human rights. (Butler 2008)

1.1.2. Forced treatment

The forced treatment is a common place of the juridical and medical discourse. All of my interviewees were sentenced to forced treatment, officially because they had got into a life-threatening state. According to the law on forced treatment, a person can be forced to undertake a psychiatric treatment without consent if he or she has 'dangerous behaviour.'⁶

In the case of anorexia, forced treatment is extremely frequent, because most anorectic are very smart and hide their problems, until they get into life-threatening physical condition. Anorectics are mostly aware of their anorectic behaviour, but they do not ask for help because they are afraid to get fatter by the lifesaving treatment. (Túry 2002) This is the paradox of anorexia: they can comprehend their state, but they do not perceive it as a problem. As one of my interviewees told me:

'When I started not to eat it wasn't conscious for the first time. But there was a memorable moment when I noticed that my collarbone sticks out. I stood in the bathroom, watched it. It was fascinating and attractive.'

A psychiatrist told me that in many cases anorectics do not want to ask for medical help because they regard their fasting habit as a lifestyle.⁷ But 'the longer prognosis is the greater risk of mortality,' as he said. A person who interiorized anorectic habits can live under constant self-starvation for decades, but because of the physical consequences of the malnutrition, the

⁶ It means the risk of someone being harmful to oneself or to others. (CLIV Law on the Health Care 1997) In the Hungarian Healthcare system, according to the statistics, the practice of forced treatment is very frequent. (TASZ 2002)

⁷ There are specific anorectic communities on the internet, where the members can give advises to each other to be successful in their anorectic behaviours. These are the so-called 'pro-ana' websites, where the members constantly articulated that their anorectic practices stand for a specific lifestyle. (Norris et al. 2006)

risk of the death is constantly growing. Therefore, the environment of the anorectic could realize the problem only when it is manifested obviously in the form of the drastic loss of weight. By this time, lifesaving interventions became inevitable.

Anorectics with serious weight loss usually sectioned to the Vadaskert child psychiatric institution in Budapest.⁸ This institution is one of the few in Hungary that has a separated department for children with eating disorders. One of my interviewees explained some anorectic practices that she and her anorectic mates used to do in the psychiatric institution:

'There are many practices to hide that you don't eat. I had never eaten at school, but at the end of the day, I could tell my mom in detail what was my meal. [...] In the hospital, we got forced feeding and they measured us in every morning. We knew that we can get home only if we gain weight, but most of us didn't want to get fat. Therefore, many of the girls drank usually 2-3liter water before the weighing...therefore, the scale showed more than they were in fact...sometimes they drank from the tank of the toilet to keep it in secret... I knew many girls who secretly ran up and down on the stairs after the weighing, because they still wanted to lose weight. Another girl told me that she ran every day for hours round and round in her little room of the estate where she lived to do exercises without the knowing of her parents. I had never heard about these 'techniques' before I get to the hospital. But that's what happens if anorectic girls have to live together in a shared room. We learn the practices from each other.'

If the family can realize the anorectic behaviour, they could send their child to forced treatment without the child's concern.⁹ I believe that there is a structural similarity between forced treatment and criminalization. E, another interviewee of mine, made a three-week long forced therapy in Vadaskert. She described to me her daily routine in the psychiatric institution in detailed:

'I was 17, legally a child, so my mother's consent was enough to get into the hospital. She arranged it behind my back a week before while I hadn't suspected anything. When my mother and my psychiatrist forced me to stay I felt anger and betrayed by them. I cried and shouted. So there was no choice. I had to attend in this three-week long program for anorectic children.

The nurses forced us to eat six times a day. If we refused the food, we had to stay on our chair till we finished the dish. We also had to consume shakes... Since then I cannot eat bananas... It was not allowed to go out so we had to lay on our beds between the meals. The nurses measured us every day. I had to take off my clothes and stand on the digital scale almost naked, but I wasn't allowed to look at it. They only told me that if I was good or bad. It was very humiliating. Everybody in the program had her own drawn "staircase" and if we gained weight we could step higher and got a prize.

During the first week, we couldn't have contact with our family. The first prize was a phone call. Of course, the biggest prize was at the end of the treatment: they let us go home. There was no communicate therapy with any doctors but they prescribed antidepressants for us. They weren't too strong, but one of my

⁸ Besides the allocated department for anorectics, the institution also has departments for kids with various problems: hyperactivity syndrome, behavioural deviation, attention deficit, or drug addiction.

⁹ This is the reason why most of my interviewees attended in forced medical treatment when they were under 18, because this is the age limit of adulthood in Hungary. Below that age, parents have the right of decision making instead of their children.

roommates was given medicine that is used for schizophrenic people. I didn't understand why I had to take them. They told us that it is needed to break the wall between me and the doctors to get to my real problem, but I think, as a matter of fact, in Vadaskert the point was only to gain weight.'

E's experiences show that the main point of the forced therapy is the preservation of the biological body and the normalization of the everyday habits of the anorexic girls. The doctors reached it by the system of rewards and punishment and other seemingly non-violent means, such as confinement, medication, or forced feeding (including the use of a stomach tube). Consequentially, in the case of the forced treatment of the anorexia in Hungary, we should experience the structural similarity between the penal and medical system, that causes an implicit criminalization of the underage patients.

1.1.3. Biopower

To understand the medical practice that criminalizes and protect the anorectic at the same time, we have to understand the underlying power structure of the modernity that calls forth these dynamics. This form of control is the so-called Biopower. The main characteristic of this power structure is the centralization of the production of life. (Foucault 1998; 2003; 2008) While earlier regimes maintained their dominance over people through the menace of the death penalty, modern Biopower operates through the discipline and organization of life. Consequently, in the regime of Biopower, life has the highest value. This is the reason why the biological body, the population, and the productivity has come into focus at least from the last century. 'The subjugation of bodies and the control of population is the core of the Biopower.' (1998: 184)

Modern biopower uses their apparatuses in order to the maximization of the human body and its capacities to optimize the growth of its usefulness. Institutions, such as schools, hospitals or the army, exercises control over the performances of the body and surveillance, discipline, economic control, demography or life expectancy as regulatory technologies to achieve the demanded docility from the bodies. (1977)

1.1.4. The Criminalization of the anorectic – The case of L

One of my interviewees, L, was sectioned to a psychiatric unit in the early 2000s when she was 16. She had been abused by her father for 12 years. L led a double life from her very early ages. She was an abused child who hid under the mask of a girl who can manage her everyday life properly. During her first relationship she could not hide behind the mask anymore, the assaults had transparent signs on her body that her boyfriend noticed. She made a police complain against her father. The Hungarian law had no instrument to imprison the abusive father if there is no flagrant delict, however, because of the confession, L had to come out behind her self-defensive mechanisms. Her life collapsed from one moment to another. She started to suffer from posttraumatic stress disorder, then she could not eat or drink anymore. It was clear that she needed professional help and Vadaskert was the only institution where she could get proper hospital service with her dangerously low weight.

When I arrived the chief medic sent me to a group therapy for drug addicts. The group leader was a young resident. We were freaking him out in a short time. I said I hate this place and I do not want to go back anymore. Therefore, they sent me to the department for children with eating disorder. I was not a classic anorectic, I had PTSD with anorectic episodes, but I never wanted to be skinny, I just cannot eat, but they didn't care about it. Nothing happened. We had to paint every day, and sometimes young medical students filled up questioners with us. 'Do you see Satan?' 'Do you feel a desire to torture small animals?' and questions like these. I was very bored. Most of the kids had the chance to go outside to the yard and do sports, but it was not allowed for anorectics. We couldn't go out, moreover, we couldn't move. We had to keep our gained weight, so we were forced to lie in our bed. Besides, there was no psychotherapy, only medication. I had to use Xanax. I spent three months there. It had no meaning. I mean, most of us became better physically, but mentally everything remains the same. That is the reason why most of my roommates had relapses. I think, the only reason for this manner of treatment is that after all, professionals can tell parents that their problem child is hopeless and the best thing that they can do is to put them into an asylum as soon as they became adults. So, if you do not cooperate, your life is over even before you turn 18. But they should consider that anorexia is not a decision, and we are not criminals, so they shouldn't deal with us like that!

The case of L highlights some important aspects of the biopolitical coalition of the medical and juridical discourse, especially in Hungary. One of the most important is the shift in who is being criminalized. However, L father was a child abuser, the Hungarian legal system cannot do anything with him, therefore, the criminalization shifted from the father to the abused child. In the name of protection, the medical and juridical system put her into an asylum where she had no right to express her own problem and where her freedom was literally limited.

Instead of paying attention for the child needs and care about her psyche the psychiatric treatment focused only on her biological symptoms. During the three months of her therapy, the medical apparatus disciplined L's body for self-preservation while they left out of consideration the reason why she denied the food and her life too.

According to the logic of the treatment, the core problem was not the abusive father, but the girl who endangers her own life by self-starvation. If she cannot cooperate with the normalizing process of the psychiatry, she might become as abnormal and dangerous for the society as an abusive father would be. Therefore, this therapy was not about the protection of the child, but the protection of the society from her possible deviance. Every personal problem, fears, and desires were L's private matter. And if she could not cooperate with the normalization process of the psychiatric institute, she, or any inhabitants, reserved the deprivation of freedom and the exclusion from society.

For the present Biopolitical power structure, the preservation of life is its most important aim. However, in this establishment, individual life has ordered under the higher goals of the life of the population. In this context, the main aim of the female body is the reproduction of the life of the society. But the anorectic subject is incapable of fulfilling this requirement, because her disease causes infertility. Thus, the anorectic subject is not only ill, but guilty, because her abnormal behavior endangers the life of the population. Therefore, anorexia counts as a medical and a legal issue at the same time in the present constellation of Biopolitics.

1.2 The Discipline of the Re-Production

1.2.1 Expectations Towards Femeness

To understand the medical attitude towards the anorectic we have to take into account the gendered meaning of the disease that is developed in accordance with the reproductive necessity of the female body in the present power structure. The economic background of the Biopolitical power structure is capitalism. By this economic improvement, the production of

life goes hand in hand with the reproduction of economic value. (Foucault 2008) In this political juxtaposition of biology, usefulness, production and reproduction, the female body had its specific destination: the reproduction of human beings, the population, the species, and after all, life itself. (Mosse 1982: 18)

The female body is a reproductive body in the first place through its biological destination. Consequentially, the ultimate target of the woman in the biopolitical establishment is childbearing. Because of this biological burden, the female body is subordinated to the higher goals of humankind. Those disciplines that concern to the femaleness, refer to the maximization of the reproduction too.

Foucault uses the example of the hysterization of women to discuss the political techniques of the regulation of the female body. (Foucault 1998) Psychiatry, as a medical state apparatus, disciplines irregular female behaviour through the medicalization of their body and sexuality. The figure of the hysteric symbolizes a woman who denies her socially determined female roles, a woman who cannot accept her prescribed position and the duty of reproduction. Therefore, they deserve discipline and psychiatry have the power to this discipline, but it happens in the name of the health of the subject and its potential children, the solidarity of the institution of the family, and the safeguarding of the society. (1998: 153) The intervention of the life of the hysteric was grounded by the protection of the fictive future population.

The figure of the hysteric and the anorexic women are very similar. They are women who failed in their female role, because they cannot function in accordance with the norm of reproduction. Therefore, these women are disrespectful to their symbolic and biological body. Interestingly, while anorexia counts as a mental disease, its main diagnostic criteria refer to biological symptoms. This fact serves as a fine representation of how the psychiatric discourse of biopolitics centralized around the biological existence of the human being. These biological factors dominate not only the recognition of the illness, but the official medical treatment too,

which chiefly concentrates on the patient's bodily functions, at least in Hungary, as we have seen in the case of E.

The Hungarian medical system uses drastic means to the regulation of these irregular female bodies. We can regard these means as the violation of the patient's body and psyche. However, according to the modern reading of the Hippocratic Oath, the protection of life is the most important function of the medical profession. (1996) From this scientific point of view, these violent acts are completely justifiable. As the head of the Institution of Behavioural Science told me: 'It is not that easy to let someone die. We don't want to see this. Maybe it is a social consensus, rooted in Christianity. It is the question of value. We have this responsibility for this kind of people.'

1.2.2. Disciplinary institutions – The case of B

In the light of the Foucauldian theory and my interviews, I regard the Hungarian child psychiatry as the intersection of psychiatry, pedagogy, and prison. These institutions, in contrast to the earlier penal systems, do not simply isolate abnormal people from the rest of the society, but discipline and normalize them into docile bodies who can reintegrate to it. (Foucault 1977)

Discipline creates subjects in accordance with the culture's actual ethical, economic, medical, and political requirements. The new institutional processes did not apply directly violent acts to punish people, such as in the case of torture, but use examination, grading, registration, and compartmentalization. These processes still influence and modify the person, not just its corporeality, but its subjectivity too. The person has to incorporate those means above, because these processes initiated its subjectivity, therefore the person will act and perform its subjectivity through the implicit measures of the norm.¹⁰

¹⁰ In modern disciplinary power, the subjects behave and accomplishments are measured by the binary system of reward and punishment which system is also appropriate for the division and the hierarchization of the members of an actual group. From the perspective of the power, the creation of docile and productive bodies is more useful than the liquidation of those people who break the rules. Under the modern biopolitical regime death cannot be the part of the political techniques, because it marks the limitations of the power structure that can only operates with vital bodies.

Discipline 'makes' individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise. It is not a triumphant power...it is a modest, suspicious power, which functions as a calculated, but permanent economy. (1977: 170)

The case of B shows how the disciplinary practices of the psychiatric power can modify one's subjectivity. B was 13 when she started anorectic practices. She was depressed before she fell into anorexia, then, she started dieting, but after a while, she could not stop it. Her parents pushed her to attend psychotherapy, but it was not successful, till she lost so much weight that an ambulance had to take her to Vadaskert.

I haven't got a good impression on Vadaskert. Overall, I spent one year in it and it had no effect on me, except that the treatment traumatized me for a life. I was only 13 or 14. I was locked up in the hospital and I had to eat, and if I didn't, it was followed by sanctions. Despite this, they did nothing, just stuffed us. I was completely locked away from my family as well. It was not allowed for them to visit me, because visitation was a prize, but only if you gained weight. And I didn't follow their rules, for example, I usually circumvented the meals. Therefore, I had several relapses. But I think their method was also bad.

The nurses and doctors never dealt with our problems, there was no therapy, only eating, eating, and eating... I guess I talked with my doctor only twice during the whole year that I spent in Vadaskert. So, I had never an occasion to share my real problem with anybody, which I think was depression, not anorexia. I felt desire for death, but nobody helped me in the hospital, and I was separated from my family too. I felt lonely like I was surrounded by walls. That's why I tried to commit suicide several times. So, my condition didn't change, thus, after a year, my parents took me to another psychiatric unit. I had to spend my first few days in the locked ward for adults, because the hospital had no space in the regular psychiatric department. Then, my new doctor threatened me: if I won't start eating, I'll get the stomach tube. But I still didn't eat. So, I got the tube and I got sick immediately. I vomited constantly, therefore, they had to take it out. It was shocking, and I started eating, but only because I feared to get the tube back. This issue changed my attitude.

B's story shows how confinement, restriction, and violence against the body become medically justified disciplinary tools in psychiatry. The patients of the child psychiatry were not allowed to speak, with their parents, or with their doctors about their own problems and opinions. Their time was strictly scheduled by the meals and they literally could not move in the name of the protection of their life. As the professor of the Institution of Behaviour Science told me: 'the most important thing is to teach those girls responsibility. Responsibility for their own body.' In order to reach this purpose, the treatment has right to intrude into the patient's private life by confinement, to their body by the stomach tube, and to their nervous system by tranquilizers. My interviewees, such as B, had no choice, they had to acquire a new, 'normal' lifestyle or their body would become the object of more and more disciplinary processes.

1.2.3 Anorexia as the Refusal of Reproduction

As reproduction is central to biopolitics, it is also the key to understanding the status of the anorectic in the web of power relations. One possible reading of the phenomenon of the anorexia is that this disease serves as a personal reaction to the high expectation towards the female body. The capitalist expectations for production and consumption and the political assumptions for the re-production of the nation put increased pressure on women. (Deleuze 1987; Bordo 1990) However, through starvation, the anorectic could escape from these socially prescribed duties.

Because of the desire of flight away from normative expectations through bodily practices, in the body of the anorectic crime and abnormality comes together. Thus, self-starvation cannot be a private matter in a system which sees life and its productive capacities as the highest value. Therefore, the ruling power discipline and normalize the rebel female bodies, not because of the alleviation of their personal suffering, but because of the preservation of the life of the future generation, as we see in the example of the Hungarian treatment.

The personal causes why a little girl does not want to care about her body is out of the question. It cannot be a question in a culture where life is a value without any doubt. Her personal problem became subverted to the higher goals of the survival of the society. Discipline is indispensable, even if it is humiliating or violent because the protection of life easily can justify anything, however, it is not clear whose life is at stake. In the name of the common good, any intervention can be justified, even if it restricts personal rights and freedom.

The attitude towards the anorectic productive capacity highlights the fact that a female subject gets legal status and affirmation only if she functions in order to the normative expectations of the culture. But anorectics do not merit recognition, because, through denying nourishment they deny the reproduction of the society. Hence, the anorectic constantly commits a crime against the population. This is that makes anorexia abnormal.

1.2.4 Female Roles in the Psychiatric Discourse

L told me that after Vadaskert she had attended a personal therapy for four years when her psychiatrist, an older man, told her that he had done all that he can and now it was time to find someone who could help L to 'become a woman again.' When I asked her why did the doctor thought that she was not feminine enough she answered: 'Well, I had short hair, and I wore loose clothes.'

Her past anorectic episodes and her appearance served with enough evidence to her doctor to send her to someone else because he supposed that L failed proper femaleness. It means that being a respectable woman is not only about productivity, but also about those symbolic meanings that our culture associates to proper femaleness. Therefore, L had to go to a woman psychiatrist. After her body became suitable for the female role again, she had to pass in proper femaleness of the culture too. But this project of feminization was not too successful, and after a few weeks, L left her new therapist. While she worked on her personal problems with her previous psychiatrist the therapy went successfully, however, when the new therapist wanted to modify her subjectivity in accordance to the cultural ideal of normal femaleness, the process did not work anymore. L has never started therapy again.

I perceived the intentions of the therapist of L as a very interesting twist. The common opinion on anorexia is that this disease is deeply entangled with the obsession and exaggeration of the female ideal of the Western modernity. However, not only women's magazines state that the unnaturally skinny bodies of the fashion industry responsible for the growing number of eating disorders, but the early medical opinions on them too. When Garner and Garfinkel, Canadian psychiatrists, invented the Eating Attitude Test (EAT) at the 80's, they traced back anorexia to the thin body ideal: 'Despite the possible biasing effects of referral and exposure factors, there is growing evidence that anorexia nervosa is increasing in frequency. This

apparent increase in the disorders has been paralleled by our culture's aesthetic preference for thinness in women.' (1980: 647)

However, their diagnosis born 36 years ago, according to the public opinion, the high-expectation of the perfect beauty towards women counts as the main reason for the disease up to this day. One of the most popular Hungarian magazines for women, the *Nők Lapja* [Magazine for Women], in 2009 writes about anorexia in the same manner: 'The pencil thin beauty ideal dictated by celebrities and the media highly influences adolescent girls' self-assessment and eating habits.' [...] 'Nowadays, more and more common the eating disorder among young people, maybe because of the contemporary ideal of beauty.' (Nők Lapja 2009)

The paradox is that while the medical and everyday discourses agree that one of the main causes of anorexia is the over-idealized ideal type of the women, the therapist of L sent her, the ex-anorectic and abused woman, to a professional psychiatrist to help her to learn how she has to act like the normative ideal of femininity.

This attitude shows that the psychiatric treatment is an education process too, a tool for the re-socialization of the subjects, and for the reproduction of normative ideals, such as proper, heteronormative gender roles. The medical message is clear: a docile body is a normal body and a docile female body is a feminine body. Unfortunately, L's treatment was not about support and encouragement her for build a livable life by her own desires, but it was a disciplinary way to repair her failed womanhood. The new therapist of L also reinforces this assumption on her website where she writes the followings about anorexia: 'In the background of anorexia we can recognize the disorder of femaleness and the problems of the self-esteem, which can be coupled with a high degree of aggression, which turns against the own body of the anorectic.' (Tari 2016)

These diffuse opinions about the ideal femaleness make an aporia: if a woman would like to be respectable she has to follow the normative ideal of femaleness, but only in a decent

manner. Be feminine, but not too feminine. Although the medical and media discourse regarding femaleness as something of a natural characteristic, the way of its expression can be good or bad, this means that being a woman depends on personal responsibility. In the light of this aporia, the therapist's personal opinion about normality must be crucial in the medical process.

I had an interview with a young psychologist who makes an attempt to build the insights of social science and feminism into her praxis, because I was interested in her opinion about the effect of the therapist subjectivity to the therapeutic process. She explained that through the training of the analysts, they have to exercise a very conscious self-reflection, to avoid pushing their own opinion onto the patient. Because of this high-level of reflexivity, psychoanalysis perceives itself an objective scientific field. However, the educational process does not deal with the therapists' personal beliefs.

This is peculiar of the scientific field, which aim is to speak about what a cheerful and healthy life. Everybody has his or her own concepts and personal values. There are Christian therapists, Jewish therapists, and so on... They have their own beliefs about joyful life. The mainstream psychology appears as a neutral scientific field, but nobody reflects on how the personal value system affects the patient. The way how each and every therapist speaks about gender roles or capitalism seems natural for them, however, these unreflected beliefs easily can become distorting factors.'

She brought forward the example of Emőke Bagdi, Hungarian psychologist. She is a very influential and popular figure in the public life of Hungarian, because she has recently published psychological books for common people and articles in magazines for women. In her book from 2013 she writes about gender roles in the following terms: 'When I speak about femaleness and maleness, I speak about principles too [...] What is the most important task of a woman, that her organs are prepared for? [...] As Carl Gustav Jung, the Swiss psychiatrist revealed, embracing and having babies. The fulfillment of the female gender is the motherhood.' (2013: 139)

Therefore, when I asked my interviewee about what is the mainstream normative expectation forward the patients in the therapeutic process, she ironically noted: 'Well, there is

no clear direction in the system of values in the Hungarian psychiatric process, but if an ambitious woman goes to a therapist such Emőke Bagdi, the doctor presumably will rate this woman's ambitions incorrect, and will shepherd her towards more traditional female roles.'

The culturally determined expectations towards the ideal femaleness, that is developed in accordance to the Biopolitical aims of the reproduction of life, extremely influences the medical description and the treatment of anorexia. According to this, the goal of the treatment is not the solution of the patient's personal problem, but the stabilization of her productive capacities. Therefore, the treatment focus on serves as a disciplinary mean to the regulation of the failed femaleness of the anorectic

3. Nation and family

The anorectic became medicalized and criminalized as she could not fulfill the socially required female roles. The importance of the reproduction expands the topic of the anorexia to the direction of the modern nationalistic discourses. This ideology in accordance with the aims of biopolitics sees the maintenance of the population as its most important goal. This aim strongly influences the subject position of the anorectic woman in the social hierarchy. According to this nationalistic discourse, the anorectic denies the reproduction of the human kind by her life-threatening practices, therefore, she casts away herself from the realm of respectability in the social sense.

According to the nationalistic discourse, the anorectic's refusal of the traditional female roles is not only the subject's responsibility, but also the responsibility of the family, as the genesis of the subject-formation and the abnormal behaviour. Therefore, this section analyses the anorectic positionality from macro-politics referring to the nation and to the race, micro-politics referring to the family, and their consequential gender roles in the Western modernity.

3.1 Macro-politics of Demography – Micro-politics of the Middle-Class

For the understanding of the macro-political embeddedness of anorexia in the Western Biopolitical power structure, we have to take a look at the concept of population and the nation. As Attila Melegh explains, the process of the census emerged in Europe in the 18th century, with the growth of the mass population. (2006: 50)¹¹ The science of demography, coincided and effected a genetic revolution. Since the birth of the demographic discourse, through healthcare, population policies, statistics, birth and death rates, population and life became the measurable and manageable object of knowledge. Therefore, in the biopolitical power structure, life itself transformed into the object of governance. (Foucault: 2003; Melegh 2006) The ultimate political purpose was the control of both the masses of bodies and the individuals for the stabilization of the security of the society. The security of the society implicitly described which life is worth to have state support for and which can be neglected, or let die. (2006: 53)

According to George Mosse, the 18th century was the triumph of the middle-class. (1982: 2) This social group became the measurement of proper life, because it served as the basis of the well-functioning state and economic progress. Therefore, it quickly became the most respectable way of life. In modern states, this micro-political unity guaranteed the continuum of the nation. The organization of people effected a new kind of biopolitical racism.¹²

As Melegh and Mosse explains, those groups that were outside the desired society, such as lower-classes and emigrants, embodied the new biopolitical fear of the bourgeoisie. (Melegh 2006: 53) Their cheap labour could reduce the wages that could endanger the welfare of the

¹¹ The census effected a very new discourse which focused on the number of men who can be available for conscription in the case of war. However, the new discursive space called forth a set of practices on the population too: age structure, mortality rate, life expectancy, fertility, etc. (52)

¹² Other groups outside the normative ideal type of the nuclear family, such as lower-classes, poor people, and immigrants, counted uncontrollable and useless, therefore, inappropriate for the reproduction of the nation and its norms. The aim of demographic discipline of the society was not only about the propagation of the growth of the middle-class, but the restriction of the gradually expanding fertility of the 'unworthy' propertyless classes. (Melegh 2006)

middle-class. This fear was not only towards these abjected social groups, but their potential children too. The anxiety had the power to legitimize the control over their fertility. In this certain point of Western history, a social question got a biological basis in the image of the racial composition of the nation. The biopolitical governance in order to improve the quality of the content of the society, absorbed and sanctioned the life, but not only of the unworthy groups of people, but the bourgeoisie as well, in order to fix the moral codes and values of the society. Therefore, the middle-class become the measurement of social respectability. (55)

This new attitude towards the mass of people categorized the population in terms of valuable and unworthy bodies which effected an interventionist politics with a strong biopolitical frame. The distinction between normal and abnormal was the basis for respectability, control, and security. The nationalistic discourse started to apply a medical manner of speak, which translated ethical values and virtue into the language of the sickness and the health of the body. Uncontrollable and unrespectable life forms became sick by this language, therefore, they meant threat for the future of the nation and danger to the security of the society.

1.3.2 Changes of the Gender Roles

State apparatuses were responsible for the new definition of the sexes and their places in the society too. The concept of the nation calls forth new gender roles and the new form of the sexual division of labour. The micro-politics of the family as an institution mirrored the patriarchal order of the society and functioned as the policemen of sexuality. (Mosse 1982: 19) The man as the breadwinner was the head of this unity while the duty of the women was the reproduction of the nation and the protection of the home, the 'warm nest' of the next

generation. The female body had central importance to give the continuity of the nation, therefore, women became the symbol of the nation and the guardian of the traditional order.¹³

Consequently, the family became the basis of the national spirit and the future of the population. Melegh calls this development ‘family-planning industry.’ (2006: 64) This campaign for the nuclear family created a mixture of modernization and racist-interventionist discourse. It effected overall control over fertility, the reduction of larger families, and those social groups who counted abjected for the ideal society, in order to improve the quality of life and after all, the quality of the population.

1.3.3. Anorexia as Abnormal Femaleness

Racist and classist discourse are played central role in the diagnosis of anorexia too.

According to the Hungarian version of the DSM-5:

[E]ating disorders are representatively the disease of young girls. [...] The prevalence of eating disorders in the developed Western states among young adult women (between age 18 and 35) is 1 to 4%. [...] Eating disorders the disease of the higher and middle-class, however, in the last few years, it proliferates to the lower classes too. [...] There are transcultural differences too: among white people it is more recent than black people. [sic!] In developing countries, the disorder is very rare [...] (Túry 2004: 439)

Most of the professionals who gave me an interview confirmed this statement. A psychiatrist told me:

There is no anorexia in Siberia, Asia, or in the Islamic environment. This is a disease of the West, and from this point of view, Hungary is a part of the West. Because of the globalized cultural ideals, the boundaries between the East and the West are blurred. Anorexia is a civilizational maleficence. Where starvation is dominant, for example in sub-Saharan Africa, nobody can manipulate by denying food. As we used to say: if you want to create an anorectic get a teenage girl, whose got problems in her family and who has high or middle-class background. Because there is no anorexia among gypsies. I had 1200 patients during 3 decades and there were only 3 gypsies among them.

The professional experiences of the psychiatrist reinforce the idea that anorexia is the disease of young middle-class girls, but these experiences and description do not go further than this

¹³ ‘That this function was, in fact, exercised on children is quite clear. The whole system of education both inside and outside the family had become geared to the teaching of virtue and the avoidance of vice, as so-called character-building and the inculcation of respectability, for the most part, took priority over book learning. The disciplinary function of the father seems central to the maintenance of hierarchy and order in the family and thus of respectability.’ (Mosse 1982: 19)

statement itself. The statistically higher percentage of white middle-class girls in the case of anorexia does not mean that this disease harms only that group of the society.¹⁴

Maybe the professor was right and there is something in anorexia, which made this disease an appropriate tool for young middle-class girls of the modern nuclear family to express their problems, but we could not dismiss the possibility that other classes and ethnic groups are concerned too. The description which states that lower classes or Roma people could not be anorectic does not count with the fact that these groups of the Hungarian population have limited access to the state financial healthcare, and there is a lack of organizations that can help to inform them about mental diseases and their treatment. Therefore, the statistics can be easily distorting and nowadays, there are no existing studies on the anorectic patterns for instance in the Roma society.

If anorexia correlates with reproduction, and the medical treatment focuses on the repair of the fertility, the abjected groups of the society are systematically driven out and excluded from the politics of medical treatment. This is a clear example for that biopolitical-racism that Melegh speaks about. As he emphasizes, nationalist politics supports the reproduction of those who can inherit national values, in this case, the young, middle-class women. (2006: 56) Consequently, the statistical data on the percentage of anorexia in the Hungarian society does not express the social distribution of the disease, but the group of people whose reproduction is desirable for the nation and the state, for the security of the future of the race.

¹⁴ Susan Bordo in her early works on anorexia in the late 80's also emphasized the class boundedness nature of the disease. From a Foucauldian perspective, she establishes that anorexia is deeply connected to capitalism and consumer society and its norms, therefore, the occurrence of the disease in other cultural settings is not as likely as in Western countries. (1990; 1993) Later, Bordo herself revised these ideas in her article from 2013. In this study Bordo highlights that while anorexia associated with 'white, heterosexual, North American, and economically secure' girls, (2013: 265) nobody picture Black, Asian, or Latina girls with the same problem. These social groups are harmed with anorexia as well, however, most of the clinical data came from the treatment of white girls, because they are the first ones who recognize it and seek for treatment. (265) Therefore, the cultural support and the financial situation of the subject is a more important factor behind the statistical data, than the mere fact of the representation of class and race.

1.3.4 The Failure of the Family - State Invention

The protection of the appropriate race justifies control over the most intimate details of the social life. (Melegh 2006:64) In the case of the anorectic subject, this protectionist state control has the right to intrude the principle unit of the society, the middle-class family. This disciplinary intervention has two consequences: the infantilization of the anorectic and the consequential shunt of the responsibility from the child to the family.

From a medical perspective, a child who struggles with anorexia is still in the process of psycho-cultural development. She refuses the social norms of womanhood, the traditional female roles and the reproduction which means childishness and the failure of the development of adulthood. Therefore, the anorectic could not capable of self-governance and could not deserve the rights of the adults. She necessarily falls back upon the protection of the state apparatuses, such as the psychiatry. But because for the medical gaze she is only a child, the responsibility incumbents on the family.

The head of the Institution of Behavioural Science referred to international medical discourses and emphasized me the importance of the family therapy in the treatment of the anorexia. This psychiatric attitude towards the family as a micro-unity, highlights how the responsibility from a person to its environment happens.

According to the international recommendation, family therapy is the core element of the treatment of teenager anorectics. The family is one of the most important factors in the subject's cultural orientation. I believe in family therapy too. Anorexia is very often a message to the family. It says that something is not functioning well within. There is something irregular in the way of their life. Therefore, in the treatment, the family has a key role. Some girls use anorexia to the retardation of their self-development, because they would like to remain kids. It might be because there is a tension between the parents and that is the way how the child tries to hold together the parent's relationship. Consequently, the conflict between the parents links to the child's self-development.

The failure of the anorectic is the failure of the family, which is one of the major cultural instruments for the reproduction of the norm, as Judith Butler formulates. (2008: 8) The teaching of cultural practices and gender norms is the main task of the parents. If a girl does not want to reproduce this family structure, her family has to malfunction too. The family is the representative of the nation, therefore, the parents of the anorectic fail as respectable citizens.

The state must step into the life of the family to take the place of the absent parents, protect the child, and regulate the family as a whole in order to construct the girl's female subjectivity instead of the parents. This interventionist politics reinforces the idea that the self-development and the emancipation to the society can be accomplished only through the acceptance of power and its apparatuses, as these are the safeguards of the nation. (Butler 2008: 19)

1.3.5 Family Therapy

In an average family therapy, both the child, and the parents have to be present. It means that not only the child needs medical discipline, but also their parents, who can have many potential conflicts, for example, divorce. Thus, the treatment medicalizes the whole family. The therapy has to resolve their conflicts and hold together the micro-unity of the family in the name of the protection of the child. To this end, the therapist has right, through the anorexic child, to judge the way the family lives and rate the quality of the parent's relationship. If it does not fit the cultural standard, the parents became guilty for the disease of their child. The message is clear: you can become a reliable parent only if you follow the norm. By a divorce or with an 'irregular' family model (for example a homosexual relationship) you endanger the health of

your child, you fail as a parent, and commit a crime against the nation because you cannot educate your child to its norms and values through parenting.

The head of the Institution of Behavioural Science emphasized in our discussion the importance of the extended family as a solution for anorexia, however, the family therapy deals only with the parents. It means that for the psychiatric discourse grandparents, siblings, schoolmates, and friends are irrelevant in the self-development of the individual. This psychiatric attitude, therefore, reinforces the idea of the nuclear family and its absolutism in the process of subjectification.

When E finished her three-week program at the child psychiatric unit, she started a personal psychotherapy. Her psychiatrist constantly forced family therapy, but E did not want this. Her parents got divorced years ago. Her dad was not the part of the family anymore in a practical sense, therefore, the micro-unit of her life consisted of her mother and her little sister:

My therapist wanted the family therapy, and invited my dad, but I didn't want it. My problem arose from my position in my family, but my dad was not the part of this family. It is easy to say to a one parent family that the divorce is the cause of everything. But in fact, it was about the three of us: my mother, my sister and me and not about dad, because he wasn't with us. I mean, my mother was a strong, independent woman, she never asked for help after the divorce, but actually, I had to bear many of her problems as the older child. I think my therapist overrate the role of my dad and she only concentrated on him...so, after a while I felt that she just wants to push her theory on me. Therefore, I finished the therapy.

In the case of E, the psychiatric method which targeted the family seemed inappropriate. The problem maybe not the method itself, but the ideal typical picture of the family that her therapist called into account. For the medical gaze, the family is equal to the father-mother-children triangle and the psychiatrist wanted to stage this triangle through the treatment. But for E, the family meant something else. Obviously, the father influenced her family structure, but not by his presence but by his lack. Therefore, the family for E was her mother and sister, but that meant nothing in the language of the therapy. The failure of her psychiatrist was that she does not want to realize E's reality, but she was required by E to adopt the ideal of the abstract family model of the psychiatry. It was a miscommunication between the subject and the representative of the medical discourse that resulted the left of the patient.

This section made an attempt to introduce the broader expectations towards the anorectic subject and its environment. The modern ideal of the nation consequences a sort of biopolitical racism. While the discourse over the population propagates the micro unity of the middle-class family that stands for the respectable way of life, those groups who are not desirable for the nation becomes marginalized. The protection of the race shapes the diagnostic criteria of the diseases and restricts the access of the marginalized social groups to proper healthcare, as we see in the case of anorexia. In the case of anorexia, the whole family become medicalized, in the name of protection, because they are failed in the inheritance of the cultural norms. This medical attitude highlights the social requirements towards the family and the fact that the therapy do not focus on the healing of the anorectic, but on its discipline in order to fulfil the ideal of respectability.

2. The Agency of the Anorectic Subject

In the previous three sections, I made an attempt to give a glimpse of those specific sets of suppressive practices and institutional regulations that concern to an anorectic under the Hungarian medical care. The normative life, regular citizenship, proper womanhood, reproductivity, and well-functioning family are just some of those decisive elements that the state or nation expects from a person who suffers from eating disorder. These examples hopefully may paint a clear picture of that specific biopolitical power formation that limits and circumscribe the anorectic's possibilities. After all, the question arises: Is there any chance for an anorectic to exercise her agency in this complicated web of submissions?

In this section, I would like to argue that anorectic practices itself have already performed a sort of agency, but in order to understand this agency, first, I would like to reveal three common fallacies on power. First is that power is not an external force which only represses, controls, and restricts the subject's free acts. Second, without power the subject does not exist, therefore its existence is not intact from power, thus, the subject's relation to the power is not necessarily negative and confrontative. Third, the agency is not an authentic and self-same decision of the subject which expresses its essence, thus, the acts of the subject are not independent from power.

In the next part, I make an attempt to reframe the power-subject-agency trio, by using Michel Foucault's insights on power and Judith Butler's ideas about the birth of subjectivity.

2.1 *Performativity and Agency*

2.1.1 Power

According to Foucault, power has dual functions. It is not only repressive but productive too. The repressive potential of the power exercises limitation, prohibition, regulation and control over people. However, through these repressive means, power also constructs certain

forms of subjectivity, social groups, and relations among them. That is how power shapes and designs a set of cultural and historical relations and practices that constitute the subject, its position, and its possible actions. Identities can come into life through these discursive practices of power. (Foucault 1982)¹⁵ The continuity of the subjects comes from the repetition of those regulations that the power requires in a certain cultural and historical setting: ‘All types of subjection are derived phenomena that they are merely the consequences of other economic and social processes.’ (1982: 782)

To conclude, power is the very condition of the existence of the subject. Considering this modality of power, its apparatuses that I have introduced in the last sections (such as family, medicine, or education) serves as the institutions for individualization. In the process of individualization, the subject internalizes norms. That is how modern power acts upon the actions of the subjects. Therefore, power is not only an external force, but a conductor of modes of the existence and actions of the subject.¹⁶ Thus, power is not only about repression and domination, but creation. There is nothing outside this power, because its complicated interactions constitute the reality of the subject and the social. Subjects maintains hierarchical power relations by their own acts.

2.1.2 Subjectification

The subject itself is the effect of power relations, therefore, it could not be intact from power as the person has to manifests it in the process of subjectification.¹⁷ Personal practices and performative acts constitute the continuity of the subject: the everyday reiteration of the culturally recognized norms is the way how the subject exist in the given power structure.

¹⁵ Regulatory practices produce social categories, such as the group of criminals, insane, or genders. (Foucault 1977)

¹⁶ Foucault calls the conductive works of the power governmentality. This governmentality has not only political meaning, but this is the way how its structure the field of actions through other actions. (Foucault 1982)

¹⁷ Incorporated power is the very condition of the subject as its identity is the effect of cultural laws. As Butler refers to Foucault: the postulation of identity as a culturally restricted principle of order and hierarchy, a regulatory fiction. (Butler 1997).

The subject can be recognizable for the power only through the proper performance of these norms.¹⁸ Judith Butler in her book, *The Psychic Life of Power*, describes the process of how the subject comes into life inside the power structure. She goes back to the original, Latin word for the subject which means ‘underlying.’ It reflects on the person’s subordinated position by a sovereign or a superior power.¹⁹ However, Butler assumes that if there is no subject before the act of the inaugurate subordination by the dominant power this subordination is the act of the subject too. The subject's existence hangs on this fundamental dependency on power, but the actual form of power also hangs on the acts of the subject.²⁰ For life, the subject has to repeat its founding subordinations in the holding of norms, reiteration of its discursive practices and rules. Thus, human beings transform themselves to subjects.

In sum, the subject is not a stable or pre-existing being. Power and its effects creates subjectivity, that means there is no subject before subordination that is independent from time, space, culture and society. These factors are the conditions of the acts of the subject, but these acts are also necessary to the maintenance of power. It is the model of the fundamental and mutual relationship between subject and power.

2.1.3 Agency

Paradoxically, the founding subordination makes possible the agency of the subject. Butler assumes that, because there is no original and authentic self before and outside the power,

¹⁸ These repetitive acts stabilize the person’s position inside the power structure. The process of subjectification carried out only through culturally intelligible practices and their repetition. (Butler 1990)

¹⁹ According to Butler, the condition of the 'subjectum' is a priori submission by the domination of another. In the Aristotelian sense, there is a core of the self, this is the subjectivity. On the one hand, that serves as the essence of the person, before its apprehensible and recognizable characteristics, the accidents. On the other hand, the accidents (such as shape or size) are apprehensible for the conscious, but these always change through time and space. The only fix and constant component of an existence are its core subjectivity, but it is not apprehensible without its accidents. This basis of the self, assures the continuity and authenticity of the human being and its deeds. However, this subjectivity necessary has to be subordinated to its accidents in order to manifest. Following the Aristotelian logic, power also has to be something external to the essential subjectivity, therefore, it has to underlying of its external and temporal forces.

²⁰ The subject has to passionately attach to his or her subordination because this act calls he/she into existence. For life, the subject has to come through a mandatory submission. It founded by the desire for life and survive. Butler references Spinoza, who claims that desire is always the desire to persist in one’s own being. However, the longing for existence makes the subject vulnerable to the power, that can easily exploit this desire for existence. In this sense, the subject has to desire the restrictive norms, because these assure its existence. (Butler 1997: 28)

the only thing that makes the subject is its actions. In other words, there is no doer, only deeds. As Butler expresses: Subjection consists precisely in this fundamental dependency on a discourse we never chose but that, paradoxically, initiates and sustains our agency. (Butler 1997: 2)

Every subjective act is always already domesticated by the power and the possibility for action is conditioned by its founding subordination. If one could not reproduce the norms in a right way, he or she can become the subject of further sanctions that can easily put the person on the margins of the society, as we already seen in the example of psychiatry. This is an ambivalence in the heart of the agency: any effort against subordination presupposes and reinvokes power. (12) How can the agency possible if there is no act independently of the culture and its norm, and if it is already embedded in the power structure?

Butler states that the way of agency is the modification of the subject's position through its repetitive actions. One could not change the very fact of subordination, but it can change the shape of subordination. The agency is located in the possibility of variation of the repetition of cultural norms. The new forms of variations can transform power relations within society. However, as I mentioned before, the possible failure of reiteration constantly threatens with exclusion from the society of normal, therefore the subject has to make its performative acts in order to be accountable for the dominant power structure. (Butler 1990)

If the power and the subjects constitutes each other, we have to regard performative acts as the form of communication. The precondition of a successful communication is the mutual understanding of the members of the conversation. For the correct understanding, the participants have to be reasonable for each other. Butler also emphasizes that the variation of the reiteration has to be intelligible to became successful. If one of the participants could not make itself comprehensible it becomes incoherent and discontinuous and the communication fails.

The new variety of performative acts can open alternative domains in the social sphere, and disorganize former relations, but only if they are recognizable and intelligible. It is the only way how one can make an intervention inside the power regime. (Butler 1990)

2.1.4 Anorectic Agency

I am arguing that anorexia is the bodily performed suffering by the cultural and symbolic constructions of the current ideals of femininity. (Bordo 1993). I assume that anorectic performances are already the acts of agency and its practices are bound to the question of control of their subordinated positionality. Diagnostic handbooks such as *DSM-5* describes anorexia as the ‘disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.’ (2013: 339)

According to the medical meaning, anorexia nervosa is a disturbance in body image and eating behaviours. As I have shown in the previous parts, psychiatric institutions chiefly focus on biological (pharmacotherapy) and personal (Person-centered psychotherapy, family therapy) angles, while they schematize the socio-cultural factors only into an individual obsession with the normative beauty ideal, promoted by the media and the fashion industry. In this context, the anorectic self obsessed with the practices of food intake and being slim. However, I believe that it is important to realize that the desire for slenderness is not the only reason behind the extreme food denial.

The main criteria of its medical description could not map out satisfactory that complicated web of subordinations that is decisive to the development of anorexia, therefore, the therapy does not deal with the power bounded symbolic meanings of the body and femininity. (Csabai 1998: 102) As my interviewees stated, anorexia for them was not about the achievement of an ideal body, but more about control. All of them started their anorectic practices because they wanted to get control of their present situation. It seems that the anorectic

achieves this control through the extreme self-control over food intake. Through starvation they make an attempt to elevate themselves from their body, that attaches them to their critical situation. Thinness in this context means a triumph of willpower over the flesh. Anorectic through starvation feels that she keeps her body under her control and uses it as her own instrument in order to her will.

In the following section, I would like to demonstrate different motivations behind anorectic practices through the stories of three of my interviewees. All narrative sets up different contexts, however, all of them has intersections. These common places could highlight deeper structures behind the anorectic behaviour that could provide a more complex meaning of the disease.

2.2 Case studies

2.2.1 Seeking for Attention - The case of J

The 15 years old J was my youngest interviewee. She started anorectic practices when she was 13, mainly to please her father. He was often away from his family, because of his work, therefore, he did not spend much time with her daughter. J's family structure refers to the ideal middle-class nuclear family. In this micro-political system, the father is the head of the family institution. As Mosse expresses 'The disciplinary function of the father seems central to the maintenance of hierarchy and order in the family and thus of respectability.' (1982: 19)

My dad was the one who started a diet first. I think I learned this practice from him. He made comments constantly on my weight. I don't think that he meant it seriously, but I took upon myself. I was 13 and a half when I started dieting, but my parents didn't recognize it for a long time. We cannot spend a lot of time together. Dad works a lot. He usually gets home at night, and my mom always busy with housework, so we never really have family meals. Dad has to travel often to abroad, because of his work. You know, he has a big corporation and he has to look after it. But I had a need to spend more time together. Sometimes I asked him to be with me more often, but he answered me every time that 'if I were home, instead of work, we would have no money.' I had no answer for this. My relationship with my mom, however, was good. We are friends. There was a strong linkage between us. We learned together and we organized joint programs. But she didn't notice my anorexia too. At this time, my grandfather died and my mother was too engaged with the grief. So, they didn't see that I don't eat, moreover, my dad was proud of me when I started to lose weight and encouraged me to continue.

J's father has the dominant role, because he is the principle breadwinner of the family, and while J's mother also works, her job is to support the head of the family as his secretary.

Because of the material means, the father has monopoly on his family and the right to allocate the hierarchical relations in this micro-institution. In this hierarchy, J has the minimal space to deliver her opinion to her family. She is only a child, a person who is not over the process of self-development. However, J was not delighted with her position. She frequently expressed the lack of communication with her dad during our interview.

When I was in elementary, I never really had friends. I was an A student and my classmates shunned me. I think, I have a low self-esteem and I'm constantly questioning myself. I cannot speak before people, but I'm not sure of myself even when I have to speak with my parents. In fact, they don't really listen to me as well. My dad thinks that he knows everything, that he is a psychologist, gynecologist, engineer and mathematician at the same time. And my mother listens to him instead of me. I don't think that my opinion has much credit in my family. But I was more self-confident when I did my diet.

J felt constant failure whenever she made an attempt to express her desires or opinions, however she constantly tried to please her father. These bad experiences proliferated to other spheres of her life. She also failed in the self-assertation at school, therefore, she had no friends or other groups for self-expression. She had a marginalized position in both important spheres of a teenager's life, in the school and the family. Therefore, she had to find another way of self-expression and that was anorexia. It is notable that she started dieting because of her father, to get more recognition, as she could not raise his attention in other ways, for example through her school achievements. She regarded the diet as something respectable, because her father dieted too, and also as a shared act that might connect her to him.

The family of J did not realize that their daughter's dieting became pathological. At this time, J had also lost her mother's attention, who was grieving her father. In the end, nobody heard her voice and her parents were ignorant of her. She was subordinated as a voiceless child to her family. Therefore, by her symptoms, she subordinated herself to another system, the institution of psychiatry, but at this time by herself. The medical treatment modified her positionality inside the family dynamic.

We were on vacation with another family and they drove the attention of my parents to my eating behaviours. My parents had never heard about such a thing that anorexia before. But they found me a doctor. He offered us family therapy, but my dad thought it's crap, and he didn't attend in it. He didn't even care about my illness till I went to the hospital. In the hospital where I was, my parents could visit me every day, but only if they went together. It was good because we spoke a lot during these visitations. My father gradually realized that this is a real problem. But first, he didn't know how to deal with it.

The father of J was critical of the intervention of the psychiatry. In the scene where he refuses the family therapy, we can see how two institutions clash with each other. In the family, the father claimed monopoly over the other members, but psychiatry in the name of protection intruded into the family unity, and took control over the child from the parents, moreover, pathologized the other family members too through the family therapy. J told me that her dad blamed her, because of her anorexia, and he closed his ears to the therapy which had the right to dominate the family after the diagnosis of J. The parents of J questioned the therapy till the doctor of J shouted with them to bring their daughter to the hospital. By this exaggerated act, psychiatry won control over the child, but the father constantly tried to take it back, for example in his violent acts against J.

When I went back home from the hospital, he constantly asked me if I had gained weight or not. And if I didn't, he didn't speak with me for a day. Once he even wanted to hit me when I had a relapse. But now everything is fine, he tries to pay more attention to me and if I ask him to spend more time with me, he comes home.'

In J's storytelling, the scene in the hospital was the first time when she mentioned that she had big conversations with her parents. Therefore, however, self-starvation was dangerous and life threatening, that was her only mean to expose her problem to her family and reorganize its strict relationships by the intervention of another institution. At last, her subject position was indeed modified. This act opened a space for new dynamics in her family, and they gradually accepted J's problem and gave more credit to her opinions, even if it was because of the pressure of an institution.

A friend of mine who wrote his thesis on anorexia in medical school told me a story about his work practice during his medical studies in a child psychiatric unit. He spoke about a little child who had a stomach tube because of anorexia: 'She seemed so vulnerable, in need of help. I felt so much sorry for her, therefore, I spent hours next to her bed and I talked with her. After that day, my lead professor drew my attention to the fact that that's the trick of the anorectics. They easily manipulate others in order to get more attention.' I asked my friend why

he thinks that this is a mean for manipulation, why he could not imagine that these children need this attention. He considered it for a moment and then he replied: 'Yes, I guess they need this attention.'

2.2.2 Seeking for Relief - The Case of E

Not the need for attention is the only reason why one starts anorectic practices. There are other complicated subject positions where the person could not find other means for a cry for help. I have already presented E's story. The core of her problem was not the lack of the attention, or the too strong family hierarchy, but on the contrary, the responsibility that her family required from her.

E's parents got divorced when she was 9 years old. After her father left the family, E remained alone with her mother and little sister. The mother of E tried to remain strong, but this new family dynamic unintentionally imposed E on an adult role. Her mother had to look after the family and more so E's sister who could not process the divorce, therefore, she had to go to therapy. E remained the person whom her mother could rely on, thus, she had to suddenly grow up.

My mother went to therapy in order to not use me as a therapist, but still, it was the oldest kid's task to do the hard job. Without our dad, I became a father-like figure for my sister. I think I started anorexia because I felt that I cannot take it anymore. I had to control myself to comply with my family in this new role, but I got tired after years. I cannot handle that much responsibility.

After years, when E started to grown older, she tried to escape from her forced adult position.

However, her circumstances had not made possible for her to break out in other ways, only through anorectic acts.

I think unconsciously I wanted to break out from my situation with my family, my sister, my mother, and my awful relationship with my dad. And I felt if I lose weight, I could control other things and my problems would go away. When I turned 17 I felt everything is fine and normal, so I could not have to being responsible for my family, but suddenly I went back into a child stage, maybe because a child has no responsibilities. It was the last year of high school, and the time of the final exams. I remember that I had to write an essay about Madame Bovary. Through the writing process, I had a breakdown, I started to cry hysterically, in the medical sense. After, I did nothing but colouring child colouring books. I didn't go to school on the next Monday, but to a psychiatric institution.

The self-starvation served as an activity to get out from her present situation. She could not control her family, but she could control her weight. But after a while, the excessive control turned upon herself, she fallout from her earlier subject position to another, childish subjectivity. Her nervous breakdown subordinated her to the institution of psychiatry, however, as a consequence, her position radically changed. Interestingly, before the diagnosis, nobody thought that E or her family needed help to manage their everyday life. The mother tried to pass as the head of this new kind of family, but she could not bear that much burden.

In the case of single parent families, institutions, such as schools or workplaces, do not provide assistance. The divorce, for example, in the present bipolitical system counts as the family's own responsibility and choice. A private matter, but at the same time the failure of the middle-class family ideal, that has to be responsible for the future. (Mosse 1982; Butler 2008) Therefore, one parent families do not receive help from institutions, only when the situation of the family becomes drastic in one sense or another. The medicalization of the child, for instance, retroactively had driven the attention to the need of help.

Diagnostic handbooks also do not count with the proliferation of one-parent families in the description of anorexia. While it creates an abstract picture about the anorectic's background and familiar relations, it does not pay attention to the possibility of divorce. As I have already shown, E's psychiatric treatment focused only on the normalization of E's body and then, the personal therapy aimed to repair the failed family. But the therapist did not deal with its already existing relations, she saw the reconciliation of the father with the other members of the family as the only solution. The therapy served as a normalization process aimed the family and the recovery of its ideal structure, however, for E, anorectic practices served as the language to speak about her demand for relief, not her demand for her father.

The therapy of E's anorexia failed, because it could not provide a space for E to communicate her real problems, however, by these practices she could communicate at least

with her mother. The disease saved time for E as her mother realized that E needs more caring for and she dealt with her as a child again after a long time.

After I came home from the hospital, I still had to keep the regular meal times that we used during the therapy. It influences my whole family and reorganized its everyday life. Once my mother went home from a New Year party, because I had to get up early to eat, and she had to help me to manage it. Because of the therapy I had to become a private student for a while. Thus, I got two more years to prepare for my final exams. My new school was really good, it gave me a lot of positive experiences and at the end, I did my exams very successfully. I think I would not be the person who I am now without anorexia.

The radical act of the medicalization subordinated E. Her therapy in the child psychiatry gave her bad memories. The institutional help failed twice, in the psychiatric treatment and in the personal therapy, when it is not give attention to E's real problems, however, E managed to drive the attention of her environment to her critical position through her disease. She lost a part of her childhood because of her parents' divorce, she could not express her suffering by her subordinated position, but after medicalization she regained time which would have been lost from her childhood otherwise. Consequentially, anorexia served to E as the means for relief.

2.2.3 The Lack of Positive Feedback - The Case of N

Medical handbooks and observations on anorexia also notice that the too high expectations towards a person can be one cause of the extreme self-control through starvation. (Bordo 1993; Túry 2002; 2004) In the case of N, these expectations did not come from her family, but her wider environment.

Of course, my godmother always teased me because of my weight, and I saw my mother who constantly dieted, but my problem started at the high school. I studied in a drama faculty. Once, we prepared for a drama competition with a play and the head of my class noticed that I should lose some weight for the dress that I had to wear. I had a normal body weight, but I learned from my godmother as a child that I'm chubby so I accepted my teacher's advice and I started dieting. I'll never forget that on my 16th birthday, I didn't eat my cake, but I drank a diet shake. We won the competition and my class travelled to London. But the head of my class did not stop mocking me. He spoke about me behind my back to my classmates about my weight. I felt anger towards my whole school, but at the same time, I stopped eating and I did sports in order to become thinner. I don't think that this institution had the proper atmosphere for teenagers. For example, I had another classmate who struggled with anorexia at this time too. And my parents...well...our home was a loving nest, and my parents supported me in everything. I mean, literally. Everything that I did was totally fine, but after a while it was disturbing. I felt I never got real feedbacks about myself. So, honestly, I wanted to get into the child psychiatry, because I wanted to feel that somebody cares about me, if my parents do not.

N fled to the hospital from the public shaming of her school and the recklessness of her family. Her problem was that she never had real responses about herself. While her parents

were delighted with whatever she did, she constantly got negative feedbacks from her school. On the one hand, her family had no expectations at all towards her, on the other hand, her drama teacher raised too high expectations, and when she failed, she became the victim of by public shaming. N felt that there was no stable ground under her feet and she could not find her position. She did not stop dieting, because it was the only stable set of practices that fixed her doubtful subjectivity.

After that N came out with her problem, her family tried to turn to various professionals for help, but it was too late. N got into a life-threatening state and she had to stay in a hospital. She told me that the therapy did not dig really deep into her problem and the treatment was only about her body, however, she felt safe in this environment, because she felt that she can express her serious problems through the medicalization. The treatment of the child psychiatry contains constant scaling and rating of the achievements of the patients. These processes give the illusion of the objective feedback on the subject. The belief in this objectivity can give a stable positionality for the subject, thud the feeling of security, even if it is a negative rating.

N tried to find herself through the medicalization process, because her environment was too contingent for the development of her individuality. By the hospitalization she also had the chance to change her school that gave a temporal solution for her anorexia. Her weight stabilized in a short time, but because of the lack of any communicative therapy, she fell into depression soon. Then she needed to go a private analysis.

2.3 Control and Communication

2.3.1 Self-Starvation as an Alternative Communication

The three cases above are very different in regard to the personal motivations. J wanted to get more attention from her family, E felt too much stress because of her too early grew up, N could not handle that contingency that surrounded her during her teenage years. Besides the differences, anorexia served as a mean for the change in all three cases. Consequently, the

problem of these girls was not the eating disorder itself, but those repressive forces that pressured them before the disease. In all cases, anorexia helped the subjects to practice self-control when they could not control their environment.

Many doctors told me that anorectics are obsessed with their weight, because they could not influence other things in their life. As one expert said:

If you already have a problem with your environment, but you cannot control it, you have to turn to something which controllable anytime. And this is the body. People have to feel a sort of control over their life, and some people start to manipulate their body if they get into a situation which is beyond their personal power. You can earn easy, fast, and very visible achievement through it, to demonstrate that you have the capacity for control to yourself and to the others.

There are multiple personal and cultural reasons for the connection between control and food intake. (Lawrence 1979) For nuclear families, mealtime might be the only occasion for the members to spend some time together. In this environment, denying food is equal with the denying of family values, members, or those duties that the family dynamic prescribes for the subject. When the anorectic refuses the food, the bread that her parents win, or the nourishment that her mother can provide her, she refuses the community with her family and its associated values. It would be not surprising that a girl unintentionally refuses the identification with the feminine role model that her mother stands for if she sees her as an overloaded, lonely, unhappy, or dependent person.

The performative acts of the anorectic make a sort of oscillation between active and passive role: the anorectic emphasizes her powerlessness by the demonstration of her power on her body. Thus, we should regard these performative practices as a non-verbal form of communication. Communication for point out the problem that the person suffers from, although, this suffering seems unspeakable in other ways, because the environment of the anorectic does not hear her voice otherwise. Therefore, the anorectic has to choose another set of performative practices in order to modify her subordinated position.

2.3.2 The Failure of the Anorectic Performativity

I believe that anorexia is a bodily performed communication or performative act, in the Butlerian sense. (1990: 25) Anorexia has its own repetitive exercises, such as counting calories, avoiding a specific kind of foods, excessive workout, or the masking of the symptoms. These practices have already modified or created a new kind of subjectivity, through the sense of control. (Hepworth 1999) However, starvation has its bodily effects, therefore, sooner or later, the anorectic become the subject of medicalization for instance in the radical form of forced treatment. It is another subordination, but it does not come from uncontrollable external forces, but by the anorectic's own acts.

Starvation is the variation of the practice of consumption. The anorectic consumes the nothing, consequentially she reproduces the opposite of the required female duties. The Gender Trouble emphasizes that the act of parody might be one successful form of the agency as long as agency means the opening of alternative domains in the social sphere, and the reorganization of its former relations. In this sense, parody is a performative act with subversive potential. It is a repetitive exaggeration of the socially respectable norms, however, this exaggeration highlights that the seemingly natural norms that ordering the life of the society are mere "phantasmatic" constructions. (147) In this context, anorexia is the parody of consumption and reproduction. Through these acts, the subject can flee from one subordination to another and can re-organize her previous position, at the same time implicitly and unintentionally questioning the necessity of production and consumption too.

The problem of the anorectic practices is this does not become intelligible because of the medicalization process. According to my interviews, this new subordination might cause more suffering than the one before. The institution of psychiatry deprives the patient from the right of reason. For the biopolitical apparatuses someone who could jeopardize her health, life, or reproductivity, could not be a meaningful being, because she refuses the higher goals of her

population. Therefore, the anorectic by her attempt to made her agency recognized, became not even a subordinated subject, but a vulnerable epistemological object of the medical gaze.

The anorectic's agency fails, because it could not fulfill the very condition of intelligibility. The anorectic speech and acts are not acceptable for the ruling cultural establishment, because these practices are inappropriate to self-governance, therefore they fall back upon the governance of other institutions. Thus, the anorectic unintentionally marginalizes herself. The consequences of their acts are the opposite of their will. Through the medicalization, their subject position modifies, but through very radical discipline and normalization (for example, the application of stomach tube). These disciplinary processes eternalize their illness, criminalize and infantilize them, and limit their agency more than it was before.

2.3.3 Communicative Therapy

I believe that communication is the core element not only in the case of anorexia, but in the Butlerian notion performativity too.²¹ As psychiatry has the potential to deprive rights of the patients, it also has the right to inaugurate them into the world of reason. Communicative therapy could provide a space for this inauguration, because it gives an opportunity for the

²¹ The origin of Butler's performative act comes from the British language philosopher J. L. Austin's speech act theory. According to Austin, utterances are always already actions, because they could form the speaker's reality. (1962) Butler inverts and expands the speech act theory. She assumes that every act is an utterance about the speaker subjectivity and reality. (Butler 1990)

The philosophical school of pragmatics, that Austin stands for, works on the definition of those general rules that determine the communicative situations. It is seemingly the opposite of that Foucauldian theory that emphasizes the historically and culturally changing nature of the things. Therefore, the communication as an emancipatory mean for the anorectic seems contradictory, in the light of the Foucauldian frame. However, I believe this contradiction does not exist if we can describe properly the conditions of the emancipatory communicative situation.

Foucault in the third part of *The Archeology of Knowledge* (1989) implicitly arguing against the pragmatics, because Foucault claims that the rules and conditions of the communicative situation are determined by the actual discursive space. Thus, the communicative situation temporally and locally determined which means that we could not order communication under rules because there are no fixed meanings of statements. However, I would like to emphasize that Foucault also claims that every discourse has its own and particular relation to speech and expression, even if its temporally and locally changing. It means that psychiatry has its own set of communicative rules. The variable nature of these rules makes communication into a mean for the emancipation of the patient into the world of reason. However, it creates second-rate citizens through its disciplinary practices, it can change, because the borders of the discursive spaces are flexible. Otherwise, the agency would be impossible, and our existence would be fully determined by power.

accomplishment of the anorectic agency. For a more successful therapy, psychiatry has demonstrated mutual recognition between doctor and patient, and the communicate space of a therapy could be perfect for it.

The present form of the medical treatment in Hungary does not enable the patients to complete their agency. The anorectic necessary fails her performative act because the treatment does not regard her as a subject who capable of communication. It is not a mere misunderstanding between institution and subject, because of her marginalized subjectivity and 'unreasonable' acts, the anorectic does not even reach the communicative situation. There are crucial situations when the normalization of the anorectic's behaviour and the repair of her body seem necessary, however, it could not solve the core problem that the patient wants to perform through her life-threatening practice.

All of my interviewees reported that after the psychiatric treatment they had not become healthy in the psychic sense. Most of them fell into depression after their therapy and they had to find other sources for help. They medicalized themselves in the hope that they could express their problem in another platform, but the treatment did not provide a space for them to the communication of their core problems. The medical treatment, at least in Hungary, after the stabilization of the anorectic psychical conditions, sends back the patients to that particular environment that they previously tried to escape from.

An anorectic expert of the Institution of Behavioural Science expressed it in a very neglectful and simplistic way:

We have to restrict their autonomy. A drug addict, an alcoholic, an anorectic is not free. We have to liberate them, to live like normal people. But it is the mental disease itself that decreases freedom. You know, every mental patient is the same. Healthy people in the outside world are different. In a psychiatric institution, everybody is the same, like they wear a prisoner's uniform. In the case of anorexia, it can be known exactly that they are thinking in the same way. They are typical. Because of the disease, they are not themselves. The disease dictates to them. And we, with the cure, give them back their freedom.

The doctor believes that professionals have the right to deprive or give back the autonomy of the medical patient through the power of psychiatry. (Foucault: 2003) They regard these girls not even as human beings, but only as the manifestations of their diseases. But in a medical

treatment that could not perceive the person behind its symptoms the communication is impossible. For successful communication, it is necessary that both members of the discussion recognize the other. But it could not come true in a situation where the doctor embodies the gatekeeper of the reason and the patient counts as an underdeveloped child, or a liar.

I ask all of my interviewees about how they can imagine the perfect therapy. All of them mentioned the importance of more communication that they had not gotten in their psychiatric treatment. The professionals had no impersonal relationship with them, therefore, nobody dealt with their core problems, instead of the forced feeding and medicine treatment. However, a proper communicative situation can reverse these hierarchical relations, through the arrangement of a safe discursive space where the patients have the right to speak (not necessarily verbally). In this special mode of communication, the representative person of the institution of psychiatry could provide recognition and account for the anorectic's voice, which can help to complete the anorectic's performance and the aimed modification of her subject. Therefore, if the psychiatry could change the conditions of communication, it can inaugurate the patient's performed subjectivity into the order of reason again, instead of disciplining the subject's acts to the scheme of normativity.

I did an interview with a psychologist, who has worked for the Vadaskert child psychiatry from 2008. She emphasized the importance of the complex therapeutic method which bases on communication and cooperation.

In the Vadaskert child psychiatry, the method changes frequently. Mainly because of internal issues, such as general disagreement between the colleagues or between the colleagues and the leadership. I can easily imagine that your interviewees' experiences were real in the early 2000's. I started to work in the hospital at 2008. By that time, the situation was a bit better. Every anorectic had his or her own therapist, therefore, everybody got more attention. But it is really hard to work with anorectics. They are hardly cooperating with their doctors, therefore, they can easily raise their anger. There is a lot of failure in their treatment, however, the process requires lots of energy by the therapist. Therefore, there are psychiatrists who specifically hate them. But I think, the countertransference that the patient causes in the therapist can be a good tool to understand them. I think, it is a hypocritical attitude when a therapist tries to look neutral. If its need, I used to express my own feelings for the patience, because it makes easier the personal communication. Sometimes, I swear before them, if I feel anger...and they like it. However, in the case of the anorexia, the communicative therapy only the beginning. It is a very complicated disease, therefore, there needs a teamwork to cure it. From the doctors to the cleaning lady, we have to take everybody into the therapy... it is not easy and we have not enough resources for this up to this day.'

My interviewee made an attempt to transform the therapeutic situation into a discursive space. I think, the fact that she had the courage to express her feeling to her patients do not mean the lack of professionalism, but on the contrary, it shows her openness for the other, and the recognition of the patient as an equal actor in the discussion. This mode of communication is necessary calls forth the proliferation of different modes of existences and the recognition of new variations of performative acts. Every case is different but tolerable. Through the recognition of the patients, these different modes become acceptable. This institutional approval can explode the one-dimensional conception of the normality and elevate the anorectic from the category of abnormality.

2.3.4 The Agency of the Professionals

According to my interviewees' experiences, in Hungary, psychiatric institutions the therapy mainly focuses on the normalization of the body, therefore, it has no interest to find out the reasons behind the anorexia and create a discursive space for it. My partners' treatment lacked the communication, not only in the form of the personal therapy, but also the group therapy, and the medical follow-up after the psychiatric intervention. It demonstrates a very neglectful medical attitude that verifies the assumption that the modern biopolitical power structure focuses on life, but not on the quality of life. However, the lack of these means depends not only on psychiatry but also on its relationship with other, political and economic circumstances .

At this point, we also have to take into account another kind of agency: the possibilities of the doctors. One of my interviewees worked at the Vadaskert child psychiatric unit where most of my anorectics spent their forced treatment. He worked there for 6 years, but then he had to change his job, because his payment was not enough for his family. He described the financial situation of the hospital that makes clearer why Hungarian psychiatry works in a way that I described.

‘The personal therapy, the co-work of the psychologists and psychiatrists, and the follow-up sessions are necessary, not only for anorectics, but all of the patients of the psychiatry. The problem is the lack of capacity. However, this child psychiatry is the biggest in the country, we have not enough doctors and economic resources. As a clinical psychologist, I had to work 8 hours a day and I earned 97000 forints net [the net minimal wage in Hungary is 73815 forints now]. Almost all early-stage graduated doctors look for another job after 5-6 years. For this money, only those going to work who otherwise cannot be successful in this profession. The institution provides good medical experiences, but you know, if you want family and kids, this 97000 forints is not enough. You have to look for a second job or something like this if you want to live. But it makes us more overloaded. We have no time and energy to train ourselves, to go conferences, or study the newest methods when we don’t even have enough time for caring for our patients. To go conferences to abroad seems like a dream for a doctor who works for a Hungarian medical institution. Without proper state finance, the hospital frequently has to use the children for medical trials of new medicines. These corporations at least provide us financial support. But the way how these institutions work in Hungary is intolerable.’

It seems that the state does not support the development of these psychiatric institutions, even if the doctors want to put more effort to the carrying of these anorectic kids. They have not enough time and energy for this extra work. The lack of the financial support of these institutions in Hungary shows that the mental health of the citizens does not play a central role in the governance. Specific civil organizations might provide relief for these state-owned institutions, but they also do not have the appropriate financial background. Another doctor of the Vadaskert told me:

When I graduated, I started to work for a foundation. Their main profile was to deal with kids who were criminalized. The aim was the reintegration of those youths to the society who were marginalized by something. Therefore, we applied a special American method. Its intention is to bring closer the criminals to their victims through communication. We usually take the families into the therapy as well or if we had occasion the wider environment too, like schoolmates or teachers. These people could form a group where the

communicative situation can easier highlights tensions. We also went to small towns in Hungary and our therapeutic sessions had been successful most of the cases. Sometimes we also did training for doctors in big psychiatric institutions, such as the Vadaskert. I had worked for this organization for one year. Then, we had to finish the program, because we ran out of money. At the beginning, an American corporation founded us, but they stopped it after a year, and we had no state support. So I had to look for a new job, and I found one in the Vadaskert.

I believe that mental diseases do not count as a recognized health problem nor for the state, neither for the people. The public perception of psychiatric problems is very bad in Hungary. While in the fin-le-sec the science of psychiatry flourished in the country because of the Austro-Hungarian Monarchy, during the state socialism, these institutions served not only as asylums, but as alternative prisons for people who meant potential danger for the regime. The regime had changed in the early 90's, but the broad public opinion about mental diseases has not. Without proper information and education, people with psychiatric problems count as weak, dangerous and unreasonable in the Hungarian society until this day. This attitude reflected in the state financial of the institution of psychiatry too, irrespectively to the currently ruling government. (Lafferton 2002; Füredi 2011; Fábián 2016)

It is not only the question of the anorexia anymore, but the question of the attitude towards all mental diseases in Hungary. The state's ignorant attitude has several harmful effects on the society. Especially as depression, alcoholism, and the suicide rate in Hungary are one of the highest in Europe. (Rhimer et al. 2013) As the former psychologist of the child psychiatry told me:

It is a marker of a welfare state when a health care system can provide medical attendance for those who are not in a direct life threatening state too. It is important for the citizens to be able to deal with ourselves. And who is healthy, can benefit the society too, if I look it in purely economic terms. Instead of football stadiums, our government should give more financial support to psychiatry...but it is the question of politics.

The purpose of this chapter was to demonstrate that, however, many oppressive circumstances influence the position of the anorectic subject, they have the desire to exposes their agency exactly as a counter-act of the oppressive practices. Behind anorectic acts, there is a more complex web of subordination and action than the medical discourse assess it. The

anorectic's core problem is the loss of control over her environment. In this sense, anorexia serves as a tool for the modification of the subject's situation. Unfortunately, the medical gaze blinds for this core problem, and it restricts the anorectic's rights for self-expression on the basis that a mental patient could not be reasonable. According to my interviews, however, communication could be very important for the person who suffering from eating disorders, because the heart of the practice of self-starvation is its non-verbal communicative potential. A successful therapy has to take into consideration this communicative potential and provide the space for the anorectics to perform their suffering. A personal therapy where the discussion plays a central role can be more effective than any medication or force feeding.

Conclusion

The present thesis made an attempt to step beyond the medical meaning of anorexia nervosa and analyze it in a wider socio-cultural context through the Hungarian-specific treatment of the disease. The medical discourse and the common opinion see this disease as the abnormality of womanhood, therefore, anorexia provides a tool to reveal those multiple underlying power relations that define the ideal femaleness in the present system of power. By the critical reading of the disease, my main aim was to highlight the possible agency of the anorectic under these normative requirements and expectations. To make my assumption more representative, I used interviews with both patients and professional who had a relation with the Hungarian psychiatric treatment of anorexia.

According to my interviews, I suggest that anorexia is the bodily performed suffering of the body by the cultural and symbolic requirements toward the subject. The set of practices that the anorectic performs, therefore, has already fulfilled the requirement of agency in the Butlerian sense. The subject, through self-starvation, exercises extreme self-discipline on her body in order to modify her actual subordinated position that is beyond her control. In other words, the anorectic emphasizes her powerlessness by the demonstration of her power on her

body. The consequence of the anorectic practices is the medicalization, however, this subordination is the effect of the subject's own agency.

Unfortunately, the performative practices of the anorectic have failed, because it could not make itself recognizable for the institution of psychiatry. The medical discourse sees anorexia as the abnormality of self-development and proper femaleness. Therefore, the hospitalization makes the subject's position even worse than it was before. The example of the Hungarian medical treatment offers a subtle picture of this subordination. While the anorectic subject makes an attempt to expose her problems by her practices, the treatment only deals with the stabilization of the biological body, in accordance with the requirements of the biopolitical power structure.

I suppose that the present form of the Hungarian psychiatric treatment is shaped by the current biopolitical power structure and its consequent nationalist ideals. According to Foucault, this form of power regard to the production of life and the maximization of the usefulness of the human body as its most important role. Thus, under the biopolitical power formation, the ultimate duty of the female body defined by its reproductive capacities. However, the anorectic's body is not capable of childbearing, because the long-lasting self-starvation causing fertility. Fertility endangers the future population of the nation, as the anorectic subject could not take apart in its reproduction. Therefore, the anorectic subject does not reach the requirement of the normative femaleness, thus, it does not deserve respect and recognition by the power.

The deprivation of respectability makes the anorectic abnormal, a marginalized subject who falls back upon the disciplinary practices of psychiatry. The medical treatment, especially in Hungary, uses confinement, medication, or forced feeding to re-socialise the subject to the socially respectable reproductive female role. The treatment, however, does not pay attention to the meaning of the anorectic performance, which originally intends to modify the

subordinated position of the subject. These practices inapprehensible for the power which sees life as the highest value.

When the anorectic denying nourishment, she denies her reproductive role, which endangers the life of the future population. In this sense, the anorectic constantly commits a crime against humankind that justifies the state intervention by their apparatuses to the life of the subject and the restriction of its rights in the name of protection. In the end, the intervention and the medicalization reproduce the heteronormative gender binaries of the present biopolitical power structure.

Consequentially, the problem of the present form of the medical attitude towards anorexia is that it could not go deeper than the healing of the body and the regulation of the personal behaviour, therefore it could not cure satisfactorily the subject. After the therapy, the anorectic has to return to her previous position that was the cause of their life-threatening practices. Therefore, even if the anorectic stops her practices, she easily falls into other mental diseases, such as my interviewees reported. It means that the aim of the therapy is not the healing of the subjects, but the rehabilitation of their reproductive capacities to make them useful again. In this process, the quality of the person's life does not matter.

Through my interviews, I conclude that the proper treatment has to recognize the anorectic's performative acts, instead of this, anorectic practices could not be intelligible and could not reach the required communicative situation. The lack of the communicative therapy hinders the anorectic to get recognition, therefore, it only reinforces the subject's subordinated position. A discursive space, however, can reintegrate the patient into the world of reason, because a communicative situation that based on mutual recognition might provide a discursive space for the patient to express her real problems. If it happens in the context of the treatment, the representative person of the institution can provide an account for the patient's voice, which can help to complete the anorectic's performance and the aimed modification of her position.

Therefore, the institutional approval can explode the one-dimensional concept of the normality and elevate the anorectic from the category of abnormality.

As long as the Hungarian psychiatry does not consider the deeper meanings of the anorectic practices and its embeddedness in the socio-cultural space the treatment could not be successful. However, we have to note that the present form of therapy is shaped by the wider web of the existing power relations. The Hungarian psychiatric complex strongly dependent upon the country-specific political and economic discourses, that drives further the perspective of the research.

The present thesis could not touch upon this dimension of the psychiatry, however, it could be a fruitful direction for further investigations. I think this kind of research has two possible directions. One is the examination of other therapeutic processes in other countries. An international comparative analysis might help to highlight those country-specific circumstances that influence the development of the anorexia. These differences and similarities could point out the most successful way to deal with this issue and could also expand the diagnostic criterion of this disease in the light of the country-specific social and cultural differences.

Another direction of the further research could be the examination of those country-specific and culturally determined circumstances that shapes the present form of the Hungarian psychiatry. It could show those underlying power structures and interests that design and limit the present form of the medical treatment of anorexia and other mental diseases. This further investigation necessary has to take into account other Hungarian cities or villages, where the psychiatric therapy not as frequent as in Budapest. This research could provide a useful and practical tool for a more successful psychiatric treatment, not only in the case of anorexia, but in the cases of other wide-spread diseases of the country, such as alcoholism or depression.

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