The Boundaries of a Good Anorexic: Exploring Pro-Anorexia on the Internet and in the Clinic

Anna Claire Lavis

Thesis presented to Goldsmiths,

University of London, for the degree of

Doctor of Philosophy, July 2011.

I, Anna Claire Lavis, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

❖ Abstract

This thesis explores pro-anorexia, a desire amongst some anorexics to maintain or enhance their existing illness. Through ethnographic fieldwork in an English eating disorders unit and with participants to pro-anorexia websites this anthropological research centrally explores relationships between personhood and illness as they are articulated and experienced by anorexic informants. Without assuming pro-anorexic desire to be either fully agential of just a product of the illness itself, the thesis traces the ebb and flow of informants' desires for anorexia and the selves, bodies and anorexia(s) that such processes enact. Moving across these two field sites reveals not only how each illuminates pro-anorexia in the other, but also that both tangibly impact on ways in which informants experience and desire anorexia in the other. This thesis therefore suggests that in both spaces relationships between anorexia and personhood, agency and desire, bodies and eating, are perhaps both 'virtual' and 'actual.' Importantly, an analytic emphasis on exploring experiences and subjectivities, rather than on corporeal emaciation, seeks to listen to informants' desires for anorexia whilst also recognising the realities of the illness. This reveals how desire and ambivalence are often conjoined as pro-anorexia signifies both a response to, and reconfiguration of, compromised conditions of possibility. By exploring ways in which seeming antitheses such as pro-anorexia and biomedicine or desire and ambivalence are not only related, but are mutually productive, in informants' accounts, this thesis not only addresses the largely unexplored topic of pro-anorexia; it also reflects on the practices of anthropology itself, its ethics, ways of looking – or perhaps listening – and its modes of representation.

❖ Contents

❖   Acknowledgements

Chapter One   The Introduction

"Anorexia is a great source of pride and pleasure."

Quotation from a pro-anorexia website

"People don't seem to understand that eating disorders really are Hell."

Tanya, pro-anorexia website participant,

interviewed online

During my fieldwork in an English eating disorders unit, Poppy, a hospitalised anorexic, recounted the first time she had been allowed to leave the hospital grounds during her admission. After six weeks of escorted ten-minute passes to a bench by the Unit's front door, Poppy's sister visited and staff agreed that they could walk together to the nearby high-street. Once there and feeling tired, Poppy suggested they sit on a bench in the sunshine and chat. Only minutes into their conversation two teenaged boys walked past. Doubling-back on themselves, the boys began to circle the bench and, laughing and pointing, they shouted "eat this!" as one tore up his sandwich and scattered it over Poppy. Her sister hastily accompanied a sobbing Poppy back to the Ward. Recounting this story during her interview, Poppy said tearfully:

> "It was the thinness. They just saw the thinness…That's the thing about anorexia, it's all anybody ever notices but there's so much more to it than that."

Poppy, inpatient

At first glance anorexia nervosa might seem to be already much-chartered terrain; discussions of it stretch across the social and medical sciences to the media and beyond. Yet there has been almost no previous ethnographic work on pro-anorexia and little on individuals' relationships with their anorexia overall. The term 'pro-anorexia' describes a desire to maintain or enhance their illness found amongst anorexics. Turning its full attention to pro-anorexia, this thesis explores neither why people develop anorexia, nor why some wish to develop it. Rather, it asks

what shapes and fuels desires to hold onto existing illness. Such a desire may be fractured or fluid, tinged with ambivalence or akrasia and pro-anorexia therefore does not signify a fixed identity or community. Rather, this thesis suggests that an attachment to anorexia weaves through informants' relationships with, as well as practices and experiences of, anorexia. Hence, whilst recognising anorexia's rootedness in wider cultural contexts, this research investigates the intricacies of informants' day-to-day embodied subjectivities of "being anorexic" (Gooldin 2008). Yet, although taking issue with the claim that "the anorexic has no story to tell" (O'Connor & Van Esterik 2008: 9) and "what happens makes no sense" (ibid. 9), I also acknowledge throughout this thesis that "to see the illness as anything less than cruel is to do an injustice to those who struggle with an eating disorder every moment of their existence" (Allison 2009: 20[1]). It is viscerally clear why, in anorexia, "the story of illness that trumps all others" (Frank 1997: 5) is the clinical. However, it is perhaps because, not in spite, of anorexia's dangers that it is important to find ways to hold other stories alongside the clinical - ways that ethically address the complexity and simultaneity, pain *and* desire, in informants' accounts of their illness. Only by doing this, I suggest, will we be able to take account of articulations of pro-anorexia amongst anorexics.

Suggesting pro-anorexia to be "multiply-located" (Clifford 1997: 189), I carried out multi-sited fieldwork, comprising participant observation and interviewing, in an English eating disorders inpatient unit and on pro-anorexia websites. In each of these spaces, and between them, I traced the ebb and flow of informants' pro-anorexia, exploring ways of desiring and the subjectivities, selves and bodies these ways entangle and enact. This revealed that informants in both field sites articulate and experience complex relationships between anorexia and personhood. Moreover, not only does each field site illuminate informants' pro-anorexia in the other, but their connections are also concrete and conceptual; texts, affects, anorexia(s) and both virtual and actual bodies travel between these spaces. Making a "concerted effort to speak with people who would represent a variety of views and experiences" (Ries 1997: 5) fieldwork also comprised interviews with members of a pro-anorexia research group I established on *Facebook*, as well as with treatment professionals, recovered anorexics and carers. I

---

[1] See also Luhrmann 2001 on not 'romanticizing madness.'

paid attention to mental health law; treatment protocols; carers' literatures; autobiographical memoirs of anorexia and other "heteroglossias" (Bakhtin 1982) and materialities that frame, and perhaps produce, anorexia(s) within each field site and at their intersections.

The multi-sited praxis of "follow[ing] the metaphor" (Marcus 1998: 92) of this research also involves a reflection on previous and current cultural and clinical framings of anorexia. Whilst recognising that these cannot be simplistically separated from how informants experience anorexia in the field, I actively seek to prevent them from undermining informants' experiences in this text. Hence, this thesis draws together extracts from clinical texts with magazine articles, cultural theorists with memoirs of anorexics, allowing these to share the page and to critique each other in non-hierarchical ways. This textual technique not only derives from how these are often entangled in the field by informants' reading of them, but also from my wish to resist any simple or neat position in relation to anorexia. The technique allows the voices of informants[2] to take precedence over all others, including my own, thereby disallowing a "quick jump to representational thinking" (Stewart 2007: 4). Thus, whilst acknowledging that "in a complex world there are no innocent 'methods'" (Law & Urry 2004: 402), this research actively attempts to hold together contradictions and ambiguities in one analytical space, and to not attempt an unethical neatening of "mess" (Law 2007[3]). Recognising that "the topography of subjectivity is multi-dimensional" (Haraway 1991: 193), the central ethical praxis of this study of pro-anorexia is therefore a taking-up of the suggestion that "it is time to attribute to the people we study the kinds of complexities we acknowledge in ourselves, and to bring these complexities into the forms of knowledge we produce and circulate" (Biehl & Locke 2010: 317).

---

[2] Throughout this thesis where I use the term 'informant' unqualified, it always refers to anorexic informants. Where it designates a treatment professional, a carer or recovered anorexic this is made clear at that time. I use 'patients' if talking generally about life on the EDU, and 'anorexic' where I am referring to a general grouping, such as in clinical literature.
[3] Also Law & Hetherington 2003.

Part One   Introducing the Field Sites

1: A   Pro-Anorexia Websites

Pro-anorexia websites are established, and participated in, by anorexics who, simply put, desire to maintain their anorexia and resist recovery. In her interview, one informant, Aurelie, offered me their history:

> "Pro- Anorexia (pro-ana) started in 1998. The very first one was started by a person whose screen name was Empressanorexia_nyc. She started the group on Yahoo called Anorexia with Pride (AWP). It is unknown how, at that time period, many other folks came across it and decided to start their own. It expanded to other various host (i.e. MSN, Excite, E-groups) until attention was brought to it from other eating disorder recovery sites. Soon, the webhost of those sites started banning and deleting any clubs and groups."

> *Aurelie, Facebook Pro-Anorexia Research Group participant,*
> *interviewed online*

It is unclear how many pro-anorexia websites there currently are; they are not as easy to find as they were when I first explored them for MSc research in 2002. Then there were frequently estimated to be around 400. Since 2001, starting with *Yahoo*, service providers have systematically closed the sites. In response they continually reappear in different guises. Since it became a public site in 2006, *Facebook* too has seen many pro-anorexia groups but these are also closed by the site's administrators. *YouTube* is also a space in which pro-anorexia videos appear, often evoking video response. That these are sometimes then followed by counter-responses institutes video dialogues. Of those who participate in pro-anorexia websites, the majority are female, but there are also some male participants. Age, on the other hand, varies widely and the sites are certainly not only used by adolescent girls as press coverage has suggested. This became clear, in particular, through interviews with members of my *Facebook Pro-Anorexia Research Group*. Many of those who were aged between 30 and 40 said in their interviews that although they visited the sites every day, they did not post to them, their engagements thus being active but 'silent.'

Pro-Anorexia websites arose during a growing "medicalization of cyberspace" (Miah & Rich 2008[4]), which brokered intimacy between biomedicine and the Internet and made 'health information' "the fourth most cited reason for Internet use" (Flicker et al. 2004: 131). Websites such as *Net Doctor* and *Patient.co.uk* illustrate that "where information technologies flourish, patients are often knowledgeable of their illness and aware of their rights" (Melamed et al 2003: 617). These Internet emergences mirrored moves in the early 21st century within British health policy towards "pastoral power" (Wilson 2001) and "expert patients" (DH 2001). Cyber "biosocial" (Rabinow 1999) groupings also extended an existing history of patient support and activism groups. The re-evaluations of medical knowledge amongst such groups had been recognised (cf. Kellener 1994). But, the Internet has drawn together groupings around conditions and identities previously clinically conceptualised as rare;[5] it is possible to "find a community to which you can listen or reveal yourself, and instant validation for your condition, whatever it may be" (Elliott 2004: 217). Online interactions around health are "a forum in which self-redescription can take place" (Dumit 2006: 584) and Internet engagements with "iatrogenic identity" (Charland 2004: 336) have seen clinical categories not only rejected or contested; people have also "mobilized their forces on the Internet to defend their right to wear and live by their labels" (ibid. 336). If pro-anorexia websites have a unified standpoint, it is this assertion. Beyond this, it has been suggested, "who they are supporting, why, and to what ends, remains unclear" (Brotsky & Giles 2009: 103). But, rather than imputing what *is* or *is not* definitively 'pro-anorexia' or attributing this ambiguity to their online environment, I suggest that the sites' inchoate, multi-vocal and ambiguous nature is part of what requires exploration about informants' pro-anorexic desires themselves.

However, pro-anorexia websites do share key elements.[6] Alongside discussion threads, there are journal entries of the *webmistress/master* (creator) and sometimes, of participants. These may take the form of food diaries or resemble more classic autobiographical writings. The latter are at times "innocuous, dealing with mundane adolescent concerns such as boys and school" (Giles 2006: 464) but at other times, they are poignant admixtures of pain, pride, and both desire for, and

---

[4] Also, Gibbon & Novas 2008.
[5] See Elliott 2004 on apotemnophilia.
[6] See Borzekowski et al. 2010.

hatred of, anorexia. There are letters to anorexia as a friend and, sometimes, an enemy; these resemble, and even derive from, writing tasks in eating disorders treatment. On the sites, these are shadowed by letters from anorexia – or, from *Ana* - which outline what anorexia will do for participants, why it is good (and sometimes why it is bad) and what *Ana* expects from anorexics; the latter is also circumscribed by lists of *Thin Commandments.* Some sites have drug recommendations and exchanges between participants do take place, although these are rarer than has been suggested.[7] More frequent is an acknowledgement that some participants use laxatives or slimming drugs.[8] Thus, advice is offered on how to remain 'safe' and 'healthy 'in relation both to drugs and starving practices, with all the ambiguity and subversion embodied by delineations of these concepts on the sites. Some also have information sections outlining clinical nosologies of anorexia, bulimia and EDNOS,[9] most frequently taken from the DSM-IV (APA 1994). This information is part of a wider engagement with, and reconfiguration of, the practices and discourses of biomedicine on the sites, as will be seen in Chapter Five.

Thinspiration is another very common aspect of the sites. This is generally described as "pictures of 'waif-like' models, super-skinny celebrities and pictures of emaciated anorexics with the premise to inspire the anorexics to carry on their anorexic behaviours" (Williams & Reid 2007: 142). But, I suggest that it is important to recognise that many images found on the websites are of diagnosed anorexics. This, perhaps paradoxically, suggests that to see pro-anorexia as only a desire to be as 'thin' as possible misses very specific contexts in which thinness can come to be valued, as well as denied, by informants as a part of their relationships with anorexia-as-clinical-entity. Accompanying *Thinspiration* are pages of *Tips & Tricks,* which comprise advice on how to avoid food, vomit, forget hunger and hide starvation's physical effects. It is *Tips, Tricks* and *Thinspiration* that have dominated vilifying press-coverage of pro-anorexia websites.

Press discussions have often focused on how "the desire to be the 'best anorexic'" (Atkins 2002) makes the sites competitive.[10] They have included first-

---

[7] cf. by Chelsey et al 2003; Norris et al. 2006.
[8] See Fox et al. 2005.
[9] Eating Disorder Not Otherwise Specified.
[10] cf. Asthana 2007; Catan & Bennett 2007; Howard 2007; Wostear 2006.

person accounts of being an "internet anorexic" (Lipinksi 2007), describing "group fasts" and "diet pills, laxatives, diuretics" (ibid. 63). Many press authors have assumed that "pro-ana refers to the rejection of the idea that anorexia nervosa is an eating disorder" (Udovitch 2002). Not only does this claim of denial not tally with my research findings, but also, the denial itself is often construed in the media as an unknowing one; it is suggested that participants have "no idea of the potentially deadly consequences of developing anorexia nervosa" (Bloomfield quoted in Catan & Bennett 2007) and that "the site owners don't mention (probably because they don't know themselves) the risk of osteoporosis, the effect on fertility and the hugely increased risk of heart disease or heart failure" (Bloomfield 2006: 3). However, I have found that these are often graphically acknowledged and neither this acknowledgement nor extreme suffering precludes pro-anorexic desire.

Yet press discussions have dually positioned participants to the sites; as well as unknowing victims, they are also seen as dangerous to others. It has been suggested that pro-anorexia "seduces girls into anorexia" (Levenkron in Dolan 2003). Termed "sick" (Wostear 2006) and "porn" (Goodchild 2006) that is "literally killing people" (Daily Mail 2007), the sites have been described as "sinister online groups" (BBC 2005) "pushing vulnerable people in anorexia and bulimia" (BBC 2007). Sontag writes, "any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally contagious" (Sontag 1993: 6). Such coverage signifies the coming together of clinical framings of anorexia as morally 'contagious'[11] with wider discourses about the influence of the Internet on behaviour and the media on women's subjectivities. Within this latter are perhaps embedded assumptions that women are more susceptible to media than men,[12] a viewpoint that emerges in debates around size zero. Moreover, that press discussions of pro-anorexia websites and anorexia merge with those about size zero[13] was sometimes pointed out by informants. In her interview, Miriam said:

> "There's lots of people who think it's just a vanity thing like, you know, anorexia is just the thinness and wanting to look thin but it's not a vanity

[11] See Chapters Three and Five.
[12] See Bell 2009.
[13] eg. Atkins 2002; See Howard 2007; Spencer 2006; Wilson 2006.

thing, it's not at all. People go 'oh everyone's trying to copy this size zero trend' and it's not, it's not! You don't open a picture…look at a picture, and say 'oh I must look like that girl, therefore I must lose weight, therefore I'm an anorexic!' It's absolutely nothing to do with that."

Miriam, inpatient

The potential harm of participating in pro-anorexia websites was clear from Josie's interview:

"I have lost quite a few friends to eating disorders and I live with the physical consequences of anorexia and personally believe that pro ana sites should be made illegal because then at least fewer people would be motivated even more to continue in an eating disordered pattern."

Josie, pro-anorexia website participant,
interviewed online

Likewise, Nora said:

"If I wanted help I wouldn't be looking up pro ana websites… so people who are on those sites want to be supported to continue with the illness… pro ana is an enabling group."

Nora, Facebook Pro-Anorexia Research Group participant,
interviewed online

The sites arguably do normalise anorexia for anorexics participating in them instead of seeking other forms of help.[14] However, notions of 'turning' people into anorexics are not supported by my data. Rather, visitors to the sites asking how to become anorexic are discouraged with often-graphic accounts of the heinousness of anorexia. *Wannarexics*, as they are called, are thus not part of discussions in this thesis. To discourage anyone from stumbling on them, the sites display warning texts on entering.[15] Interestingly, the visits of *Wannarexics* were often attributed by my informants to press coverage of the websites; Aurelie said:

---

[14] See Bardone-Cone & Cass 2006; Mulveen & Hepworth 2006; Tierney 2006; Wilson et al 2006 on impacts of viewing pro-anorexia websites.
[15] See Martijn et al. 2009 for discussion of these.

> "Why there are ever expanding members since it started? If you look back, the newspapers/TV talk shows/news/magazines merely glorified it. Given the huge media attention, all these youngsters these days will simply google them up."

Aurelie, Facebook Pro-anorexia Research group participant,
interviewed online

In her interview another informant, Laura, said:

> "I have always known that pro ana sites existed because i had seen them mentioned in the media."

Laura, Facebook Pro-Anorexia Research Group participant,
interviewed online

Before pro-anorexia sites, it was suggested that "anorexia is the disease of the McLuhan age, disseminated by telecommunications rather than by contact" (Ellmann 1993: 24[16]). Relationships between press and pro-anorexia websites have added another layer to anorexia's discursive entanglements.

Arguably, a notion of 'turning' people anorexic links to discussions of choice in relation to the sites. That the sites "construe eating disorders as lifestyle choices that one should strive to attain" (Rouleau & Von Ranson 2011: 525) has been frequently mentioned in press and academic analyses.[17] My data, in contrast, suggest that claims of a chosen lifestyle are not central and, moreover, that anorexia can be an illness *and* a lifestyle to informants. Rather, pro-anorexia signifies a willingness to accept and live with anorexia as "a state to be maintained" (Ward 2007[18]). We thus perhaps need to reflect on choice in more nuanced and fractured ways; whilst many informants described choice in accepting the illness, they said that choosing to become anorexic was neither wise nor even possible. Moreover, this idea of *maintaining* anorexia is important but under-acknowledged; thinking of pro-anorexia only as starvation orientated towards a future goal risks ignoring the present as a "locus of reality" (Mead 1932) in which subjectivities, experiences, and relationships between personhood and anorexia are played out day-by-day. Furthermore, maintaining has ambivalence to it which, as will be seen throughout this thesis,

---

[16] Also, Bogle 2000; Jacobs Brumberg 2000.
[17] eg. Doward & Reilly 2003; Mulveen & Hepworth 2006; Williams & Reid 2007; Wilson 2006.
[18] See Csipke & Horene 2007.

arguably needs as much recognition as desire in ethical and nuanced discussion of pro-anorexia.

It cannot be assumed from participants' "anti-recovery stance" (Fox et al. 2005) from which they "offer inappropriate encouragement" (see Schmidt 2009) that pro-anorexia websites "celebrate eating disorders" (Ferreday 2003: 277). Rather, although participants may want their illness, "this does not mean anorexia is regarded as problem-free" (Williams & Reid 2007: 150). Thus, the support aspect of at least some of the sites needs acknowledging.[19] Leanne said:

"It's not like some evil cult trying to brainwash people into starving themselves it's about giving people support in some of their toughest times of their lives."

Leanne, Facebook Pro-Anorexia Research Group participant,

interviewed online

The sites "are intended as a sanctuary for those already suffering the illness, a place where they can share their thoughts on anorexia away from the pressure of family or friends who may encourage or enforce recovery" (Burke 2009: 63 – 64). Many informants described friendships that went beyond competitions to be good at, or even conversations about, anorexia. These websites are spaces of "storied sociality" (Stewart 1996: 9) in which intimate narratives of trauma and degraded physicalities are woven through chat about everyday lives shaped by, and in spite of, anorexia. Given that "the dispersions of stories points to the dispersion of the memorable as well" (de Certeau 1984: 108), the concretisation of affects and desires into textual form on the sites constitutes a mattering of participants' experiences of, and feelings about, anorexia. But, as such, it is, again, also clear how the sites might be harmful as well as positive; "the real danger is that the visitor affected by an eating disorder has at last found someone who really understands the way they feel about themselves" (Bloomfield 2006: 2[20]). Although, it was also not unusual during fieldwork for participants to encourage each other to seek help or to fight anorexia.

It remains true that "little research has been conducted to look at the attitudes and feelings that visitors to pro-anorexic websites have towards their

---

[19] See Davies & Lipsey 2003; Dias 2003; Pollack 2003; Wilson et al. 2006.
[20] Also, Rouleau & Von Ranson 2011.

anorexia and why they use pro-anorexic sites" (Williams & Reid 2007: 141 – 142[21]). Given that "pro-anorexia websites are the first example of anorectics discussing the illness in its immediacy without the benefits of hindsight or reflective analysis" (Burke 2009: 64) it is precisely relationships between illness and personhood that these sites so valuably allow us to glimpse. However, exploring these necessitates moving away from viewing the sites as "the radical, underground web-based pro-ana movement" (Ward 2007: 1). This stance reifies and dislocates them from anorexia (and pro-anorexia) beyond virtual reality, actually *creating* an arguably false division between 'virtual' and 'actual.' Complexities, ambiguities and multiplicities articulated by pro-anorexia website informants were also present amongst those in the eating disorders unit, as will be seen throughout this thesis. Holding these two field sites together in ethnography for the first time, as this thesis does, illuminates the "valued and visible" (Schmidt & Treasure 2006) nature of anorexia in both.

1: B   The Eating Disorders Unit (EDU)

The EDU is an eighteen-bed inpatient unit in a large psychiatric hospital on the outskirts of an English city. Containing units from high to low security, the hospital is an architectural miscellany of buildings between which stretch scrubby grass, pathways and benches. The cluster of communal buildings housing Occupational Therapy facilities like the pottery, dance and music studios, the swimming pool, and the patient Snack Shop and Community Centre are lined with flower beds. Planted by the volunteer patient gardening teams, these contain tulips and daffodils in various states of dehydration. During the day, predominantly male groups of people hang out in and around the Community Centre, smoking and eating. A different relationship with food and the regimented arrangement of time around meals on the EDU means that ED patients rarely go to the Community Centre where food is a social focus. During my fieldwork, those who did go to watch TV or read the paper not infrequently narrated how patients from other wards advised them to eat. Such narratives tallied with my own experience; when around the grounds with informants from the EDU it was not uncommon for patients from other wards to

---

[21] And Williams & Reid 2009. But see also Brotsky & Giles 2009.

approach us and, prefaced with a phrase such as "I'm not being funny but...", to ask, "why don't you eat?"

In order to encourage eating, the EDU offers a variety of therapies[22] against the background of behavioural modification, in line with the remit that "treatment goals should include weight restoration and normalised eating, but also attitudinal and psychological change" (Bell et al. 2001: 2). A multi-disciplinary team of nurses, psychologists, psychiatrists, dieticians, family therapists, occupational therapists and social workers oversees inpatient admissions. Per protocol these run from one to six months. During fieldwork, most informants had been there for a few months, a couple for over two years and many had been in and out of this unit and others. I met just over 50 patients in total over a period of twelve months. Of these four had a diagnosis of bulimia, all the others of anorexia. Patients ranged in age from 14 to 72, with the majority being between 20 and 40. That "eating disorders certainly affect people across a wide class spectrum" (Garrett 1998: 21) was reflected during fieldwork. The unit is a tertiary centre to which people came from across the United Kingdom and from Southern Ireland, as well as from the local city area.

In the EDU time is arranged around meals. There are three meals a day, each consisting of two courses, and three Snacks. Each meal is followed by a Rest Period of between fifteen and forty-five minutes during which activity is limited and patients are observed, even in the loo. Rest Periods were described by many informants as "awful" because during them they felt unable to do anything but contemplate what they had just eaten. During my fieldwork many informants tried to sleep through Rest Periods but others read, watched TV, or knitted. If I ever passed through the Patients' Lounge during mealtimes it had a blank expectant air; in neat demarcated piles on sofas and floors had been placed pens, paper, notebooks, novels, knitting needles or crossword books by patients who knew that their bedrooms would be locked and inaccessible following the meal. As such, the EDU's arranging of time around meals, and how this quite literally opens and closes spaces of possibility, vulnerably exposes the tangible intimacies of patients' lives. In order to ensure that inpatients eat everything on their plates, the EDU operates a Peer Pressure System in the Dining Room; each meal has a set amount of time in

---

[22] eg. CBT, carried out by the Psychologists; MET usually carried out by nurses; intense work with the Occupational Therapists; drug regimens managed by the psychiatrists; and, sometimes, managed physical therapies like aikido and swimming.

which everybody must finish and if one person has not finished eating in that time, everyone else must wait at the table. If someone becomes distressed and unable to eat mid-meal, everyone else must down their forks and, again, wait. Informants' reactions to the system in interview were mixed; many regarded it as punitive but acknowledged it as lifesaving. If, in spite of this peer pressure, patients do not finish meals in time, they are given a high-calorie drink in addition and so many mealtimes do keep to time. However, during fieldwork I also sat through a few meals lasting many hours. From all these meals emanates an almost-constant presence of industrial cooking smells; these cut across the EDU's spaces from personal to clinical, trapped by barred windows. These smells were a frequent topic of conversation amongst informants who resented that their clothes and hair constantly smelt of food, as indeed, did mine. Given this shared embodied experience and also that this is a thesis that seeks to find ways of knowing (anorexia) beyond the visual, it is perhaps apt to introduce the space of the EDU through a map of its smells, from kitchen to drains.

Stepping through the three-locked front door into the bright white Administration Corridor, one is met by a mingling of photocopier ozone and coffee, so characteristic of office space. These come from staff meetings in the Conference Room or from the various offices that flank the corridor. This is the only space onto which visitors are allowed without a CRB check, which sets it conceptually, as well as sensorially, apart from the Ward part of the EDU which begins on passing through another locked door at the far end of the Admin Corridor. At that intersection new smells begin; at first a vaccination rub, hospital smell marks the open hatch of the meds room where patients queue for medications twice a day. Beyond this lies a large square space lined with doors. Here the smell of food is first sensed, but it is mixed with a strong odour of sulphur; behind each door are showers and loos, all with no windows and blocked drains. These are pungent with communal living, particularly if someone has just managed to vomit unnoticed. Informants described others' hairs in showers with equal claustrophobia as they did being watched in the loos by staff. Turning right down a narrow corridor, the Nursing Office and Laundry Room face one another. The olfactory character of the Laundry Room is precarious; it is frequently a warm atavistic waft of soap, which attracts patients to chat to one another whilst ironing. But at other times it too

emits a familiar smell of vomit if someone has washed their clothes with full pockets. Past the Laundry Room, the central corridor is banked on each side by the patients' bedrooms. The smell here is a vying for communal space; both therapeutic intervention symbolised by food, as well as the odours of one's neighbours, are speedily rejected by sprays of deodorant or perfume. At the end of this corridor lies the Patients' Lounge. In here the brown sofas smell musty – damp despite the constant heat of the room. The betting-shop curtains let in the sun throughout the day and the heat even in winter makes the atmosphere sleepy; patients often lie covered with starchy cotton blankets inked NHS in blue. Occasionally another hospital's nametags narrate trajectories from general medical wards where patients have been fed out of danger whilst waiting for a specialist unit. In here the smell of food is strongest; just beyond the Patients' Lounge lies the Dining Room and beyond that the Kitchen where foods are heated and carefully portioned six times a day. This olfactory traversing of the spaces of the unit illustrates that in the EDU the "charged rhythms of an ordinary" (Stewart 2010 A: 2) can neither be dislocated from the clinical nor reduced to it; treatment and lives mingle as food becomes medicine. Such minglings are also apparent from the words that constitute the spaces of the Unit.

Like smells and ethnographers, texts and uttered words 'hang around' – the former in concrete presences, and the latter woven through therapeutic practices and the conversational intangibilities of daily life. Certain words remind me of fieldwork. Maupassant texts recall helping an informant with French homework; numbers on a TV screen remind me of Saturday evenings spent watching *X-Factor*; and the pharmaceutical company pen on my desk is a remnant of when I was asked to be minute-taker for a meeting which decided how long local authority funding would be provided for a patient who had been in and out of specialist units since the age of nine. This latter text evokes the clinic's "emplotments" (Mattingly 1998) and how the structuring of experience into clinical texts acts to "shape and reshape the body" (Good 1993: 81). In the EDU words are powerfully enmeshed with bodies in intimate ways as they "are instrumentalized in getting things done" (Butler 1997: 44). A staff signature on a section 17 form can open the locked doors to allow a patient detained under the Mental Health Act a leave of absence; a patient's name in the signing out book marks "chronotopes" (Bakhtin 1982) in which "the

inseparability of time and space" (ibid. 84) is illustrated not only by the current placing of patients' bodies, in the swimming pool or on a bench for example, but also by how that placing attests to the trajectories of their treatment – to how physically frail or how trusted they are. During fieldwork, like the signing out book, other texts threaded together patients and staff in formal and informal ways. Writing on supply boxes filled with hundreds of one-portion cubes of butter spoke of institutional life and individual struggle; weekly hospital menus were signed, but also lost, swapped and torn up by informants; the whiteboard outside the Nursing Office mixed patients' doodles with staff rotas; and carers' literature was pasted to the EDU's walls alongside notices for film club and goodbye cards from recently discharged patients. These processual re-mappings of wall space hint at wider reconfigurations and contestations on the part of informants in the EDU, which are also apparent from the texts that strew the Patients' Lounge.

In her interview Kate said:

"I read as much about anorexia as I can."

Kate, inpatient

Kate, like other informants in both sites, sometimes read academic texts about anorexia as well as many memoirs written by recovered anorexics. During fieldwork I found both the former and latter on sofas in the Patients' Lounge, as well as seeing them quoted on the Internet. Such texts are simultaneously meta-narratives and tangible actors in the field. They illustrate that, alongside claims by website informants of being or having been in treatment, and admissions by some EDU informants of visiting or having visited pro-anorexia websites, there are other moments and locations at which these spaces meet; through memoirs in particular, their edges touch. Although in the EDU memoirs were sometimes lent to patients by staff to inspire recovery, informants in both field spaces used them to inspire anorexia. Memoirs' liminality is acknowledged by one author, Grace Bowman. She says of anorexics reading her memoir *Thin* that, "strange as it may sound, it might lead them to try and imitate, even emulate, my behaviour, twisting it to their own needs" (Bowman 2007: xiv). Bowman's words are echoed by one of the press reviews for *Thin* which states that it is "too intoxicating to make it safe reading for the vulnerable" (Lee-Potter 2006). Alongside engagements with texts through

which informants resisted or reconfigured their clinical experiences, in a sociality as richly storied (Stewart 1996) as that of pro-anorexia websites, treatment was also mattered and ruptured through talk.

In the "free places" (Goffman 1961: 206) of Group Walk or the EDU's back steps, which afforded "time away from the long arm of the staff" (ibid. 206), some informants discursively reclaimed anorexia. Others rejected treatment and anorexia and some wished to recover. Importantly though, almost all talked in ways that in the EDU's other spaces might be classed as "the anorexia talking;[23]" informants expressed pain that might otherwise be thought of as 'anorexic' or discussed food, which was therapeutically disallowed. Illustrating how "the very surfaces and tactility of built spaces play[...] a strong role in the doings and imaginings of its users" (Desjarlais 1997: 73), this correlation between spaces and dis/allowed words also illustrates how texts, spaces, smells and words are all entangled with various delineations of illness and personhood on the EDU. From everyday conversations between staff and patients emerged clinical ontologies on the part of both groups, sometimes in tandem, sometimes at odds. As staff and patients shared chat, laughter and tears, each moved within a plurality of roles in relation to the other. Frequent weavings of lives into teleological narratives of cause and effect in relation to anorexia on the part of staff, both in clinic notes and day-to-day conversations, were mirrored by conversations between informants who connected the points of their lives with anorexia in many different ways. But, whether on the back steps or in the Patients' Lounge, during fieldwork the EDU's sociality was as replete with silences as it was with stories. Although so utterly corporeal in some ways, fieldwork in the EDU was constituted as much by glimpses and silences, partiality and fragments, as the disembodied fieldwork on the Internet was. In both spaces the plethora of words exchanged between informants was mimed by "pasts that others are not allowed to read" (de Certeau 1984: 108) and in the EDU, in particular, "the presences of diverse absences" (ibid. 108) were palpable. By patients confined to the Ward newspapers were requested from others who had more freedom as often as contraband substances like chewing gum were. Within these, cinema listings were a frequent topic of conversation about what was happening elsewhere, out of reach. But informants also sometimes talked of how as

---

[23] See Chapter Three.

the outside world receded, the past repeated. Some described how feeling 'full of food' kept them awake at night and evoked memories. Such nights echo how both objects and words also "have hollow places in which a past sleeps" (ibid. 108), and photographs and letters were pasted to bedroom walls.[24] The EDU is a place at once both dislocated and yet ordinary. It is divorced from informants' life worlds and yet for months at a time it holds their everyday lives within its walls; it is "where the difficult, intricate process of living could sometimes give rise to incredible harmonies of happiness and sometimes to near-tragic disorder" (Yates 2007: 274) and these can be neither reduced to, nor dislocated from, informants' varied relationships with their anorexia. It was in quiet moments in the Lounge, or laughing in pottery class, as well as in the Dining Room, that informants expressed their feelings about the illness. I do not wish to assume pro-anorexia where it is not; some EDU informants hated anorexia, some expressed love for it and many shifted between wanting to enhance or maintain it, or recover. And, as on the websites, even informants who desired anorexia often encouraged others to get better and fight it.

Thus, both pro-anorexia websites and the EDU resonate with ambivalences and complexities. Each is replete with movement and transience, but also stasis and relational ties. As such, both emerge as "non-spaces" (Augé 1995) in informants' narratives whilst also encompassing many facets of "the messiness of everyday life" (Passaro 1997: 157). They are, following Lisa Malkki, "accidental communities of memory" (Malkki 1997: 91) in which "sharings of memory and transitory experience" (ibid. 91) are simultaneously contingent yet constitutive of their fabric. This thesis therefore explores how in both spaces, relationships between anorexia and personhood, agency and desire, bodies and eating, are played out on many levels in ways that are perhaps both 'virtual' and 'actual.'

---

[24] See Warin 2005 on bedrooms in institutions.

Part Two   Theoretical Perspectives

2: A   Anorexia as Terminology

Some previous non-clinical writers have rejected the term anorexia,[25] arguing it to be too tied with biomedical designations of a "reified and bounded condition that is removed from cultural ideologies and processes" (Gremillion 1992: 59); "human beings are far too complicated to be summed up by any single word" (Liu 2007: xiii). However, it has also been suggested that "even when they are critical of the medical model, most theories of eating disorders unconsciously rely on psychiatric definitions and assumptions" (Garrett 1998: 49). Navigating between these perspectives, I suggest that recognising eating disorders as "complex heterogeneous and shifting collectivities of socio-historically located subjectivities, bodies and body management practices that are constituted within and by (rather than outside of) the normative discursive contexts of contemporary Western cultures" (Malson 2009: 137) does not preclude also paying attention to anorexia as a clinical category. I suggest that integral, not antithetical, to pro-anorexia is how anorexia is "virtual object" (Mol 1998: 154) *and* lived experience - how informants' subjectivities are enmeshed with anorexia's psychiatric categorisations. Therefore, to address anorexia in all its "complex darkness" (Martin 2007: xvii) whilst also taking account of desire, I use 'anorexia' as a "blanket term" (Garrett 1998: xi) that informants "live under" (Martin 2007: 35) but also to which they relate on a number of, sometimes contradictory, levels. When not using the appellation anorexia, in this thesis I use the term 'the illness.' This is neither intended precisely to utilise anthropological distinctions between disease and illness,[26] nor to entirely refute them, but rather to navigate between them. 'The illness,' particularly with its article intact, is a term that stretches from the clinical to the subjective; it was as 'the illness' that informants in both field spaces referred to anorexia throughout fieldwork as, also, did staff in the EDU. This term was sometimes starkly clinical, sometimes intimately experiential and into it were invested diverse conceptualisations of what 'illnesses' do to personhoods. As such, 'the illness' encapsulates the mobility and contradiction that are apparent in many other discussions in this thesis.

---

[25] eg. Eckermann 1997; Malson 1998.
[26] See Kleinman 1986.

2: B   Anorexia in the Clinic

The term anorexia nervosa was coined in 1874 by William Gull, Queen Victoria's physician. It is a "heterogeneous disorder[…] with complex multifactorial aetiology, involving the interaction of genes and the environment, particularly social factors" (Collier & Treasure 2004: 363). Its symptoms include "restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics" (WHO 2007: F50.0). It is suggested that "a dread of fatness and flabbiness of body contour persists as an intrusive overvalued idea" (ibid. F50.0). Therefore, "anorexia has low weight as a criterion" (Palmer 2005: 2), which differentiates it diagnostically from bulimia nervosa. In the DSM-IV (APA 2000), anorexia bars diagnosis of bulimia and there are now two subtype categories of anorexia: 'restricting' and 'binge-eating and purging.' However, "the diagnosis of eating disorders is a tricky business: diagnosis can be unstable, with clinical features changing over time often switching from anorexia to bulimia" (Colllier & Treasure 2004: 363). Estimates of full recovery vary from 50% (Bryant-Waugh at al. 1988) to 80% (Bell et al. 2001) but anorexia has "one of the highest mortality rates of all psychiatric illnesses" (Bogle 2000: 2); "in the long run subjects with anorexia nervosa have an almost four-fold risk of dying compared to healthy people the same age and sex" (Van Hoeken et al. 2005: 18).

Although "most patients with anorexia nervosa receive treatment solely on an outpatient basis […] a substantial minority receive inpatient treatment." (NICE 2004: 6.5.2). It is suggested that "patients may require inpatient care if they are suicidal or have life-threatening medical complications, such as marked bradycardia, hypotension, hypothermia, severe electrolyte disturbances, end-organ compromise, or weight below 85 percent of their healthy body weight" (Williams, Goodie & Motsinger 2008: 187); this tallies with the EDU during fieldwork. Treatment can be enforced through sectioning (MHA 2007) "where substantial risk cannot be managed in any other way" (NICE 2004: 6.5.7.3), although "a relatively low proportion of inpatients with anorexia nervosa are placed on formal compulsory treatment orders, with reports ranging from 9% to 28%" (Tan et al. 2010: 14). However, "the outcome of reported legal challenges to compulsory treatment in anorexia nervosa, including the use of forcible feeding if necessary […] have tended to favour those applying for or defending the right to treat" (NICE 2004: 6.5.7.2). A

misalignment between how inpatient treatment is viewed by treatment professionals and patients has been documented, with the former more likely to regard treatment as having been effective at discharge.[27] This may be linked to "perceived coercion" (Tan et al. 2010) where anorexics "can experience treatment as compulsory whatever their legal status." (NICE 2004: 6.5.7.0); they may "present under duress from alarmed relatives, friends, or co-workers who have cajoled or blackmailed them into the therapist's office" (Vitousek et al. 1998: 392). Moreover, "non-compliance throughout the whole treatment process is also a major problem" (Griffiths & Russell 1998: 128).

Given this context of treatment resistance, pro-anorexia is discussed within the clinic in terms of "the role of pro-anorectic beliefs as a maintenance factor" (Schmidt & Treasure 2006: 354) and it is recognised that "core features of eating disorders can be highly valued by the patient" (NICE 2004: 6.5.5). One aspect of the illness that makes it valuable to anorexics is how anorexia is "a functional coping strategy in which control of eating serve[s] as a means of coping with ongoing stress and exerting control" (Eivors et al. 2003: 96[28]). Because of this, anorexia has been described as "an illness of the emotions" (Treasure et al. 2007: 73). Anorexia as a 'strategy' and a modality of control particularly intersects with my discussions of pro-anorexia and of how anorexia emerges in informants' accounts as a way in which they mediate (and produce) their day-to-day lives. Accompanying these discussions of anorexia's functionality, there has emerged from the clinic a recent body of qualitative studies looking at "illness perceptions" in anorexia (Holliday, Wall, Treasure and Weinman 2005[29]). It has been suggested that more qualitative research "could inform the therapeutic process and provide a greater understanding of recovery" (Le Grange & Gelman 1998: 182) as many clinical studies "tell us little of the relation between the 'self' and the 'illness'. […] How an individual relates to their 'illness' may have a significant impact upon outcome" (Higbed & Fox 2010: 308).

However, despite the value of these recent works, there is a slight aporia in their explorations of anorexics' relationships with their illness. Starvation has

---

[27] See Gowers at al. 2000.
[28] See Bruch 1974; Treasure & Schmidt 2008; Williams & Reid 2009.
[29] eg. Higbed & Fox 2010; O'Connor et al. 2003; Nordbo et al. 2006; Reid et al. 2008; Tan et al. 2010. Federici & Kaplan 2008 explore anorexics' accounts of relapse and recovery. Fox & Leung (2008) explore anorexics' "existential well-being" (Fox & Leung 2008).

cognitive effects (cf. Keys et al. 1950); it induces "distorted" thinking (Bruch 1974) and may affect "decisional balance" (Prochaska & DiClemente 1992[30]). In her memoir of anorexia, Mandy Allison writes, "I had to remind myself that, possibly, the way I saw reality was filtered through the lens of the illness" (Allison 2009: 198). It is perhaps to acknowledge these cognitive effects that in this qualitative work there is widespread usage of the word 'beliefs' and/or 'perceptions' in relation to pro-anorexia. As Jeanne Favret-Saada stated in her ethnography of witchcraft, to describe a person's conceptualisations as 'beliefs' is "automatically to deny them any truth: it is just a belief, it is not true" (Favret-Saada 1980: 4). As such, these qualitative works leave overarching models of "false reason" (Foucault 2003) in anorexia intact in a way that could limit the reaches of their qualitative praxis. As such, they remind us that "what it means to be rational or irrational depends on what notions of personhood are in play" (Martin 2007: 7). Clinical paradigms of anorexia's effects on personhood can affect our ability to simultaneously address *both* informants' pro-anorexic articulations *and* anorexia's effects on selves and bodies. Throughout this thesis I attempt to hold anorexia's realities and effects alongside informants' voices, however oxymoronic these may seem. Also exploring ethical issues engendered by the effects of the illness, particularly related to refusals to consent to treatment, there has been a valuable recent body of work exploring competence, capacity[31] and autonomy in anorexics.

Asking "whether people with anorexia nervosa are actually competent to make valid treatment decisions is […] important […], since it is a central tenet of medical ethics and law that patients should have the right to make their own treatment decisions, so long as they are competent to do so" (Tan 2003: 1246[32]). It has been suggested that "although patients may have some difficulties with concentration as they lose weight, they often appear to have a very good understanding of the facts of their disorder and the risks involved and the ability to reason, which they retain even at very low weights, whilst at the same time resisting or refusing treatment that is judged to be of benefit to them" (Tan, Hope, Stewart & Fitzpatrick 2003: 629). As such, it has been argued that some, even many,

---

[30] See Blake, Turnbull & Treasure 1997; Cockell et al 2002.
[31] See Tan, Hope & Stewart 2003A on differences between competence and capacity in relation to anorexia.
[32] See Tan et al. 2006.

of those who refuse treatment do so with competence intact.[33] Because "anorexia nervosa presents a challenge to current legal conceptions of capacity to refuse treatment because the disorder affects patients' values rather than understanding and reasoning" (Tan, Hope & Stewart 2003 A: 545[34]), some theorists have turned to look at the effect of anorexia on values. This work, like that on emotions (cf. Charland 1998 & 2006), explores anorexia's effects in nuanced ways that inform my explorations of pro-anorexic desire.[35]

There is a further tension around how we listen to the treatment refusals or pro-anorexic articulations of anorexics. "The ill body is certainly not mute – it speaks eloquently in pains and symptoms" (Frank 1997: 2) and, in anorexia, often also through extreme visual emaciation. But, in the clinic the, sometimes urgent, necessity of saving lives privileges the information offered by the visible, and quantifiable, starved body over the anorexic's voice. In *The Golden Cage,* Hilde Bruch writes about one of her patients "since she continuously protested that she would eat normally if only the intravenous feedings were stopped, this was put to the test. In one week she lost five pounds while talking about how much she enjoyed eating and gaining weight – a complete disregard of the facts" (Bruch 2001: 81). This quotation illustrates how seeing anorexia *through* the body can silence the voice, setting up body and voice as in dualistic conflict. Given the high mortality rate of anorexia, it is clear why and how this is enacted. But, I suggest that this privileging of bodies over voices extends beyond the clinic, influencing how we view, quite literally, anorexia in the humanities and social sciences; silences enacted by 'looking at' anorexia through the vector of bodily emaciation can themselves be silencing; they settle and solidify, affecting our ability to think beyond them.

---

[33] See Gans & Gunn 2003 for an overview of previous discussions of competence, autonomy and treatment of anorexia. See also Draper 2000; Tan, Hope, Stewart & Fitzpatrick 2003.
[34] See Tan, Hope & Stewart 2003 B.
[35] See Chapter Four for an exploration of 'desire.'

2: C   Anorexia in The Humanities & Social Sciences Part One:

Thinking (Through) Thinness

Discussions of anorexia in the 1980's and early 1990's widely read the 'anorexic body' as a metaphor for the social body, as titles such as *Hunger Strike* (Orbach 1993) and anorexia as *Crystallization of Culture* (Bordo 1988 & 1993) attest. Such works tended to hold one of two viewpoints: that anorexia reproduces dominant paradigms of femininity and is a form of repression, or that anorexia is a modality of rejecting such cultural constraints.[36] Those authors who discussed anorexia as a metaphorical 'vomiting' of ideals of femininity argued anorexia to be "an attempted solution to being in a world from which at the most profound level one feels excluded" (Orbach 1993: 84). It was suggested that "food-refusal is a metaphor for word-refusal: for what it is that anorectics cannot 'swallow'" (Ellmann 1993: 24). This discourse of resistance has, albeit differently, entered discussions of pro-anorexia websites; these are described as "eschewing the fast-food loving, alcohol swilling, materialistic nature of contemporary Western society" (Tierney 2006: 182). Drawing criticism inside the clinic[37] for paying insufficient attention to anorexia as psychiatric illness, anorexia as resistance has also been critiqued by social historian Joan Jacobs Brumberg. She wrote, "if the anorectic's food refusal is political in any way, it is a severely limited and infantile form of politics, directed primarily at parents (and self) and without any sense of allegiance to a larger collectivity" (Jacobs Brumberg 2000: 38-39). On the other hand, discussions of anorexia as a 'swallowing' of dominant paradigms of femininity positioned the illness at the extreme of a "continuum that begins with normal dieting" (Garrett 1998: 23), part of the "tyranny of slenderness" (Chernin 1981) that is "supported by the fashion and diet industries" (ibid. 99[38]). This viewpoint is also present in some discussions of pro-anorexia websites. Burke states, "pro-anorexia participates in the same structures of power which feminists for a number of years have identified as sources of women's oppression and unhappiness" (Burke 2009: 60).

These works are extremely valuable for having unpacked the "constitution and regulation of femininities, subjectivities and the female body" (Malson 1998: 33) in western cultures. However, my fieldwork data suggest that although fat may

---

[36] For a discussion of both perspectives in relation to pro-anorexia websites see Day & Keys 2009.
[37] See Tiller et al 1993.
[38] See Chernin 1986; Heywood 1996; Wolf 1990.

indeed be a feminist issue (Orbach 1998), to include anorexia in such discussions not only engenders a narrow[39] conceptualisation of the illness, but may also limit our ability to take account of pro-anorexia. In particular, discussions of anorexia as an extreme modality of achieving' a "slender body" (Bordo 1990 & 1993) suggested the illness to be *about* a quest for thinness. Echoing Georges Perec's discussion of how trains only begin to exist at their derailment and the more people die in that derailment, the more the train exists (Perec 1989: 9), such discussions have bound together anorexia and the spectacle of visible emaciation, making it difficult to think about one without the other or to 'see' beyond thinness in analysis. But, their relationship may not be so axiomatic.

There is a temporality to this focus on thinness; it not only makes anorexia *reactive* - a temporally later "symptom" (MacSween 1993), produced by external forces wrought on a passive body, but also imputes meaning retrospectively from the thin body, thereby assuming a teleology that is not present in my informants' accounts. As such, just as some analyses of pro-anorexia websites are overly-focused on a future-orientated conceptualisation of the sites as spaces in which to work towards thinner bodies to the detriment of seeing what is happening in the present, this retrospective interpretation also risks marginalising the embodied present. Assuming thinness to be the central goal of anorexia interprets informants' day-to-day practices of eating and starving as all *about* the body, which ignores nuanced meanings and imaginings with which they are imbued. During fieldwork, some informants did note that they had been complimented on initial weight loss and others told me that they could not understand why they should put on weight as 'surely losing weight is what the government always tells us to do.' But, this latter was offered as a 'socially acceptable' reason to maintain anorexia, not as a causative factor.

Instead, my fieldwork data suggests that practices of eating and starving are not only means-to-an-end body managements, but are central in their own right to how "the everyday is produced" (Tucker 2010: 526) both within, and with, anorexia by informants. Such practices are enacted *with* the body but are not centrally *about* the body. Bodies emerge in informants' accounts as "both active and productive" (Grosz 1994: 12), indexical and indexed; informants processually disconnect and re-

---

[39] See also Gooldin 2008; Lester 1997; Warin 2010.

connect bodies with anorexia in various ways. Thus, although "it is not possible to make sense of the construction of the person unless the body also forms part of the picture" (Moser & Law 2003: 2), perhaps thinking about bodies "has to be done carefully" (Grosz 2001: 26). This thesis therefore seeks to find other ways of knowing anorexia, not by ignoring thinness, but by contextualising it within wider discussions of informants' relationships with anorexia. But, this also requires reflection on how we think about gender.

2: D   Gendered   Preoccupations: Clinical   &   Cultural Entanglements

Discussions in the 1980's and early 1990's which positioned anorexia as part of wider practices of female body management also served to gender the illness as female. Thus, just as it came to be seen as *about* thinness, it has also not infrequently been discussed as "fundamentally *about* gender" (MacSween 1993: 6 – *italics mine*). Albeit with very different emphases, early cultural analyses extended the gendering already present in psychoanalytic discussions. Most famously in the work of Hilde Bruch (1974 & 2001), early psychoanalytic analyses prevalently conceptualised anorexia as a denial of womanhood and a desire to return to "the cozy compensations of infantilism" (Ellmann 1993: 2). There is, of course, "no such thing as an uncoded body" (Spivak in Barr 1989: 12) or indeed, subjectivity; each is marked and produced, framed and constrained by cultural and political forces. And, the importance of acknowledging gender when thinking about anorexia is clear, not least but most simply, from the illness's unequal distribution between the sexes. But, I suggest that there are other, equally valuable, ways of exploring anorexia; these may further comprehension of aspects of informants' subjectivities and experiences that are overlooked by a focus on gender. This is a suggestion that does not signify an imposition of my own analytic concerns on the field; it derives from fieldwork. I noted earlier that many informants had read a lot of literature on anorexia. One informant in the EDU, Gillian, discussed gender in depth in her interview, talking both about psychoanalytic theories of anorexia as a denial of womanhood and discussions of anorexia as an extreme form of dieting. About both, Gillian was not alone in saying:

"It's rubbish all this stuff about how it's about 'being a woman, blah blah'… anorexia isn't about that. It's so much more complicated than that…It's about so many things, other things. I find all that stuff really annoying, to be honest."

Gillian, inpatient

Gillian's words are echoed by Marya Hornbacher in her memoir, *Wasted*. Hornbacher writes that treatment professionals pay too much attention to "when you've become utterly powerless, delusional, the center of attention, regressed to a passive, infantile state – and they treat you as a passive infantile creature, thus defeating their own purpose. The end result is not your intention at the outset" (Hornbacher 1998: 68). Hornbacher's words illustrate the enmeshment of the two focuses of gender and thinness and how they can become narrowly tautological and silencing. It has been argued that a similar gendering of clinical paradigms of anorexia dates from the term's inception (cf. Hepworth 1999: 29); from this ensues a second silence.

Although it has been suggested that "if there is one fact that would evoke nearly universal agreement, it is that the overwhelming number of people who develop eating disorders are female" (Gordon 1990: 32), "adolescent boys and young men may also be affected" (WHO 2007: F50.0). Moreover, "descriptions of anorexia nervosa occurring in male patients are as old as descriptions of anorexia nervosa itself" (Crisp & Burns 1983: 5). However, "few reports report incidence rates for males" (Van Hoeken et al 2005: 17) and "this therefore makes it difficult to evaluate the size of the problem for them" (ibid. 17). As such, recorded numbers of male anorexics "are extremely sensitive to the policies of the respective clinics and reticence should be exercised in drawing firm conclusions from them" (Crisp & Burns 1983: 5). Illustrating "the process of solidification and inversion whereby a statement becomes a fact" (Latour & Woolgar 1986: 106), between the 1960s and 1980s research on anorexia not infrequently left out male patients on the basis that they were atypical, thereby making them atypical (Crisp & Burns 1983). Thus, "males with eating disorders have been relatively ignored, neglected, dismissed because of statistical infrequency, or legislated out of existence by theoretical dogma" (Andersen: 1995: 177).

Although the various pragmatic ramifications of this are really grist for another thesis, they are worth briefly noting as they too point to a need to look beyond gender. During fieldwork I interviewed four male anorexics - all of the male patients that I met on the EDU. All noted how their anorexia had been framed as a 'female disease' in clinical encounters. Two recounted how it had taken their GPs a long time to diagnose them, with one informant even reporting that his GP had told him, "but of course you are the wrong sex to be anorexic!" Another male informant, on the other hand, discussed how he had been taken into hospital "much quicker than the others," referring to the women in the EDU.[40] Although a tiny snapshot, these experiences of diagnosis did seem to differ from those reported by female informants. Furthermore, there were differences in how male patients were discursively constructed in the clinic; I noticed early on that in the admission interviews, sexual histories and sexuality were discussed in great detail with male patients but only with female patients if they had been abused. As well as, perhaps, the "structuring of the clinical interview in relation to historical and social discourses about gender" (Hepworth 1999: 71) this might suggest an adherence to early findings of sexual anxiety amongst male anorexics.[41] It is also interesting to note that anorexia itself is gendered as female by discussions of it as a "minx" in some clinical literatures,[42] as it was in the EDU.

All of my male informants related to anorexia as a condition gendered as female. On the sites I encountered males but none wanted to be interviewed and none joined the *Facebook Research Group*. All the males interviewed in the EDU described their shame at having what they regarded as "a women's thing," as one informant put it. Thus, although anorexia is rarer in males, pervasive cultural imaginings of the illness may also limit our abilities to gain access to the voices of male anorexics as they serve to stigmatise the illness. Jim had told his friends he had cancer to avoid the stigma and Robert stressed in his interview that what he had was not the same illness as "all the girls" in the EDU because, he said:

---

[40] These temporalities are also noted by Andersen 1995; Garfinkel 1995.
[41] eg. Crisp & Burns 1984; Fichter and Daser 1987.
[42] cf. Treasure 1997; Treasure et al. 2007.

> "With the girls it's all about image and media and my anorexia isn't about how I look at all; it's about eating and control and all sorts of things."

Robert, inpatient

Robert's words say more about how *both* his embodied experience of his own anorexia *and* his vision of the anorexia of others were shaped by gendered paradigms than it does of an actual difference between male and female informants' experiences of anorexia.[43] In fact, discussing their relationships with anorexia, and their practices of eating and starving, with informants revealed no differences between the sexes; in their tropes and focuses, male informants' interviews were markedly similar to those of female informants. Both males and females described complex and diverse relationships with their anorexia, discussing it as illness, comforting carer, friend and/or enemy. To address pro-anorexia, we need to find ways to explore these many relationships and not allow our vision (or rather, our listening) to be filtered through gendered paradigms or emaciated bodies. This thesis therefore draws on and extends recent work about anorexia in the social sciences to think about embodied subjectivities of anorexia as a way of exploring pro-anorexia.

2: E   Anorexia in the Humanities & Social Sciences Part Two: "Embodied Sentience"[44] to Pro-Anorexic Desire

The later 1990's saw a turn to Foucault's work; investigating how "discourses involve practices that position the subjects of the diagnosis of anorexia nervosa in particular ways and in turn reproduce dominant ideals of science, medicine and women" (Hepworth 1999: 3) provided a "double critique of medicine and, by extension, of patriarchy" (Warin 2010: 10). It was suggested that "Foucault's notion of 'technologies of the self' can provide us with a useful tool for bridging the split between the "inside" and "outside" produced and reified in both the medical model and the feminist cultural formulation of anorexia" (Lester 1997: 479). These works moved beyond a conceptualisation of anorexia as 'about' thin bodies passive to cultural forces, instead exploring "embodied subjectivities, experiences, and body-

---

[43] See Margo 1987; Sharp et al. 1994 and also BBC 2009.
[44] Warin 2003.

management practices" (Malson 1999: 138[45]). However, they did perhaps leave intact a model of anorexia as tied to the (female) body.

Mirroring discussions of 'illness perceptions' in clinical analyses, noted above, recent works in the social sciences and humanities have addressed wider aspects of anorexics' experiences, paying attention to practices and beliefs. O'Connor & Van Esterik (2008) explore anorexia in the context of cultural discourses of hygiene[46] and morality, arguing that "anorexics [are] misguided moralists, not cognitive cripples" (ibid. 7). Likewise, Giordano suggests that eating disorders "are the symptoms of ordinary morality, which is just being taken seriously – or more seriously than usual" (Giordano 2005 [A]: 8 – 9).[47] Garrett's discussion (Garrett 1998) is unique in its focus on recovery from anorexia. Warin (2006 & 2010) looks at relationships between anorexics. Lester (1997; 2007; 2009) and Gremillion (2003) explore personhood, particularly in relation to treatment regimes, charting their reproduction of cultural paradigms of gender, individualism and authenticity. Of particular value to this thesis are Gooldin's discussion of "being anorexic" (Gooldin 2008) and Warin's explorations of "everyday worlds of anorexia" (Warin 2010) which address "the embodied sentience of anorexia" (Warin 2003: 78) in nuanced and complex ways.

In her own discussions of anorexia, Megan Warin bemoans how little attention is paid to how "food is talked about and experienced by people with anorexia" (Warin 2003: 78). Annemarie Mol, in turn, suggests that focusing on eating may productively problematize a Greco-Roman muscular model of the subject, thereby engendering nuanced and inclusive ways to re-figure subjectivity and agency (Mol 2008). This echoes Lauren Berlant's suggestion that eating is "an exercise that violates any definition of sovereign identity" (Berlant 2007: 777). Conjoining these discussions, this thesis explores how informants' day-to-day practices of eating and starving are enmeshed with subjectivities of pro-anorexia; it asks how they processually mediate and produce relationships between anorexia, personhood and bodies. I explore how, at times, informants see anorexia as part of themselves and, at others times, as both external *and* internal 'other.' As such, I see

---

[45] See Malson 1998.
[46] See Warin 2003 & 2010.
[47] These are also contextualised by earlier discussions of historical accounts of female asceticism (Bell 1985; Jacobs Brumberg 2000; Lester 1995; Walker Bynum 1987).

"personhood […] as an unfolding process, with identity conditions which evolve over time" (Curtin & Heldke 1992: xiv[48]) – as something that is shaped by, through and in spite of, the, sometimes invited/sometimes unwanted agency of anorexia, and also through wider social paradigms of normality and pathology, as well as by specific social contexts.[49] Paying attention to the "intricacies of power, mouths and bodies" (Probyn 2000: 7) signifies a way of exploring not only how anorexia is (re-)produced everyday through starving and eating but also how anorexia produces (and constrains) informants' everyday lives. As such, in this thesis I take experience as "not an existential given but rather a historical possibility predicated on a certain way of being in the world" (Desjarlais 2010: 161), thinking about it relationally, "in ways far more collective and 'external' rather than individual and interior" (Seigworth & Gregg 2010: 7).

In their emphasis on intimacy and desire, subjectivities and experiences, my explorations of informants' relationships with anorexia intersect with a recent (re)turn to "microanalysis" (cf. Biehl & Locke 2010), which aims to bring "into view the immanent fields that people, in all their ambiguity, invent and live by (ibid. 317), influenced by the work of Gilles Deleuze. Micro-analysis is particularly pertinent to pro-anorexia not only because it enables a concomitant focus on intricacies of life worlds and wider social contexts, but also because it allows us to think about pro-anorexia as desire rather than 'belief;' Deleuze emphasized the "primacy of desire over power" (Deleuze 2007: 126), arguing desire to be "the element of a micro-analysis" (ibid. 125). Although my use of 'desire' stems directly from informants' accounts of 'wanting' anorexia, I do not assume this term to be unproblematic or even adequate to account for informants' subjectivities; it is, rather, a way to start thinking. As such, this signifies "an anthropological approach that includes from the start the possibility of diverse motivations for human action and diverse grounds for, and forms of, personal agency" (Desjarlais 1997: 202). This recognises pro-anorexia as neither fully agential nor just the product of illness. In it "agency can be strange, twisted, caught up in things, passive or exhausted" (Stewart 2007: 86), as well as shared with anorexia. Furthermore, I recognise that wanting to hold onto

---

[48] See also anthropological discussions of personhood such as those in Carrithers, Collins & Lukes 1985 & in Lambek & Strathern 1998.
[49] See also anthropological discussions of subjectivity and illness within a range of social contexts, such as in Biehl, Good & Kleinman 2007 & in Kleinman, Das & Lock 1997.

something can be about finding ways of living within compromised conditions of possibility as well as an expression of preference. However, as Donna Haraway reminds us, we "cannot relocate to any possible vantage point without being accountable for that movement" (Haraway 1991: 192). Exploring pro-anorexia necessitates paying attention to how ways of looking and modes of knowledge production can be kept continuously ethical and open from field to text.

2: F   "Ethical Ambivalence:"[50] 'Brackets' & Juxtapositions

 "Illness is the night-side of life" (Sontag 2002: 3), writes Susan Sontag, suggesting that although we "hold dual citizenship" (ibid. 3), we prefer the "kingdom of the well" (ibid. 3) to the "Kingdom of the sick" (ibid. 3). But informants' pro-anorexic articulations remap this "night-side of life" (ibid. 3), challenging and reconfiguring concepts of health and illness. What may seem incommensurate from the outside - such as desire and suffering, pro-anorexia and biomedicine – may be not only intertwined, but mutually productive to those affected. Thus, from field to text, we must be careful that we are not "heaping reaction formation upon reaction formation" (Butler 2000: 20), (re-)instating binaries blurred and subverted by informants. As such, taking account of pro-anorexia requires thinking in open – meaning not binaried *or* stigmatising – ways; it necessitates "doing and writing research that is sensitive to the textures and nuances of personal stories" (Saukko 2000: 3000) and takes account of simultaneity and multiplicity. This demands balancing clinical realities with informants' voices, empathising without encouraging informants' potentially fatal practices and desires. "Bracketing diagnostics" (Biehl & Locke 2010: 318) is useful here; bracketing permits anorexia's stark realities to be neither marginalised nor lost whilst also allowing other narratives to share our listening.

Les Back invites us to pay "attention to the fragments, the voices, the stories that are otherwise passed over or ignored" (Back 2007: 1). He argues that "the listener's commitment to hearing places us on the side of the story from the outset" (ibid. 8) but underlines how this does not preclude, but rather encourages, critical thinking; it involves an "active listening that challenges the listener's

---

[50] Butler 2000.

preconceptions and positions while at the same time it engages critically with the content of what is being said and heard" (ibid. 23). This signifies a continual negotiation of being "caught and 'catching things'" (Favret-Saada 1980: 14), allowing a certain "interpretive drift" (Luhrmann 1989) in which the "slow slide from one form of explanation to another" (ibid. 322) is balanced by death, pain and harm at the margins of the page. This thesis therefore attempts a listening that allows irony, where that is about "contradictions that do not resolve into larger wholes, even dialectically, about the tension of holding incompatible things together because both or all are necessary and true" (Haraway 1991: 149). Irony is also, according to Kenneth Burke, "an explicitly dialogical rather than rhetorical trope" (Murray 2001: 22); it is the "inclusion of the voices of others" that "distinguishes irony as ethical" (ibid. 22). Continually practising an open listening, sensitive to contradictions and multivocality, allows us to not "distinguish between the important and the trivial, one listens to whatever, or perhaps to whatever it is that matters" (Grossberg 2010: 160) in informants' lives, even if that is the maintenance of a serious illness.

Throughout this thesis this openness to what may seem trivial and a looking beyond what might be assumed to be important is also enacted through continual reflection on my own reading and writing; I ask whether my "analytics remain attuned to the intricacy, openness, and unpredictability of individual and collective lives" (Biehl & Locke 2010: 318). Given that pro-anorexia problematizes what *is* desire, and even, what *can be* socially desirable, I seek to engage with informants' relationships with their anorexia and listen to their desires whilst also exploring wider pragmatic and philosophical questions regarding how we can access and address this desire. Part of the overall "ethical ambivalence" (Butler 2000) of this research is an exploration of how current ways of looking at anorexia can be both "critically interrogated and mobilized at once" (ibid. 17); this involves a particular way of working with field data and critical theories that aims both to keep these in ethical balance and to blur any assumed distinctions between them. I therefore mirror the multi-sited practice in the field with a continual movement between diverse registers and levels of data, from memoirs to critical theorists, mental health law to my memories of fieldwork, in the thesis text. My "quilting" [51] of these seeks to reveal joins and ruptures, juxtaposition and tears, as they critique each

---

[51] Saukko 2000.

other. This is offered as a way of engaging with theoretical debates whilst also maintaining the integrity of people; it explores theory through fieldwork data, employing informants' relationships with their illness to question wider discourses of anorexia, not the other way around. This disallows the voices of informants to be subsumed into theoretical debates or, importantly, into my own voice. Hence, quotations from informants' interviews provide the basis for chapter discussions; my memories of fieldwork incidents, like theory, are offered as secondary to informants' voices.

Given that methodology is "the strategic site for reform of practice" (Marcus 2008: 5) in anthropology, also tied to this politics of listening and writing, is "a politics to ways of watching and waiting for something to happen" (Stewart 2007: 16). Thus, Part Three will now outline my fieldwork methods. The continual ethics from field to text of which these also form part are, I suggest, a way of accessing and addressing something as complex, intimate, often painful, and perhaps also as socially taboo, as pro-anorexia.

Part Three   Methodologies & Ethics

3: A   Multiple Sites, Coherent Ethics

Multi-sited ethnography is "designed around chains, paths, threads, conjunctions, or juxtapositions of locations in which the ethnographer establishes some form of literal, physical presence, with an explicit posited logic of association or connection among sites that in fact defines the argument of the ethnography" (Marcus 1998: 90). To explore pro-anorexia I conducted participant observation and interviewing in the EDU and on pro-anorexia websites. In the former, fieldwork lasted 12 months, but that on the Internet over 24, months, before, during and after the EDU. I also set up a research group on *Facebook*. This explained the research and invited pro-anorexia website participants to contact me if they would like be interviewed or wanted to offer their thoughts on pro-anorexia websites or on anorexia more generally. Initially this group was a response to the idea that "social and physical changes in the world are – and need to be – paralleled by changes in the methods of social inquiry" (Law & Urry 2004: 389) and I also felt it might proffer a way to widen recruitment for interviews. However, this group also, unexpectedly, engendered valuable insights into pro-anorexia websites which differed from those gained through Interviews and participant observation conducted on the sites. Specifically, many people who joined the group frequently visited the websites but did not upload texts/photographs or join in conversations. *Facebook* offered a way to gain access to these otherwise 'silent' presences and their 'hidden' subjectivities of (pro-)anorexia. I also engaged in other fieldwork activities that webbed out from the two main fields. These included spending a short time observing in an adolescent eating disorders inpatient unit as well as interviewing treatment professionals, carers and recovered anorexics.

"Offline and online worlds are more and more highly connected spheres of social activity" (Dirkham et al 2010: 1061) and relationships between informants, and also theirs with me, extended from the EDU to the Internet through email or *Facebook*. "Swiftly moving back and forth between online and offline research" (Dirkham et al. 2010: 1049) thereby signified an embodied methodological reflection on the "parallel processing" (Marcus 1998: 63) of identities and concepts across field sites. Internet research also intersects with, and forms part of, wider

enactments of multi-sited ethnography in which 'following the metaphor' (Marcus 1998) as well as the people is central. In discussions of research in cyberspace, "Connective ethnography" (Hine 2000) is suggested as a way of exploring "the flows of objects, texts, and bodies" (Leander and McKim, 2003: 211) in and across virtual and physical spaces. Tracing these flows illuminates how the social emerges through interactions between "human beings and endless other materials too" (Law 2003: 3) and that some interconnections between field sites may be central to both but 'present' in neither; their edges touch in many ways. Both field sites also "look sideways" (Hannerz 2003: 207) to other 'locations' of anorexia. This reminds us that "multi-site ethnography almost always entails a selection of sites from among those many which could potentially be included" (Hannerz 2003: 208[52]); there are other pro-anorexia websites and other EDUs that are not part of this study. Multi-sited fieldwork is at once holistic and yet so partial.

It has been suggested that the image of "a thorough, formative, exclusive engagement with a single field is of course at the base of the enduring power in anthropology of the prospect, or experience, or memory, or simply collectively both celebrated and mystified notion, of 'being there'" (Hannerz 2003: 203). However, exploring pro-anorexia across field sites not only offers an alternative by asking where 'there' is; it also explores *what* and *how* 'there' is. This "creates new opportunities for innovation in ethnographic writing to break out of old narrative constraints by constituting a much more complex object for ethnographic study and representation" (Marcus 1998: 34). In this research, 'there' is at once the EDU and the websites, but it is also anorexia and, pro-anorexia; field and 'object of study' are not easily disentangled. Thus, I engage with "*shifting locations* rather than *bounded fields*" (Gupta and Ferguson 1997: 38 – *italics in original*), taking pro-anorexia to be embedded in and constitutive of "fields of action and significance—leaking out on all sides" (Biehl & Locke 2010: 317; see also Deleuze 2007: 127); the websites and the EDU are both "field[s] of relations'" (Olwig & Hastrup 1997: 8) that stretch, shrink or "shift across occasions, to one degree or another, through processes of redefinition and negotiation" (ibid. 41). This imaginary takes into account "multiple sites of encounter" (Clifford 1997: 198) within the EDU and on pro-anorexia websites as well as between these. It also, importantly, does not ever assume pro-

---

[52] Also, Candea 2007 on "arbitrary locations."

anorexia. Rather, I explore differing and mobile relationships with anorexia between informants, as well as with the same informant at various times.

The importance of not assuming pro-anorexia also reminds us that "any method decision is an ethics decision" (Markham 2005: 810). In particular, ethical complexities are engendered by the possibility that this research might actually produce potentially harmful linkages between field sites. I was continually careful not to advertise pro-anorexia websites to informants in the EDU, although the majority, it emerged during conversations, had visited them. Moreover, both cyberspace and hospitals are spaces in which the need for ethical primacy is clear and pro-anorexia makes existing considerations more exigent; "those researching sensitive topics may need to be more acutely aware of their ethical responsibilities to research participants than would be the case with the study of a more innocuous topic" (Lee 1993: 2). Exploring pro-anorexia does not only entail considering "possible benefits of the study and possible harm or discomfort that might affect participants; issues relating to data storage and security; and the degree of anonymity and confidentiality which may be afforded to informants and subjects" (ASA 1999); it also illustrates that taking "discussion about research and thinking itself as a moral act" (Back 2007: 98) begins in the field.

3: B   Participant Observation & Interviewing on the Internet

Given that "observing is not just a visual phenomenon, but includes all of the senses" (Dewalt & Dewalt, 2002: 68), one might assume that ability to engage with "the flow of intersubjective human experience" (Hastrup & Hervik 1994: 9) is limited on the Internet. But setting aside notions of the 'purity' of fieldsites (see Gupta & Ferguson 1997), I suggest it entirely possible to conduct "intensive participant observation in a different community without […] every physically leaving home" (Clifford 1997: 192). The two theories of cyberspace that have evolved since its inception are as "culture in its own right, [or] as a cultural artefact" (Hine 2000: 14). Pro-anorexia websites are not divorced from the EDU, and, moreover, "virtual space is always housed inside another space – the space of bodily dwelling" (Grosz 2001: 23[53]). However, acknowledging their embeddedness

---

[53] Also, Dirham et al 2010; Leander & McKim 2003; Miller & Slater 2000.

does not preclude viewing websites as "a place where people do things" (Hine 2000: 21) in which we can "study just exactly what it is they do, and why, in their terms, they do it" (ibid. 21). It is therefore with this 'doing' in all its forms that participant observation engages. But, "arguing that online interactions are sufficiently real to provide a context for an ethnographic study has an ethical corollary: online interactions are sufficiently real for participants to feel that they have been harmed or their privacy infringed by researchers" (ibid. 23). Thus, as "we navigate a vast network of interlocutors and pockets of information in a matrix that is at once amorphous, anarchic, and intensely social" (Kirshenblatt-Gimblett 1996: 21), particular ethical questions arise; "are publically available websites, chat rooms, blogs, etc. a free source of data for researchers to use, or must they negotiate access? In participating in chat rooms or email exchanges, must ethnographers disclose their identities and purposes? How far are their responsibilities here similar to or different from those of other participants?" (Hammersley & Atkinson 2007: 213). I paid attention to all these questions during fieldwork.

At the beginning I searched for as many pro-anorexia websites as I could find, assessing their number, looking at their public pages, exploring commonalities and differences. Following systematic closures, I found some site once and then never again and others changed their names. Having encountered ten sites that seemed to be stable I contacted the *Webmistresses* to explain that I had been looking at the public areas of their sites, asking for permission to continue. I described the research and asked for permission to continue to read writings posted on public pages. Having gained permission, I continued to engage daily with the material on the sites, keeping up to date with new material uploaded by the *Webmistresses*, corresponding with them from time to time and reading archived conversations. Through this I mapped out and pieced-together a portrait of pro-anorexia. But, although to read archived conversations, I had the *Webmistresses'* permission, these elicited the first ethical reflection.

Archived conversations invite consideration of "whose permission ought to be asked as well as whose needs to be obtained" (Hammersley & Atkinson 2007: 42). There is an inherent tension in attempting to avoid being a "person who violates another's right to privacy by observing behaviour that is not intended for public viewing" (Friedman Hansen 1981:133) in what is ostensibly a 'public' space.

As such, "there is considerable controversy in the literature as to whether obtaining consent is necessary (or appropriate) when nonreactively studying online communities" (Flicker et al. 2004: 128). "For some researchers, the statements made in publicly accessible discussion boards or other communication spaces are in the public domain and may be freely used by researchers. For others, this is a form of electronic eavesdropping that violates the speaker's expectation of privacy" (Wilson & Peterson 2002: 461); the former stance was often taken in early Internet research.[54] In relation to pro-anorexia websites, Mulveen and Hepworth (2006) requested retrospective consent for the use of discussion forum postings that they had found in the public domain, whereas Williams and Reid (2007) obtained consent from the *Webmistresses* but not from participants for interactions observed - and then quoted. I felt that these archived conversations were both "publicly private" and "privately public" (Waskul & Douglas 1996) and so I chose to navigate this dualism in an equally dual way. Although participants to these conversations knew that they were potentially public, in the midst of conversation it probably also did not occur to them that they would be 'used' by a researcher. Perhaps such conversations are comparable with those overheard on a bus. From them we may learn a lot – gaining a feeling for nuances and complexities, perhaps - but they cannot be 'used' beyond this. Thus, rather than attempting to trace participants, which is likely to have been difficult and may also have been intrusive, I decided that archived conversations would not appear in this thesis. In the few instances where they do, it is because I knew the informant, through the *Facebook* group for example, and was able to gain consent. I thereby went beyond the recommendation that quotations obtained through 'nonreactive research methods' information should not be traceable back to their authors (King 1996). My decision not to fix into my text any information gained without consent which could be described as one person's words also went further than this; where I quote common tropes of the websites such as *Thin Commandments* or *Letters from Ana,* I have only cited those which appeared on more than one site, taking these as aspects of pro-anorexic discourse rather than as someone's personal property.

On two of the websites on-going discussions were public so I entered them, said who I was and asked if it was ok to hang around. Sometimes it wasn't and

---

[54] cf. Finn & Lavitt, 1994; Salem, Bogat, & Reid, 1997.

sometimes it was. If I received a negative response I left. It is this awareness of intrusion that has led to suggestions that asking for consent may change people's behaviour online (King 1996). This echoes discussions of sensitive topics in offline research, which have pointed out that the presence of a researcher can be harmful (cf. Fountain 1993). Recently, covert research has been advocated on pro-anorexia websites by Brotsky and Giles (2009). They assumed "the identity of a fellow eating disordered site user" (ibid. 95), arguing that hostility to outsiders would preclude the collection of any information. However, adhering to the premise that "being an observer as well as a participant requires that the researcher role be visible" (Chrisman 1981: 138) and feeling that visibility is an active subject-positioning, I realised that my presence in conversations might be intrusive and stopped entering conversations. I then established the *Facebook Research Group;* through the doubled methodology of the group and the websites, I patched together a nuanced portrait of pro-anorexia websites and their participants.

It has been argued that the Internet not only comprises people actively participating in chat, but also those who "lurk" (Hine 2000: 155), who are "difficult to incorporate into the analysis" (ibid. 25). By engaging with traces such as uploads or images, participant observation can, to a certain extent, take account of "lurkers" in a mirror of our engagements with those who are 'around' but quiet in an offline setting. But some participants to websites neither enter conversations nor leave tangible traces. As I noted above, the *Facebook Research Group* proved a useful method for reaching these website participants. In particular, it altered my impression of the websites' central demographic. Press-coverage has widely assumed the sites to be composed of teenagers because these are vocal and they upload photographs/texts. But, many informants in the *Facebook* group were much older. Although not uploading or entering chats, they still felt themselves to be, sometimes daily, 'participants' to the pro-anorexia websites. Perhaps we need to widen our notions of what it means to do participatory research on the Internet in line with how informants themselves define participation. The *Facebook* group thus allowed me to respect the silences of 'lurkers' whilst also gaining the perspectives of those who came forward for interviews on their own terms.

Interviews initially took place with people whom I had encountered through the websites. Later, the *Facebook* group became a more regular springboard. All

interviews took the form of textual exchanges over email or through *Facebook* messenger. After explaining in more detail what the research was about and who I was, I always asked for consent to use material and assured participants that this could be withdrawn for all or part of the interview at any point until thesis submission. I concur that "to obtain informed consent without any individual contact, it is vital that all elements that would normally be part of the consent process be available online" (Flicker et al. 2004: 126). Every interview began with my question, "if I say anorexia, what do you think of?" Under this, depending on how much contact I had already had with the person I often included a list of questions about their use of the websites. The responses to these sometimes came back with one line replies and sometimes with pages of text that went far beyond the questions or even entirely ignored them. The latter ensued from a line in my first message encouraging the interviewee to ignore any questions that they did not want to answer or which they felt were irrelevant, and inviting them to tell me anything else about anorexia, pro-anorexia or the websites that was important. Throughout this process, I was aware of my inability to give anything back to web participants, unlike in an offline setting where one can help the informant in some way to create balance. Some informants sent me detailed, thoughtful, lengthy and highly private documents and all I could do was say thank you. Interviewees were, of course, a self-selecting group but I suggest that this is not only balanced by all the other voices in multi-sited fieldwork but also may be an - or the only - ethical way of researching a sensitive topic. The tactic of allowing informants to self-select and embracing the responses received not only mirrors wider methodologies undertaken by anthropologists looking at illness (cf. Skultans 1998) but is also not as different from offline research as might be assumed; in the EDU too, some people chose to be interviewed, some refused, some were asked and some approached me. Formalised in the EDU through consent forms even for observation, described later, the informant-led nature of research participation kept the research as ethical as possible. Moreover, the sensitivity of the topic could make online interviews more comfortable for informants than offline ones[55]; they are less intrusive than the physical presence of the researcher in the informant's space, and might also afford the informant more control, in deciding how and when to reply, for example.

---

[55] See Lee 1993.

During offline interviews informants may be preoccupied with looking "not so much for ways of expressing themselves as for ways of making sure that the vast expressive resources of face-to-face interaction are not inadvertently employed to convey something unintended and untoward" (Goffman 1981: 19). Yet, this also highlights the concern over informants' identities, which has been raised by Internet researchers.

It has been suggested that online research allows deception and "identity play" (Hine 2000:20[56]) on the part of informants. Or, to put it bluntly, "there is no way of verifying that someone who posts as an 18-year-old woman is not a 40-year-old man" (Flicker et al. 2004: 128). *Facebook* interviewees often, unasked, contextualised themselves by sending me links to other settings such *MySpace* pages, discussing work and personal information or sending me photos. Through this I could montage together a sense of someone beyond their interview responses. But, one *Facebook* informant corresponded with me through both her "pro-ana account," for which she had a pseudonym, and through her "normal account," the latter being the only one her offline friends and husband knew about. This suggests that informants may deliberately have sides of life which they keep separate and to assume that one or the other is more 'real' may do informants *and* the research a disservice. I concur with Hine that in Internet research we need to rethink identity, seeing it less as fixed – meaning static *and* attached to a body - and more as negotiated within and by situations (see Hine 2000: esp. 49). Moreover, perhaps it is not just in relation to cyberspace, but also illness that this is important. Anthropologists have discussed issues of identity play and mask wearing in illness contexts.[57] Thus, exploring pro-anorexia in both settings perhaps necessitates thinking about "contextualized identities (rather than performed, negotiated, or contested) to break through the virtual/real dichotomy of online identity" (Wilson & Peterson 2002: 458). I therefore decided to take "at face value the information that users […] offered" (Flicker et al. 2004: 128) as a practice of ethics. Suggesting that there are "insights and blindness in the accounts of people" (Back 2007: 12), as indeed, there are in our own, I see "no reason to deny (or for that matter to affirm) the validity of accounts on the grounds that they are subjective, nor do [I] regard them as simply constitutive of the phenomena they document" (Hammersley

---

[56] Also, Turkle 1995.
[57] cf. Bluebond-Langner 1978; Goffman 1963.

and Atkinson 2007: 98). Rather, what people say and do not say is itself a part of exploring pro-anorexia in both spaces.

3: C   Participant Observation & Interviewing in the EDU

During the twelve months when "travel to and from the field was a daily occurrence" (Passaro 1997: 153) I participated in the activities of the EDU as a *Non-Clinical Observer*, inhabiting "positionalities at varying points along a participant observer continuum" (ibid. 156). This centrally involved hanging out – sometimes with staff, mostly with patients. If activities such as eating, Group Walk or OT sessions were not happening, the EDU was a place in which not only did a lot of hanging out take place amongst patients, but also where this was enforced by Rest Periods. With patients I did jigsaws, played scrabble and watched *Neighbours, Trisha* or *Masterchef*; once we blew up latex gloves and tried to make them buzz and swoop round the corridor like balloons; we watched a nursing assistant give an impromptu break dancing session; we read magazines; we chatted, we comforted those who cried, we sat in silence.

Before fieldwork this research went before an NHS ethics committee. It was approved with no changes, but it was suggested that there should be a consent form for the observation as well as the interviews. In my first two weeks on the Ward I therefore handed all staff and patients the information sheet, explaining that I was exploring patients' experiences of, and feelings about, anorexia and pro-anorexia. A week later I gave the observation consent forms to staff who all signed them unquestioningly. Then I gave these to patients, explaining that they need not sign but that if they did, they could retract consent at any time. Viewing consent as contextual rather than continuous, I was also clear that signing the form only consented to me being on the Ward during their admission in a general sense and that if there were times that they wanted me to disappear for any reason, just to tell me and I would do so, completely unoffended. I repeated this process with every newly admitted patient. Although I knew, when I encouraged new patients to not sign the form or to withdraw their signature if uncomfortable, that these acts would necessitate me leaving the Unit for their admission, I did not state this. Some did ask, "but then what would happen to you?" or "but then you'd leave?" I replied,

"yes, but that's ok, research is much less important than your admission." The question has been posed, "how can it make sense for the would-be ethnographer, who has carefully negotiated access […] with all the reasonable undertakings and assurances that might be expected, to accept that the research can be brought to a complete halt if one person decides to withdraw?" (Hammersley & Atkinson 2007: 227). I suggest that it *has* to make sense for the research to be ethical. Moreover, to claim that giving informants "the right to prevent the researcher observing meetings in which they participate – which is required by the common demand, on the part of the ethics committee, for opt-in consent to observation – effectively renders ethnographic research impossible" (ibid. 227) is absolutely untrue. Although the observational consent form rendered my position precarious and vulnerable, I am really pleased that it did; it led me to always consider ethics, not just periodically, but in an embodied way every day as I moved through the spaces of the EDU. It gave me a glimpse, however small, of the powerlessness of someone else being able to dictate one's whereabouts tomorrow. I continually asked for consent, from staff and patients, not only on entering meetings such as Community Group, but also in many day-to-day situations. Aware of the potential importance of five minutes alone in such a highly charged and un-autonomous environment, I asked if I could sit down on a sofa with a patient; before I sat at a table in the Dining Room I always asked those already sitting if I could join them; I asked if anyone minded if I went on Group Walk. This continually remapped the spaces of the EDU as open or closed, as did patients' invitations to sit or walk. Fieldwork was framed by a continual taking of cues from patients rather than from the research.

When I arrived, I was offered space in the OT office. Through the enormous kindness of the OT, helping with OT became a way that I could contribute to the EDU and get to know staff and patients. On two occasions I hosted *Body Shop* pamper parties with the OT and weekly, I ran an art group. One week, a few patients and I attempted origami, discovered anything but cranes was tricky and decided to make as many cranes as possible. Then we joined these together with string and floated the whole lot in a line up and down past the Nursing Office. Nurses and patients all emerged from the rooms around to watch, laugh and take photographs. Later, at bedtime, the chain of cranes was locked in the Nursing Office in the box with the razor blades, tooth brushes, dental floss, lighters

and other everyday but harmful accoutrements; unsupervised outside the art group, our cranes became a hanging risk. If someone needed an escort to a main hospital OT group such as pottery, I was always available – although I did ask if they minded my escorting them. I usually stayed in pottery and chatted, often going with patients even if none needed an escort. Likewise, I took people out for cigarettes or bench passes, played badminton with a patient or went to collect another from school. As such, part of my 'helping out' was about assuming a staff role, one that had surveillance responsibilities and required keys. Whether simply displayed on a person or in the act of opening or locking doors, keys instantly denote their carriers as staff. But, my willingness to walk up and down the corridor over and over again unlocking and locking doors at designated times, or to gain a patient access to the linen cupboard or a cigarette, was early on noted by patients. One wrote in my goodbye card that she hoped that I knew that I had "meant more to [her] than a mobile set of keys!" During certain times of the day, such as after meals, any patient needing the loo must be supervised by a member of staff or, when patients learnt that I did not mind doing it, me. About this, I was told by some informants that it was 'less like being watched', because I was 'not staff.' Because these supervisions were intended to prevent patients vomiting, when supervising a male patient I stood outside the cubicle but we had to talk – or sing; one very amicably treated me to an entire rendition of *Barbie Girl.* But, this role, alongside many other aspects of my participation, such as learning from staff how to make drinks and apportion food in the Dining Room, illustrates how I was "sort of staff, sort of not" as one informant put it. When playing balloon catch with patients and a Nursing Assistant in the Patients' Lounge once, an informant started to say that the teams should be staff versus patients. Pausing and glancing at me, she changed this to "people-who-have-keys versus patients" to much laughter.

Yet, "if you're not a patient, you're staff" is a phrase enshrined in medical ethics;[58] it is intended to protect patients by transparently directing and limiting who is allowed to do what to whom. However, this binary has an effect on how we "assume social roles that fit into the worlds [we] are studying" (Adler & Adler 1987: 8) in the field. It means that "both researcher and researched are embedded within relationships of power" (Lee 1993: 143) not only in terms of the balance of

---

[58] See Brazier & Cave 2007.

researched and researcher but also in regard to the subject-positionings into which a researcher can fit. This binary allows little middle or philosophically neutral positioning. Illustrating "the relationships between 'access', the fieldworker's perceived identity, and the data that can be gathered" (Hammersley & Atkinson 2007: 49), with the staff role came access that I felt to conflict with my role as researcher. I was privy to all information about informants and to all the staff team meetings in which this was discussed. Although I am extremely grateful for the welcome I received from staff in such settings, I also felt that this access needed limiting. I decided early on not to read case notes, not wanting to know more about informants than they were willing to tell me. This echoes my decision above to trust what I was told by online informants; both are ways of engaging ethically with the voices of informants themselves. The importance of this decision became clear when I helped the EDU's OT run a computer group in the main OT facilities. After I had sat and chatted with the first session's group of men, the OT approached me with a red folder. Apologising for forgetting to give it to me at the beginning, she suggested that I read its contents in case of any crises that might arise next time. Inside were referral slips for the computer group from the men's ward, outlining how they would benefit from computer time but also their history and behaviour. The men with whom I had spent the afternoon turned out to be a group of convicted sex offenders, whose crimes were listed alongside their diagnoses on the referral slips. However much I tried not to let it, reading these did almost imperceptibly alter my sense of the afternoon. Wishing this not to happen, I never read referral slips again. Also with the staff role came certain responsibilities that mingled surveillance and care. These were directed by a very particular moral and ontological framework. Every day, positioning myself in the EDU did not only involve attempting not to get in the way and cause no harm, but was also fundamentally a continual reflection on the delineations of harm itself. It involved careful consideration of my choices, actions and conversations and their relationships with the neutrality of a research positioning, the responsibility of a (pseudo-)staff role, and the dangers of anorexia. Continually navigating this nexus meant that I held ethics in the tensions of my muscles as I watched myself move through the Ward, always careful to be fair, kind and ethical in a number of subject-positions at once.

The NHS ethics committee had asked what I would do if someone told me of suicidal intention. The answer was of course that I would break the confidentiality of the research to get them help, and I did. But, the line was less clear most of the time and I had to think about where it lay every day. In interviews and even in conversations I was often offered information precisely because of an informant's trust in me and also because, in interviews at least, informants felt confidentiality to be guaranteed. But, what was voiced was frequently potentially harmful information regarding starving or cutting. Continually I had to decide what to do with this kind of information, always wishing to respect the informant but also recognising that they may be seriously hurting themselves. I decided early in the fieldwork not to unthinkingly assume a surveillance role just because I had keys. When escorting patients I did watch them in case of vomiting or absconding but I did not, on the other hand, report patients for minor offences, like chewing gum; I felt that I simply had no right. However, I did gently take razor blades or forks from patients if they were sticking them in their arms in front of me and I did always attempt to impede or prevent other acts of self-harm such as smashing of heads against walls or clawing of faces. But I always tried to do this through reasoning rather than simply asserting power that I was uncomfortable having, and I got them to seek help rather than automatically seeking it for them. This did usually work because of the close relationship that I had with many patients outside these incidents, but perhaps that was just luck. On one occasion, an informant I knew well, and I were on our way to a pottery session after lunch when she told me that she desperately needed to run around the grounds to "get rid of lunch." In what was a fairly traumatic encounter for both of us, I reasoned with her that since she had told me I could not turn a blind eye to her running. She was very angry with me for stopping her, viewing it as a betrayal, but many months later we laughed about it. My decision to stop this informant running was informed by a tangled web of reasoning where values were interwoven with personal feelings, paternalism and empathy. However, it might be suggested in response to this section that the inability for a researcher to maintain an inactive and value free stance in the clinic is not only a product of the binaried subject-positioning of the Unit, but of anorexia itself. Giordano argues that all choices regarding eating disorders are intrinsically

moral choices (Giordano 2005) and perhaps it is also a sense of this that resonates through my continual balancing of researcher and staff roles.

It has been suggested that participant observation involves "a constant interplay between being part of life and stepping out of it, observing it and reflecting upon it' (Olwig 1997: 35). Alongside an ontological shifting, it has become clear that stepping out of the EDU was enacted in a variety of ways through my subject positioning in relation to harm and information. However, I also stepped between my research and personal selves more overtly, directed by my sense of which of these informants were engaging with at that moment. I began to help out at therapy groups such as Cooking Group and Relapse Prevention Group, the latter of which I was co-facilitator. In these, I was privy to all sorts of extremely sensitive private information and often, raw emotion. As well as always asking those present if they were happy for me to attend, I also decided to step out of the role of researcher in these groups. Although Relapse Prevention Group was enormously valuable in teaching me about living with anorexia, nothing said in it ever appears in this thesis, nor is it in my fieldwork diaries. As such, perhaps my relationship with it mirrors that with the archived conversations on the Internet, discussed above. Where incidents from Cooking Group are described, it is because I approached the informant afterwards to discuss these and consent was obtained to put the incident into text. This tactic, moreover, extended beyond groups to general conversations on the EDU. So, if a patient confided in me or cried on me, or told me about their children or their marriage for example, I asked myself whether they were participating in research now. If the answer was no – and in such personal situations it always was - and if this was not followed by a gaining of consent later, these conversations or incidents are not in the thesis. As such, I negotiated the "multiple identities that conflict with [my] research role" (Chrisman 1981: 145) by continually reflecting on how informants were seeing me at the time, and therefore how *they* were participating with me, not I with them. This, I felt to be more important than whether or not *I* felt I was doing research at the time. I also employed this tactic in staff meetings and wider relationships with staff. From this ensues the deliberate near-absence of staff in this thesis; this is an intentional ethical stance. In the case of patients, although they always knew about the research, "it is not uncommon for participants quickly to forget this once they come to know the ethnographer as a

person" (Hammersley & Atkinson 2007: 210). Therefore, sometimes I withdrew from situations where I instinctively sensed myself to have become too invisible. Because "'hanging out' provides the chance to overhear intimate exchanges that are not specifically addressed to the researcher" (Woodward 2008: 555), every now and again I crept quietly away if patients started to talk about something that I felt I 'didn't need to know.' At other times I tried to make my researcher positioning more visible because that felt instinctively more ethical. It is therefore clear that "fieldwork engages us in identity work" (Coffey 1999: 14), encompassing "both private and public" (ibid. 57) roles. But, it has also been suggested that it is a process of "making ourselves inward with a culture to the point where we feel as comfortable in it as we do in our own" (Watson 1999: 5). I suggest that the identity work aspect relates precisely to the lack of comfort in the EDU as a whole. The EDU was a space of circulating affects and charged emotions, where informants were expected to leave their comfort zones. Thus, concurring that "it is an awareness and intelligent use of our emotions that benefits the research process" (Gilbert 2001: 11[59]), I also decided to allow myself to be vulnerable and to share my own personal information, a tactic discussed as ethical, particularly by feminist researchers.[60]

Participation and observation "appear to (and do) require different sets of skills" (Dewalt & Dewalt, 2002:35), but these are also terms that we should not leave unquestioned. It is suggested that "participant observation makes us learn the procedures which these people have themselves learned" (Bloch 1991:194) and that it gathers "tacit knowledge" (Spradley 1980: 11). That there were aspects of the EDU in which I could not participate was clearer than on the Internet. In both, we might argue, participation is not only pragmatically but also conceptually questionable - for a researcher with a body or without one. On the Internet I could participate only with the seen, gaining only glimpses of the unseen lives beyond cyberspace. In the EDU, I often could only observe but not participate in what I saw; in particular, experience of illness is outside the observer's perceptual and actual grasp. It has been suggested that understanding "begins from commonality; in particular, from shared experience that requires empathy on the part of the investigator" (Williams & May 1996: 63) and it was through the sharing of, especially

---

[59] Also, Watts 2008.
[60] cf. Oakley 1981; Tang 2002.

bodily, experiences that I participated in the EDU; bodily experiences were concomitantly most ungraspable and yet also most do-able and I productively navigated this fundamental tension.

During the year I experienced the EDU at all times of the day and week except between midnight and 7am. When I asked informants whether they felt sleeping there was necessary to understand what it was like to be in the EDU, all said no. Unanimously, they replied that what I should do was eat. Over the course of the year, I ate at all meals between breakfast and evening Snacks. Although I could never experience the space or the food as informants did, eating did offer a way in and I allowed it to be collaboratively (see Marcus 2008) directed by informants - responding to their suggestion that I eat the Full Diet, for example. I almost always ate the amount of food that patients had to, which meant eating even if I was not hungry. This was spontaneously commented on by a number of informants who said that they appreciated it. I also ate in the particular regimented ways prescribed as part of treatment. I heeded the Peer Pressure System, not leaving the table as staff might do, if lunch had become fraught and lengthy. From a patient point of view this meant doing what they had to do but from a staff point of view it was a luxury; my ability to spend hours with patients stemmed from not having anything to do that was integral to the running of the Unit or its provision of care. I also volunteered to undergo the same psychometric testing as patients. Kath Woodward, exploring "embodied interrelationships between the researcher and the subjects of the research" (Woodward 2008: 538) in a boxing gym, suggests that "a critical consciousness of the differences of lived bodies is possible through methodologies that take on board the partiality of knowledge and the situated researcher" (ibid. 556). This is reminiscent of Haraway's argument regarding both "the embodied nature of all vision" (Haraway 1991: 188) and how through "limited location, and situated knowledge […] we might become answerable for what we learn how to see" (ibid. 190). I pieced together partial insights into anorexia by, quite literally, feeling my way into the EDU through physical sensations of heat, fullness and tiredness.

In the EDU I carried out semi-structured interviews with any patients who agreed except, following the ethics committee's stipulations, those under 16. A couple of the younger patients actively wanted to be involved in the research and

knew that I could not interview them. So they told me things in conversations and said, "write that down!" Or, one wrote a page about anorexia and handed it to me "for the research." Overall, I conducted in-depth semi-structured interviews with 27 patients, some for half an hour, some for many hours over multiple interviews. I also interviewed some staff members. Many other patients and staff also contributed to the research through informal conversations, briefer interviews or email discussions. First interviews with patients all started with the same question as those on the Internet did, above. Questions after that were led by responses. The topics of interviews were also sometimes triggered by conversations that I had previously had with an informant but I always checked before starting the tape whether it was ok to repeat something we had talked about in private. Taping was the choice of the informant. A consent form was signed before every interview but at the end I always gave the informant the opportunity to withdraw consent for all or parts of the interview and told them that this possibility would continue until thesis submission.

3: D A Brief Note on the Text: From Field to Page

Interviews are transcribed verbatim, including cut-off words and sudden shifts in the direction of sentences. "…" represents a pause by the informant. All of these stand as testimony to the flows of informants' thoughts and the timbre of their speech. In quotations from textual online interviews, I have not altered spelling, grammar or punctuation. Alongside interview extracts almost no contextual details, such as age or description, are offered for informants either on the Internet or in the EDU; this signifies a deliberate protection of identities. Likewise, I have provided no visual descriptions of the websites or their content beyond the outlines in the introduction as I do not feel that consent to observe them gives me the right to make them visible in the way that such descriptions would do. Also to protect informants' identities, an informant's interview data has sometimes been given a different pseudonym from observations of the same person garnered through participant observation, particularly on the EDU. At times, when gaining consent to relay an incident or conversation, I discussed this tactic with informants. It is intended to be protective as sometimes allowing incidents and voices to remain

together would render informants too visible not only to the outside reader but, particularly in the closed environment of the EDU, to each other. Informants reading this may recognise a particular person in the account of an incident but I have prevented them gaining access through that recognition to the described person's intimate thoughts as they appear in interview data. This also prevents any staff members reading this to recognise patients and learn information that was not part of their clinical encounters. The reader will also notice that throughout the thesis I write "some informants argue" or "many informants said." In his ethnography of mental illness amongst the homeless, Desjarlais discusses how he "rel[ies] on a language of 'most,' 'many,' 'some,' 'similarly,' 'only,' 'usually,' 'at times,' or 'tends to'" (Desjarlais 1997: 264). I agree that "this language is often an inadequate, ambiguous one, for it tries both to embrace the variant and to get at something definite" (ibid. 264). However, it signifies an attempt to be as ethical as possible as it navigates the continual tension of intricately engaging with a complex and intimate topic whilst also protecting those who were willing to talk about it.

Given that there is perhaps always a "two-way traffic between investigation of the social and the social itself" (Law & Urry 2004: 393[61]), and thus that we "do not simply describe the world as it is, but also enact it" (ibid. 390), the need for ethical primacy does not just pertain to how the field is written into text, but also to how this text may enter the field; this is a more difficult situation to predict or address. Like the memoirs with which it engages, this thesis could be 'inspiring' to anorexics wanting to enhance their anorexia. It could also, in a less linear or tangible way, contribute to circulating notions of what it means to be a 'good' anorexic, or of how anorexics 'should' be. It would perhaps be virtually impossible to write anything about anorexia without this possibility. But the need to acknowledge it is heightened by writing about *pro*-anorexia. Thus, reflecting on this tension throughout the writing, I have deliberately limited visual descriptions of bodies and have tried to place those of eating practices within wider contexts of the enormous suffering described by so many informants. I have also left out of this text certain incidents, acts and discussions during fieldwork, particularly related to self-harm, suicide and death, that, rightly or wrongly, I judge to be too dangerous if they are emulated. It is possible that such omissions render the research even more

---

[61] See also Osborne & Rose 1999.

partial than it otherwise might have been. But, when exploring not only a potentially fatal illness, but one which also inspires desire, the research should always be the first to compromise.

Part Four   Thesis Outline

4: A   Overview

To the thesis there are three central interrelated themes:

- Relationships between personhood, agency and illness.

- Intersections of desire and ambivalence in pro-anorexia.

- Overlaps and disjunctures between pro-anorexia and treatment resistance.

These are explored:

- Through an analytic focus on subjectivity and materialities rather than on emaciation and visuality.

All chapters discuss at least two of the central themes, but in varying ways; at the beginning of each chapter it is indicated which themes are particularly addressed. Through this structure, the chapters are designed to "interfere" (Haraway 2008[62]) with, as much as compliment, each other. This is intended to minimise my own voice in relation to those of informants and to ensure that multiple ways of listening, looking and thinking emerge through the dialogues between chapters. Also in order to encapsulate many viewpoints and diverse levels of data, which I discussed as a central ethical praxis, above, the chapters are longer than might normally be expected; each is not so much a single unit but rather a cluster, coalescing around a theme. To illustrate this and navigate the reader through them, chapters have brief conclusions between parts and all parts are clearly divided into sections.

---

[62] Also, Mol 2002 A.

4: B   Chapter Synopses

Chapter Two, Compromises, Other People & Ambivalence: The Making and Unmaking of 'Good Anorexics,' explores the practices that informants undertake to make and maintain themselves as 'good at anorexia.' With a particular focus on intricacies of eating and starving, this chapter argues that for many informants anorexia is not a quest towards thinness but a particular modality of producing and controlling their everyday lives. There is an emerging dualism here: anorexia produces the everyday for informants but as such, it must be continually reproduced day-by-day. This is crucial to forming our sense of what desire for anorexia might be; pro-anorexia is seen to be as much about holding on to anorexia as it is about becoming thinner, or even, more anorexic. The practices undertaken by informants to re-make anorexia thereby also maintain their sense of self. The chapter concludes by arguing that being good at anorexia is tinged with ambivalence and, thus, that an exploration of pro-anorexia needs to take account of ambivalence alongside desire.

It is with ambivalence that *Chapter Three, "That's the Anorexia Talking:" Exploring Anorexia & Personhood in Multiple Uses of a Clinical Phrase*, begins. This chapter employs the phrase "that's the anorexia talking" which abounded during my fieldwork, to explore ontologies of personhood, anorexia and the relationships between these amongst anorexic informants and in the clinic. I explore how patients' ambivalence is employed within various treatment modalities to separate anorexia from what is perceived as patients' 'real selves.' By listening to anorexic informants' reactions to the conceptualisations of authenticity and of anorexia's agency embedded in clinical usage of this phrase, the chapter forms an understanding of informants' alternative conceptualisations of how anorexia may or may not talk, or even, act. This is deepened by also tracing how informants themselves use the phrase in ways that both diverge from, but also, mime the clinic. Thus, exploring this phrase offers an analytic pathway into the complexities of informants' relationships with their anorexia and its agency; it thereby opens up a way of addressing pro-anorexic *desire.*

Chapter Four, ***"Anorexia Won't Trick you Like Food Does:" Following the Many Threads of Pro-Anorexic Desire***, explores desire in pro-anorexia, arguing that this needs to be viewed within the context of informants' existing relationships with their illness. Listening to their articulations of pro-anorexic desire reveals that, to informants, anorexia is many things – a way of controlling and producing the everyday; a friend; a comforter, as well as, sometimes, an enemy. This chapter argues that the illness becomes something to hold onto simultaneously because it is part of them and also because it is a thing in itself; it is both fused and external. Furthermore, in contrast to the separation of anorexia and self encouraged by clinical utterances of the phrase "that's the anorexia talking," here externalising anorexia can also be a performance of connection. Although the chapter suggests that even when informants feel deeply ambivalent towards anorexia they sometimes continue to desire it, it also becomes clear that desire to hold onto the illness may be wanted, held onto, and actively worked upon, but also unwanted and, even, painful. As such, this chapter deepens our discussions of ambivalence in a number of ways. It explores how anorexia(s) are divided in informants' narratives into both agential and un-agential, wanted and unwanted. To mediate their lack of agency, informants discursively delineate certain anorexias as desirable in relation to others that pertain to past selves, other people, or activities other than starving. This re-assembling of anorexias continually maintains the illness in a desired relationship to personhood despite informants' recognition of its horrors.

We have seen so far that everyday productions of anorexia and anorexia's (wanted or unwanted) productions of informants' everyday lives are circularly related; anorexia's mediations of informants' lives produce their desire for it. As such, the thesis has taken discussions of the illness far away from ideas of a teleological trajectory towards thinness. The previous chapter, moreover, problematized the relationship between anorexia(s) and bodies. Now, ***Chapter Five, Dialectical Engagements: Complexity, "Bad Examples" & Thinness as Pro-Anorexia Meets the Clinic,*** explores nuanced engagements with the practices and discourses of the clinic amongst informants in both field sites, tracing hybridities and juxtapositions, appropriations and subversions. The chapter argues that these illuminate a very particular way in which thinness becomes a part of pro-anorexia.

Against this background thus, this chapter revisits the relationship between bodily thinness and anorexia. It explores how a bodily anorexia that is performed by the clinic is appropriated and (re-)inhabited by informants in both field sites. This process reveals that thinness is not simply a visual bodily state; it - and its desirability – are bound with the clinic and its categorisations of 'anorexia.' Moreover, it is these that return us to an idea of anorexia as process not goal. Thus, at the end, the thesis returns to the central theme of 'being a good anorexic' with which it started. But we revisit it in ways that highlight the complexities and paradoxes inherent to informants' experiences and subjectivities of their illness.

Chapter Two   Compromises, Other People & Ambivalence:
The Making and Unmaking of 'Good
Anorexics'

"It is more than Thinness, per se, that you crave. It is the implication of Thin. The tacit threat of Thin. The Houdini-esque-ness of Thin, walking on hot coals without a flinch, sleeping on a bed of nails. You wish to carry Thinness on your arm with her cool smile. You wish for that invisible, vibrating wire that hums between lovers, implying a private touch. You wish for such a wire humming between you and Thinness, at a party, on the street, humming softly between you and death."

Extract from Marya Hornbacher's Memoir 'Wasted' (1998: 69)

During her interview Miriam, proclaimed:

"I just want to be a good anorexic!"   *Miriam, inpatient*

Informants in both field sites echoed Miriam's yearning and Laura explained what being a 'good anorexic' meant to her:

"Anorexic language can often get confusing for those without an eating disorder because to "normal" people good and bad often is used in a reverse fashion. "For me being a "good" anorexic means that i am eating as little as possible and doing a lot of exercise, if i have eaten very little then i would class myself as having a "good" day because i have achieved what i wanted to achieve in my anorexic head. A "bad" day is when I haven't been able to avoid eating maybe due to family commitments or pressures of not wanting to let people down and then i would class myself as being a bad anorexic."

Laura, Facebook Pro-Anorexia Research Group participant,
interviewed online

A 'good anorexic' to Laura and Miriam is one who works at maintaining and enhancing anorexia by "eating little" and "exercising." Central to pro-anorexia, being good at anorexia underscores much of the content of the websites. Laura said:

> "If i visit a pro ana site then it reminds me of what i am aiming for and so i am more likely to avoid going out with friends for meals thus promoting me to be a good anorexic."
>
> *Laura*

On pro-anorexia websites pages of *Thin Commandments* frame what a good anorexic should do and be. These do not comprise any one set of ideals but, rather, a plethora of mantras underlining the necessity of not eating. Throughout fieldwork *Thin Commandments* echoed through informants' accounts of their pro-anorexic practices and desires, in the EDU as well as on the Internet. Many informants measured their own starvation against that advocated by *Thin Commandments* and some related writing commands on places as diverse as fridges and bodies. In both field sites, even more striking was the transformation of other texts and objects into *Thin Commandments* by informants' use of them as devices against which to measure their relative success at anorexia. Memoirs of anorexia and recovery were utilised in this way, as were the eating practices and visual bodies of other anorexics.

However, *Thin Commandments* are numerous and often contradictory and ways of being good at anorexia conflict. Thus, lists of *Tips & Tricks* comprise modalities of navigating between often-contradictory exigencies. *Tips & Tricks* navigate the embodied subjectivity of maintaining and enhancing one's anorexia, negotiating the compromise of what to allow in the body to stay anorexic yet alive. About these Laura said:

> "The pro ana sites help to encourage me to be a "good" anorexic because they often give *tips* on how to avoid social meal situations and also give *tricks* on how to hide food etc if you cannot avoid meals, for example like hiding food in your clothes or feeding it to the dog and so on."
>
> *Laura*

To introduce pro-anorexia, this chapter will draw on *Thin Commandments, Tips* and *Tricks* as a framing device, charting the ideals of a good anorexic through *Thin Commandments* in Part One before turning to modalities of negotiating these in Part Two. Using these textual producers and products of pro-anorexia in this way not only offers a pathway into practices and subjectivities of pro-anorexia. It also reflects the thesis's wider methodological concern; here a central feature of the websites is employed not as a comparison with the clinic but rather to cast light on parallels between field sites. The cajoling and advice of *Thin Commandments* and *Tips & Tricks* are thus woven through and juxtaposed with data from interviews and participant observation, as well as extracts from memoirs. This chapter-long dialogue between these phrases and the practices and desires that they shape and reflect allows me to concomitantly offer and also challenge a straightforward portrait of pro-anorexia across both field sites. Exploring "a set of possibilities, strategies that are partially connected" (Mol & Law 2002: 17) hints at the complexities in informants' desire to keep their anorexia, which will emerge throughout the thesis. As informants' experiences, voices and desires shift in and out of the framework that is instigated by *Thin Commandments,* as well as by texts and the bodies of others, paradoxes and ambivalences emerge. These suggest that informants engage not only with a "heteroglossia" (Bakhtin 1982) of "discourses in the air" (Gudeman & Rivera 1989: 267) regarding what makes a good anorexic but also with themselves. The interplay of *Tips, Tricks* and *Commandments* with other sources is thus also intended to draw attention to these auto-dialogues.

Part One explores intricate practices of eating and starving. I first trace how food refusal is transformed in informants' narratives from horror at the contaminating potential of food into an active relationship of absence imbued with tropes of discipline and achievement. Listening to informants' claims of agency, I examine the paradoxical role of hunger in this process; it is simultaneously both denied and central to how informants make themselves good anorexics.

Part Two turns its attention to the *Tips & Tricks* that informants employ in order to negotiate the ideals of being good at anorexia that Part One explored. Addressing how dying simultaneously signifies the ultimate achievement of food refusal but also makes you a bad anorexic illustrates that ways of being a good

anorexic do not fit together. They thus necessitate continual negotiation through strategies, or perhaps rather, in de Certeau's terms, "tactics" (de Certeau 1984), of compromise and "making do" (ibid.); these allow informants to stay alive without their anorexia being unmade by every mouthful of food.

Part Three traces the visibly thin perimeters of the 'anorexic body.' In line with discussions in Chapter One, this chapter's focus on practices and subjectivity suggests bodily thinness is not a reified thing-in-itself but is, rather, enmeshed in relationships and materialities in which *both* good anorexics and bodies are 'made.' I explore how informants' patrolling of their bodies renders processes of being a good anorexic relentless and "liminal" (Turner 1967). Moreover, these aspects are heightened by the visibility of thinness to others as well as to oneself. Exploring informants' "ways of operating" (de Certeau 1984: xi) thus "does not imply a return to individuality" (ibid. xi) as it becomes clear that anorexics are made and unmade socially as much as individually and pro-anorexic desires blur boundaries of self and other as others' bodies become *Thin Commandments*.

Part Four draws on the ideas that ended Part Three in which being good at anorexia is seen to be a network of "interacting vectors" (Massumi 1992: 14). This conceptualisation allows us to acknowledge contradictions and ambivalences. The chapter therefore concludes with an exploration of informants' accounts in which the desire to be a good anorexic is mired in ambivalence. It is this ambivalence which constitutes a first step in unpacking the unexplored and complex intricacies of pro-anorexia that will unfurl throughout this thesis and which, in particular, leads into the next chapter.

By asking how being 'good at anorexia' is enacted, this chapter introduces many of the thesis's central themes and questions. Some are explicitly explored and others merely glimpsed, to be rendered visible in later chapters. In particular, through its ethnography, it is this chapter that most makes the case for **an analytic focus on subjectivity and materialities rather than on emaciation and visuality**. It also lays the groundwork for the thesis' explorations of **intersections of desire and ambivalence in pro-anorexia.**

Part One   Individual Practices: Starving, Discipline & Hunger

1: A   Food as Dangerous, Contaminating and Fattening

Echoing Laura's interview, above, *Thin Commandments* on pro-anorexia websites delineate being a good anorexic as*:*

"Saying 'No, thanks,' to food is saying 'Yes, please,' to THIN!"

"Don't waste time with food, food is a hindrance to your progress."

Given that starvation immediately emerges as central to being good at anorexia, it might seem apposite to begin exploring from this angle. Yet, it soon became apparent during fieldwork that to comprehend the importance of food's absence for informants, it is imperative to first get to graphic grips with the experienced subjectivity of its presence. We need to think about eating and the physicality of how food crosses, ruptures and stretches bodily boundaries.

In her interview Kate, an inpatient, described mealtimes in the EDU when eating, as noted in Chapter One, was enforced by the Peer Pressure System:

"Eating just feels wrong. It just doesn't feel right. It doesn't feel natural. Everything… like… my mind is saying 'no'. Sometimes I actually physically feel like something's holding my arms down and my legs there and I just feel held still because I'm so not wanting to do it and my body's pulling away, pulling away and I'm having to override my nat... what I perceive as my natural response and really sit on it and really stay really rigid and still so that I can get through it. It's thinking about what's going on, you know, it's like you're breaking down food. There's food in my mouth - food and saliva. And I think about what's in the food and it's all being broken down. I just think it's horrible to have something in your… eurgh, I can't really explain it but I think it's horrible to have something in your mouth and you're kind of moving it around and you swallow it and it's going into your digestive system … eurgh… I feel so greedy... I just feel like, when I've got something

in my mouth, no matter how small the piece is, it just expands and it fills my mouth completely."

Kate, inpatient

Informants in both field sites described food with horror, repugnance and fear. Their interview transcripts evince a sense that food must be kept outside bodily boundaries because, as Abigail put it during one particularly difficult Snacks on the EDU:

"As soon as it's in my mouth it's fat…fat everywhere, expanding. I know it's on my thighs….expanding."

Abigail, inpatient

This threatening nature of food was apparent during participant observation of Cooking Group.

On the EDU once a week a few patients nearing the end of their admissions prepared meals under supervision. Each would plan, shop for and cook dinner with the Occupational Therapist. Then Cooking Group would eat together in a room separate from the Dining Room. The Occupational Therapist and participants generously let me join them on many Wednesday evenings. The usual atmosphere of Cooking Group was a mixture of chat, music and gallows humour, which attests to the extraordinary talent of the OT to assuage palpable tensions. Yet, participants often had difficulty touching food. Some would hold serving utensils by the tip, as far away as possible from the food and would jump back hastily if a drop of mashed potato flew off the spoon. Others would wash their hands frequently, not only after contact with food but sometimes even after stirring the saucepan. During the cooking, utensils were often continually placed in the sink and new ones got out for each stir. Some participants also held their noses and hid their faces from cooking smells. There was also a sense that foods could contaminate each other. One evening I cooked risotto with Claudine. Claudine found it difficult to place the 'cleaner' food, which to her was the drier food such as rice, in the pot with the butter. As foods sullied others – as the butter fattened the rice - they in turn threatened to sully her. Informants' relationships with food echoed, or perhaps magnified, Simona Giordano's statement that "eating is always, more or less, a form of pollution" (Giordano 2005 A: 127). Given that "an eater has *semi-permeable*

boundaries" (Mol 2008: 30 – *italics in original*) and that "what used to be outside" (ibid. 30) becomes inside, we can see how food is "liable to defile" (Kristeva 1982: 75); eating is an act of "self-interruption" (Berlant 2007: 777).

This sense of food as contaminating was also illustrated by Lola's borrowing of my medicated hand gel. Along with keys and a name badge, all staff on the EDU had to carry medicated hand gel. Lola would often take my gel off the table or out of my pocket; at first she asked to borrow a bit but when we knew each other well, she would help herself. Outside the Dining Room this was an exchange filled with humour and parody as I called her a thief and she, laughing, would squirt more. Sniffing exaggeratedly at her alcohol-soaked hands Lola would joke about her "need for medication." However, inside the Dining Room this exchange was mired in urgency and pain. On finishing eating, Lola instantly reached across the table, saying that she "really need[ed] to wash [her] hands," that they were "sticky" or "smelt of food." Explaining this in conversations outside the Dining Room Lola said that at such times she wanted to wash away both the literal food traces on her hands and also the act of eating – to "draw a line under it," as she put it. The gel allowed her to distance herself from the shame of eating and, perhaps, to reseal her bodily boundaries. To Lola, ingested food was "matter out of place" (Douglas 2002). Lola also regarded herself as 'out of place' both in a psychiatric unit and in a dining room, claiming that she needed neither food nor treatment. Thus, by using the gel Lola rejected the unit's conceptions both of anorexia as pathological and of eating as an unquestionable therapeutic necessity; she thus remade herself as an anorexic by conceptually, if not physically, rejecting food.

Hence, it would seem that eating, or even touching, food can transform someone from a good to a bad anorexic from one moment to the next; it contaminates the body, rupturing its boundaries and informants' sense of themselves as anorexics. Or, as Miriam puts it in her interview:

"If you eat you've given in, you've stuffed yourself silly and… and that's not right. You just shouldn't do that."

Miriam, inpatient

Miriam's words are echoed on the Internet:

> "There's food inside the fridge right? Wrong. All that's inside the fridge is failure."

Thin Commandment

Recent anthropological approaches to anorexia have also highlighted contamination and threat[63] in anorexics' conceptualisations of food. Extending such discussions, I suggest that keeping in mind the desire to be a good anorexic allows us to see that perceiving food as contaminating leads many informants not only to reject food, but also to actively engage with it. The potential danger of this engagement is arguably central to the process of making and proving oneself to be a good anorexic; the next section will explore this.

1: B Engaging with Food: Self-Testing

Above, Kate described eating with horror. Yet, she also recounted how, when surviving on 100 calories a day just before admission to the EDU, she would collect menus from local restaurants and peruse these alone at night. Kate said:

> "I could almost imagine I could taste what I was reading... Once I'd read it, it almost felt like I'd eaten it. I'd want it so badly but I couldn't let myself have it. And for me also, I'd look at it and think God how disgusting, eurgh."

Kate, inpatient

Kate described her menu collecting as "like food porn on the Internet[64]" and "perving," both descriptions that mingle disgust with desire. A causal link between the neurological effects of starvation and a preoccupation with food is clinically documented (cf. Keys et al. 1950) and is famously discussed by George Orwell (2001) and Primo Levi (2004). Aware of hunger's "supposed brain effect," as she put it, Kate was emphatic that her menu collecting was not biologically driven, but was an agential modality of making herself better at anorexia. To support this claim,

---

[63] cf. Warin 2003; 2010.
[64] Some pro-anorexia websites contain links to sites calling themselves "Food Porn." These comprise glossy photographs of food sometimes accompanied by equally vivid descriptions. Sometimes these are arranged in themes, such as Christmas or Thanksgiving, both of which contain numerous roast turkeys. Kate's reference illustrates her professed familiarity with pro-anorexia websites.

Kate showed me the menus she had amassed in the EDU where, she pointed out, she was eating over 3,000 calories a day. At the time of that interview, a pizza delivery menu hung on the board outside the Nursing Office. One of the healthcare assistants, who ran DVD nights, had suggested that the coming Saturday's DVD night could expand to incorporate pizza. Pizza night, I think, never materialised due to an unsurprising lack of enthusiasm. However, the take-away menu hung on limply for several weeks. Just after her interview, Kate and I happened to be standing in the corridor together. Kate rapped her knuckles on the menu, saying:

> "You see, that's what I mean, I've read that menu a thousand times; every time I walk past I have to stop… I make sure I don't want it."
>
> *Kate*

Although Kate's narrative does demonstrate "a simultaneous refusal to eat and incessant preoccupation with food" (Heywood 1996: 17[65]), she uses both of these to make (and in the EDU, re-make) herself good at anorexia. By evoking yet refuting clinical paradigms of cause and effect Kate asserts the agential nature of her food resistance. Thus, that food embodies contamination and danger may certainly enable informants to frame a refusal to eat as a sensible, even rational, response to this threat. But, importantly, Kate's emphasis on agency illustrates that we *cannot,* in turn, posit contamination as a *cause* of food refusal; in informants' accounts, starvation is claimed not as a reaction but an action. Being a good anorexic *depends on* a notion of food as dangerous and 'wrong' but to be a good anorexic informants must continually re-perform food's 'wrongness' by refusing it. Not eating thus does not signify a lack of relationship with food but, rather, an *enforced* lack; it enacts a relationship of absence.

In taking account of claims of agency here, I am deliberately presenting my data in a particular way, which aligns with my commitment to performing an open listening, as discussed in the previous chapter. Instead, notions of circularity, or even reversal, could otherwise be suggested. One might argue that it is the desire to be a good anorexic that constructs food as contaminating and once that is done, food refusal is just reactive. Or, in line with clinical discourses, both the desire to be a good anorexic *and* horror at food could be seen as "just the anorexia talking" -

---

[65] Also, Allison 2009; Dunbar 1986.

both arising only after the onset of illness. But, although these possibilities hint at wider discussions of desire, agency and how attributions of cause and effect can be problematic, which will resurface in the next two chapters, here I am leaving them deliberately unpacked. This is because to prematurely shape data into binary oppositions of agency and illness here would not only undermine informants' accounts now, but, importantly, would disallow recognition later of informants' own intricate ideas of cause and effect in anorexia which *both* oppose *and* reflect the clinic's. Moreover, following Kate and others' own narrative trajectories of agency and desire, by recognising their sense of themselves as active self-makers, is crucial to understand the logics of being, and desiring to be, a good anorexic. An informant on the EDU, Milla, once argued:

"Anorexia isn't rational, but it is logical.[66]"

Milla, inpatient

Only by tracing the flows of logic underpinning notions of how to be good at anorexia can we understand that food is horrifying and yet also:

"Starving is an example of excellent willpower."

Thin Commandment

And in turn, can we comprehend the specifics of pro-anorexic subjectivity.

One informant, Elle said:

"Starving feels like an achievement, it's feels like you've done something right."

Elle, inpatient

For starving to be an achievement, food must be attractive as well as contaminating. This was clear in Abigail's interview; she said about food:

"You're too scared to eat it. You can't eat it... There's this urge to go 'fuck it' and eat the whole plate but you know if you do those few moments of satisfaction at having eaten will turn into that familiar bloated feeling and a

---

[66] Also, Giordano 2005 A & B.

sickening feeling of guilt and the longing to run for hours to get rid of it."

Abigail, inpatient

The practice of chewing and then spitting out one's food that I noticed to be widely practiced in the EDU, and which is also sometimes advocated on the websites, also attests to food's desirability. This desirability also underscores some website content:

"Create a list of punishments for thinking about food or when you have given in and eaten. Keep a rubber band on your hand and flick yourself whenever you think of eating, eventually you will have a swollen hand but a shrunken body. Or you could do ridiculous amounts of exercise, purge, self-mutilate, isolate yourself, deny yourself the basic comforts like a blanket on your bed, or shelter when it is raining. Or you could do tasks like cleaning. Remember, you need discipline."

"Buy baby teething gel and rub it on your tongue before you eat to numb your taste buds."

"Spoil your food. As soon as you've cooked your meal, put too much salt, pepper vinegar, detergent or perfume on it. That way you won't want to eat it."

Tips from Pro-Anorexia Websites

There is an intriguing subtle difference between the location and source of desire in these two latter *Tips*. In the first it is one's own enjoyment of, and desire for, food that must be sabotaged. In the second, this sabotage is aimed at food itself. This hints that wanting food may arise from food's desires as well as one's own, which looks forward to discussions in Chapter Four. However, for now, although an attraction to food that necessitates discipline might seem to contradict discussions so far, an attention to hunger navigates this paradox.

1: C   Looking at Hunger: *Thinspirational* Practices of Food Refusal

Although claiming that even thinking about food is "punishable," pro-anorexia websites discuss physical hunger positively:

> "Feel your hunger, don't try and suppress it. You want to be hungry cos if you aren't then you're not doing it right. Hunger is not your enemy!"

> "Hunger is your friend and it won't betray you like food."

Thin Commandments

The struggle involved in resisting hunger was underlined by Milla when she gave me her own *Tip* on, as she put it, "how to get through it." She said:

> "Keep yourself really busy, almost to the point of being completely stressed out and then you can go for eight hours without feeling hungry."

Milla, inpatient

In her recent anthropological exploration of anorexia, Sigal Gooldin states, "the experience of hunger, which involves physical pain and suffering, is transformed into a feeling of self-efficiency, power, and achievement that constitutes a sense of heroic selfhood" (Gooldin 2008: 281). She suggests that through the "embodied morality" (ibid. 275) of hunger "everyday (mundane) practices acquire out-of-the-ordinary meanings" (ibid. 275). Ideas of "heroic selfhood" - of effort and achievement - were echoed by Jumela, who told me:

> "Common 'goodbyes' at the end of pro-ana emails are 'stay strong' and 'starve on'."

Jumela, Pro-Anorexia Research Group participant,
interviewed online

Jumela and Milla's words, in light of Gooldin's work on hunger, offer an alternative vision of how anorexia is imbued with ideas of 'heroism,' strength and discipline. That "a search for selfhood (and independence) exists alongside a pursuit of secular 'sainthood' ('goodness' in secular terms) in many self-starvers' constructions of themselves" (Eckermann 1997: 153[67]) has been previously

---

[67] See also Heywood 1996; Jacobs Brumberg 2000.

recognised. But, such discussions have often focused on "slenderness [as] the measure of one's moral calibre" (Ellmann 1993: 5), which locates achievement in a corporeal 'end result'. This resonates in Bryan S. Turner's statement that "the anorexic avoids the shameful world of eating, while simultaneously achieving personal power and a sense of moral superiority through the emaciated body. Their attempt at disembodiment through negation becomes the symbol of their moral empowerment" (Turner 1992: 221). Gooldin argues, on the contrary, that being anorexic is "about being hungry no less than it is about shaping the body" (Gooldin 2008: 282). This is crucially important.

In her interview Kyra said she regarded herself as never having been a really good anorexic because, she said, she would "get so hungry" that she would periodically binge. Describing her shame at being unable to resist her hunger, Kyra said:

> "I felt this was undisciplined, someone who didn't have enough willpower and determination to over-rule their body's natural urges.
>
> *Kyra, Facebook Pro-Anorexia Research Group participant,*
> *interviewed online*

She continued:

> "I think sufferers want to be better than others at starving themselves and therefore I believe that maybe this is where being a 'good' or 'bad' anorexic has come from."
>
> *Kyra*

Hunger illustrates that starving is not a means to an end but is, rather, important in and of itself; it is as much a desired practice as a practice of desire. This is underscored by informants' engagement with memoirs of anorexia. On pro-anorexia websites pages of *Thinspiration* are intended to help informants become better anorexics, to inspire, incite and motivate. As well as photographs,[68] *Thinspiration* comprises texts which are sometimes extracts from memoirs by recovered anorexics. On the sites such materials are described as "triggering." Chapter Four will discuss how such materials are always liminal – they are used to

---

[68] See this this Chapter Five for a discussion of *Thinspirational* photographs.

self-trigger both anorexia and pro-anorexic desire but they can also *trigger* one or both of these against one's will. However for now, that texts devoid of imagery can be *thinspirational* and "triggering" offers the first suggestion that hunger and material practices of food refusal are more central to pro-anorexia than the visuality of emaciation. Elle, an inpatient, discussed her frequent reading of memoirs. She said:

> "I like to see if they [the authors] do it better than me. It's inspiring; I want to starve more to be as good as them."

> *Elle, inpatient*

Elle's statement was echoed by informants in both field sites, whose subversive engagement with memoirs transformed these texts into metaphorical *Thin Commandments* of an idealised anorexia.

Recognising that achievement arises as much from the daily resistance of hunger as from the visually emaciated body indicates that being good at anorexia does not happen at a given point, but is rather a continual process of day-to-day practices; it would seem imperative to desire food as a disembodied conceptual entity, but to physically reject it and yet also to desperately want it physically but also to resist it - thereby both denying and utilising hunger. In this interplay of levels, contamination and achievement, desire and disgust are all fractured, multiplied and continually pitted against one another. Such multiplicity is also seen in the relationship between being good at anorexia and dying. Addressing death first as the ultimate culmination of 'heroic starvation,' the next section will suggest that death also makes you a bad anorexic by signifying failure rather than achievement; it is a rupture of the process of being good at anorexia.

Part One has suggested that tropes of achievement and discipline so often associated with anorexia in previous literature are part of being a good anorexic, but perhaps not in expected ways. Through the tracing of practices of refusing, engaging with, and resisting, food, being good at anorexia has begun to emerge as a process. However, *Thin Commandments,* which have framed this first part, have also illustrated that the centrality of food refusal to this process renders being a good anorexic a self-defeating and impossible goal; it is not only always unfinished, but is also perpetually ruptured by the daily need to eat. **Part Two** will therefore now address the myriad tactics through which informants attempt to negotiate the impossibility of being good at anorexia where not eating and not dying are both requisite but incompatible.

Part Two   Negotiating Impossibility: How to Be a 'Good Anorexic'?

2: A   Death: Achievement *and* Failure

Dr Dee Dawson, an eating disorders' specialist, argues, "the very best anorexics die very young" (Dawson in Grahame 2009: xii). Death does demonstrate commitment and struggle so complete as to be mortal. And, that the pseudonyms of some website participants and the email addresses of a few of my inpatient informants are variations on "Starving2death" attests to this possibility. One of my online informants, Jumela, sent me a collection of her *thinspirational* photographs, mantras and songs, the latter which she had compiled into, as she put it, "the ultimate pro-ana playlist." Within this was a section by *The Carpenters*. Next to this Jumela had written, "Karen Carpenter died of anorexia," leaving open but clear the particular significance of this sub-section of her playlist. Death also flickers constantly through memoirs; its shadowy potentiality often inhabits these texts from the first chapter or even appears on the dust jacket[69]. Although tales of recovery, memoirs' narratives are thus accompanied and arguably heightened throughout by this shadow of death – of a particular 'anorexic' death.

Examining tuberculosis's legacy of metaphors, Susan Sontag writes, "twentieth century women's fashions (with their cult of thinness) are the last stronghold of the metaphor associated with the romanticizing of TB in the late eighteenth and nineteenth centuries" (Sontag 2002: 30). I suggest that these metaphors enter into notions of how to be good at anorexia, not only through bodily thinness, but also in a specific imagining of death. Sontag writes, "TB is celebrated as the disease of born victims, of sensitive, passive people who are not quite life-loving enough to survive" (ibid. 26). It was imagined to provide a "decorative, often lyrical death" (ibid. 20) and a "person dying (young) of TB really was perceived as a romantic personality" (ibid. 31). This potent image of the wasting away of pure young bones continues in the construct of a good anorexic. In Maureen Dunbar's memoir of her daughter's anorexia she quotes Catherine's GP as writing that Catherine "had no fear of death but did get very distressed by disturbance in vision, angina-like pains and headache resulting from her extreme weakness" (Dunbar 1986: 91). These symptoms, which might otherwise be

---

[69] See esp. Caro 2008; Grahame 2009.

interpreted as warnings of the body's mortality, are here dislocated from death. I suggest that this split between conceptual imaginings of death and its gritty reality allows a death from starvation to be imbued with the kind of intangible heroism that starvation itself has.

Thus, death by starvation is set apart from any other deaths. In interviews, informants would often vehemently deny wanting to die whilst also admitting that death by starvation is accepted or even invited. Elle and I once had a very frank chat about death, which she gave me permission to discuss here. Elle argued that she had no desire to die but that, "if that's what it takes…," as she put it, then she would accept that. She said:

"I'd most like to die of starvation anyway"

Elle, inpatient

But, Elle said she would avoid any other danger of death, such as a speeding car coming towards her, without a moment's hesitation. Elle's words are echoed across pro-anorexia websites and were also heard in Lauren Greenfield's film *Thin* (Greenfield 2004), which documents life at Florida's Renfrew EDU. One of the inpatients, Alisa, says:

"I just want to be thin. If it takes dying to get there, so be it. At least I'll get there."

Alisa, in Greenfield 2004

This suggests that not only does death by starvation make you a good anorexic, but that informants' conceptualisations also perform death in a certain way that re-invest it with desire. There is a tautological circularity to this relationship.

This circularity is perhaps strengthened by the fact that death also possesses a naturalised linkage with anorexia in wider cultural and literary discourses. In the last section I echoed my intentions, expressed in Chapter One, to move away from a focus on thinness. Such an approach takes little account of the specific anorexic subjectivity that forms and maintains that body, as well as others along the way. With a similar emphasis, Jodie Allen has recently discussed how certain media portrayals of anorexia posit an "end-stage" and "ahistorical" body as "the *ultimate* signification of *the* anorexic subject position" (Allen 2008: 589, *italics in original*).

This, she argues, makes anorexics desire the subject-position embodied in this end-stage body. In parallel there is even, arguably, a focus on treatment failure, and thus by extension, on death, in clinical literature. It has been suggested, that "the literature that describes the relatively few patients who do not benefit from treatment affects the decision-making process regarding the majority of cases who could potentially recover if provided with appropriate care" (Melamed et al. 2003: 621 – 622). Thus, to extend Allen's discussion, I suggest that popular imaginings and clinical discourses serve to intertwine being good at anorexia with death. If the desired subject position is near-death, to make oneself a good anorexic, one almost *should* die. Or rather perhaps, one should *almost* die. Good, perhaps, is to embody a tangible danger. But, it is not to be dead.

It is about the possibility of dying that pro-anorexia websites warn participants:

"Do not let your eating disorder get out of hand"

Because the site:

"…can't be held responsible for your actions"

Because it is intended to help with:

"…weight loss, not suicide."

"Remember that ana is not always fun. It can be so awful sometimes you'll want to die. You'll learn a lot about yourself but we don't want any accidents do we? There's no use being thin if you're dead."

"Good Anas NEVER die."

Thin Commandments

These quotations illustrate that refracted through the lens of being good at anorexia, death also makes you a bad anorexic. Libby said in her interview of being warned she might die:

"You just think, 'that won't happen to me, losing weight's not that bad for you. Those people must have done something wrong because I'm fine."

Libby, inpatient

Death framed as "doing something wrong" is a loss of control. If being good at anorexia is enacted through day-to-day practices it is a process imbued with notions of creativity and continuity that death curtails; death is therefore a failure.

Thus, death flows in and out of conceptualisations of being good at anorexia and each imagining does not fit neatly with the others; only one death among many makes you a good anorexic. But, there is another way that death features in informants' discussions. This is in corporeal reality. Alongside warnings not to die, some pro-anorexia websites feature memorials to participants lost to anorexia. These are replete with recognition of suffering, not celebration. Likewise, when one of the patients, Moira, died on the EDU during fieldwork her death was greeted by all of us, staff and patients alike, with great sadness. There was widespread recognition that her death was a terrible waste rather than an achievement. Informants' former sense that Moira had been the best anorexic in the EDU now dissipated to be replaced by despair at losing a friend. Many expressed the wish that they had been able to help Moira and that she had recovered. Others talked of how they hoped she was at peace now and drew comfort from the fact that her struggle was over. As such, struggle lost any overtones of achievement and described instead the horror of an illness that both breaks and takes lives.

Yet although death, like a relationship with food explored above, can slip between disembodied conceptualisations and corporeal realities, eating only happens on the one level of an embodied ingestion of food and it can thus only unmake; food is "a source of great ambivalence: it forever threatens contamination and bodily impurity, but is necessary for survival" (Lupton 1996: 3). To re-enact being good at anorexia day-by-day, one must survive until the next day; food refusal depends on eating. The next section will explore the compromises undertaken by informants to avoid the dual failures of dying and eating.

2: B   **"Making Do[70]"**

2: B. 1   **From *Commandments* to *Tips*: Getting Help from Memoirs**

Despite, or perhaps because of, starvation's centrality to making good anorexics, in interviews informants continually pondered the tension between desiring to be good at anorexia and not wanting to die. Death thereby highlights how being a good anorexic is self-contradictory and, even, impossible; it is thus, a continual process of compromise and "poetic making do" (de Certeau 1984: xv). Informants described perpetually searching for helpful *Tips & Tricks* from a variety of sources to patch together ways to make do. The difference between *Thin Commandments* and *Tips & Tricks* is thus that the former signify the ideal of not eating at all and the latter negotiate a more pragmatic approach; this can be seen by their difference here:

"You don't NEED food."

Thin Commandment

"Remember that you do have to eat sometimes, not a lot but you have to eat something. Try to eat at least two things a day."

Tip

Tips & Tricks on pro-anorexia websites are intended to help participants to put *Commandments* into practice, negotiating the realities of needing food without being unmade. Like *Thin Commandments*, they are not exclusive to pro-anorexia websites; as well as observing and emulating the tactics that others on the Ward and Internet used, informants also read a variety of literatures from recovery memoirs to fiction and even medical textbooks to compile strategic ways to be better at anorexia without dying.

       The *Best Little Girl in the World* (Levenkron 1978) is a particularly famous text on anorexia; all the informants that I asked had read it. Levenkron's text is a fictional account of a teenage girl, Francesca's, anorexia and recovery. Although written by a therapist, many informants described it as notorious for being read and exchanged by those with eating disorders. As Kyra put it:

---

[70] de Certeau 1984.

"Before there were "pro-ana" websites, people used this book for "tips & tricks" on how to become, well, the "best anorexic in the world."

Kyra, Facebook Pro-Anorexia Research Group participant,

interviewed online

Moreover, the memoirs that were read as *Thin Commandments,* discussed above, also signified a central source of *Tips & Tricks* for many informants. Chloe, an inpatient, and I once bumped in to each other in the corridor of the EDU. Whilst chatting, I noticed that she was holding *Gaining: The Truth about Life after Eating Disorders* (Liu 2007), which is an upbeat memoir of recovery. As this had only recently been published and was only just starting to be swapped and exchanged, I had not yet read it. So, I asked Chloe if it was interesting. She replied:

"Oh yeah, this; Erika [nurse] gave it to me. She thought it might inspire me to want recovery. But whatever! It really hasn't. So far there's nothing in it that makes me go 'oh, yeah I want to get better now'. To be honest, I'm just skimming it for tips."

Chloe, inpatient

Chloe's reading of this recovery memoir for *Tips* erased Liu's discussions of anorexia as undesirable and recovery as desirable; it reversed the text's original framing of anorexia. By transforming the narrative's central chapters, in which florid anorexia is described, into something desirable, it also made them educative.

With this widespread accruing of *Tips & Tricks* on the part of informants in mind, the remainder of this part of the chapter will now explore some of the tactics described in memoirs or packaged as *Tips* on websites. One that particularly negotiates the tension between not eating but not dying is food rules.

2: B. 2   Food Rules

In her memoir of anorexia, Grace Bowman describes having categorised foods into dangerous and "accepted" (Bowman 2007 A: 170) during her anorexia. Discussing parallel delineations amongst her anorexic informants, anthropologist Megan Warin argues that these reflect notions of contamination, discussed earlier: "Foods that glistened (such as melted cheese on top of a pizza), or those that left remnants of

oil behind […] were considered dangerous, fatty and dirty" (Warin 2010: 117). Such foods did also feature on 'unacceptable lists' in my informants' food rules. Other foods were acceptable due to their potential to rid the body of food through a laxative effect, to stave off hunger or to give energy. Black coffee was thus widely regarded as acceptable. Artificial sweeteners are advised by some websites to maintain energy and suppress appetite but many of my informants used them simply to make black coffee palatable.[71] Alcohol inhabited an unstable position, some informants deeming it acceptable because of its intoxicating potential and others avoiding it due to its high calorific value.

Yet, it became clear during fieldwork that not only did food rules differ widely between informants but they also often did not link to food's qualities, such as fatty or calorific. Rules described by informants included eating foods in a certain order or on set days of the week, or only eating certain colours of foods – especially white. Some also ate in particular ways, such as only with a teaspoon. A related *Tip* is:

"If you're right handed eat with your left hand. It'll take longer to get food in your mouth."

It is arguably because rules do not always relate to food's qualities that they are frequently seen clinically as just symptomatic of anorexia.[72] In her memoir of anorexia, Nikki Grahame concurs that her own practices of "separating food, moving it around the plate and cutting it up into tiny pieces are all anorexic traits" (Grahame 2009: 188). But, food rules also make sense when looked at from the perspective of being a good anorexic.

One pro-anorexia website advises:

"Make up crazy food rituals and follow them religiously."

Tip

I suggest that as well as limiting food intake, food rules gain their value for informants by performing the compromise between not eating and not dying. It is precisely their "crazy" dislocation from food's physical qualities that ritualises and

---

[71] Also, Marino et al. 2009 on caffeine and sweeteners.
[72] cf. Bruch 200; Robinson 2009.

distances eating, divesting food of its power to unmake them with a mouthful. Food rules therefore illustrate that being a good anorexic is pieced together like a patchwork, continually reworked to fit with specific situations at particular times on a day-to-day basis. Moreover, that refusing to eat depends on having eaten at least enough to stay alive to make the choice is also seen in a second modality of compromise, that of refusing food but allowing oneself to be fed.

2: B. 3 Relinquishing Responsibility

During her interview Paula described Self-Serving on the EDU:

> "It's hard because it's feeding yourself. It's making the next step and when you don't… like, for me, when I'm not self-serving and I'm forced to eat, I talk… I can try and talk myself round more easily in my head: 'well, I'm being forced to do it, I don't want it, I've got to do it, I've got no other option, there's all these other threats that they can… enact if I don't do it, so I've got to eat it, so knuckle down, just eat it, you're being forced to eat it.' So it doesn't mean… it counts but it's not you, it's not you failing in such a big way. In self-serving you put it on the plate and there's such a big temptation to try and give yourself a half portion, to leave a bit there."
>
> *Paula, inpatient*

Apart from therapeutic activities like Self-Serving and Cooking Group inpatients have little control over food or drink.[73] In her interview Gillian said:

> "I know that… and this is not just myself but true for a lot of people… that when people make you do something it does take away quite a lot of the guilt."
>
> *Gillian, inpatient*

Mandy Allison, likewise, states in her memoir that putting responsibility for her eating on EDU staff "allowed me to delude myself into thinking that I was actually

---

[73] Patients choose meals from specially designed menus once a week. At each meal food is carefully served by staff members according to pre-ordained portion sizes. Self-Serving is when a patient serves their own food according to the portions indicated by an accompanying member of staff. It is intended to get patients used to handling food and to feeding themselves.

eating against my will" and so staff became "baddies" (Allison 2009:120). Many informants described this relinquishing of responsibility positively because it kept them alive and reduced their physical suffering whilst not making them actually *choose* to eat, thus allowing them to continue being good anorexics. Informants thus allow food to breach the body but not their sense of self, enacting a separation between these.

Arguably this particular compromise also worked on another level. As well as removing responsibility, being served foods renders them opaque; patients could only estimate what ingredients made up the cakes, pies and quiches, for example, on the EDU. This not knowing was described both as horrifyingly scary by informants but also, perhaps paradoxically, as allowing certain foods that they would otherwise not have allowed themselves, such as dairy products. This was apparent in Gillian's interview. She said that milk in tea:

"…doesn't count. I don't mind how much I have of that"

Gillian

Not only do patients have no control over the milk in their tea but they also cannot visually quantify it; hot drinks accompanying meals were made by staff out of sight. The milk and hot water mixture was taken to the table where the patient would add a teabag or coffee granules. It was this invisibility that Gillian cited as making milk "not count."

Yet, as a montage of processes of "making do'" (de Certeau 1984: xv) compromises also have their limits. Despite assuaging her guilt and enabling consumption of previously disallowed substances like milk, relinquishing responsibility did not entirely remove eating's potential to unmake Gillian – with that unmaking taking place on a number of levels. Throughout her stay in the EDU Gillian scratched herself with a fork under the table during meals. Lazing on the back steps one summer evening during the last escorted cigarette break before lockdown at 9pm, I asked Gillian about the deep scores I had seen her make during dinner. She said that digging the metal prongs into her arm distracted her from the emotional pain of eating, rendering more bearable the fact of having to use the fork in her other hand to feed herself. Gillian's scratching of her arms transfers pain from one location to another. As such, anorexia, desire to be a good anorexic, and

food are all, at different times, causes and attenuators of pain – each perhaps just an odynometer for the other. Thus, like being a good anorexic, the tactics that negotiate compromise around it are perhaps always doomed to at least partial failure; in successfully allowing informants to remain good anorexics whilst eating, they nevertheless cannot negotiate the pain that eating engenders. Against this background, the next section will suggest that tactics of compromise can themselves also be unstable.

2: B. 4   Vomiting: A Compromising Compromise

Mirroring the death that it aims to circumnavigate, vomit engages in a tangled relationship with being good at anorexia. It is a tactic of compromise widely endorsed by pro-anorexia websites, particularly if one has 'transgressed' and binged, as these *Tips* illustrate:

> "Only eat soft foods during a binge. They're easier to vomit."

> "Use a toothbrush- it's easier to vomit and you won't scar your knuckles."

Allowing ingestion without digestion, vomiting was described by many informants as a 'cure' for having 'given in' to food or, particularly, for having been forced to eat in treatment. In her memoir of anorexia Nikki Grahame asserts:

> "I could puke up a 1,000 calorie lunch in less than a minute."

> *Grahame 2009: 220*

As Grahame implies, particularly in a context of enforced eating, vomiting resurrects the boundary between food and the body and is thus an act of reconstitution. Yet, vomit expounds a double narrative. In her memoir of anorexia, Marya Hornbacher writes of being in an EDU:

> "It would look like someone was pulling ahead of the pack: so-and-so is throwing up, one girl says, and we'd all freak out. Oh no! we'd cry, as if we weren't all doing it. That's awful!"

Hornbacher 1998: 116

The "freaking out" of others evinces vomit's ability to makes someone a better anorexic than everyone else who has not thrown up the communal dinner. But, Hornbacher's use of "awful" is double edged and reveals vomit's contradictions. Vomit constitutes compromise not only by allowing anorexics to be both good and alive. It also involves compromising *oneself,* not only as an anorexic but also as a social person. It unmakes as much as it makes because it signifies a "danger issuing from within the identity" (Kristeva 1982: 71) into public view. This "abject" (ibid. 1982) and both literally and metaphorically re-rupturing nature of vomit - that it is, in pragmatic terms, tangibly smelly, sticky and visible - led informants to express shame at vomiting. In ridding themselves of the defiling "matter out of place" (Douglas 2002) of food, they created another out of place matter, vomit. This rendered them abject in their own eyes and those of other anorexics. Arguments over vomit found in washing machines and other public places abounded in the EDU and patients' disgust at each other was palpable.

Furthermore, informants described vomit as too closely associated with a medicalized framework of anorexia; it is pathologising. Whilst vomiting restores control over your ingestion, it also suggests you to be out of control, which problematizes any claim to be good at anorexia. This was illustrated by a conversation in the EDU with Lois. Lois was curious how I decided whom to interview. When I replied, "anyone who is willing," Lois said:

> "But you wouldn't interview, like, Holly, would you?"

Lois, inpatient

Holly, who balanced precariously on the threshold of being the best and yet worst anorexic on the Ward at that time, vomited everything that she was fed wherever she might be. This kept her the most emaciated patient and yet, not *quite* good. Lois described herself as not only "more ill than Holly" but also a "better anorexic," the two concepts here overlapping but not quite aligning. Lois grounded this claim precisely in the fact that her own recent spate of vomiting had passed unnoticed by

staff and patients alike. Lois described her own anorexia as "raging" at that time, so much so that when she ate a voice in her head told her that she was not a good anorexic and could be better. She recounted having been regularly taking food from her plate and hiding it in her pockets to dispose of later. When she did this, the voice told her she was a good anorexic. In this discussion Lois linked the hiding of food with not vomiting not only pragmatically in that if one hides food vomiting is not needed, but also conceptually. She suggested that concealment is an active part of being a good anorexic, which is a discussion that will be returned to in Chapter Four. As such, vomiting makes you a good anorexic only if it is unnoticed, and thus, controlled. But, even then, by rendering visible the fact of having eaten, vomit intrinsically *exhibits* failure; it gives too much away about how embodied both food and illness are within you. Yet, we might ask, gives too much away to whom? This suggests that it is not solely individual struggle that makes and unmakes good anorexics but that they are also socially constituted.

Part Two has explored how informants negotiate the contradictions and impossibilities in the model of a good anorexic circumscribed by *Thin Commandments,* whether those are the literal commands on pro-anorexia websites or other materials such as memoirs against which informants measure themselves and from which they also glean *Tips*. From the discussion of vomit it has begun to emerge that being a good anorexic is relationally as much as individually enacted. Thus, taking social and individual processes not as polarities but rather as mutually productive, **Part Three** will now explore how good anorexics are made and unmade relationally. I will argue that this process is inextricably linked to the thin body's visibility. Suggesting that both good anorexics and bodies are made through social interactions, discussion will begin with informants' patrolling of their own thinness.

Part Three   Thinness & Other People: Social (Un)Making of 'Good Anorexics'

3: A   Making Oneself a 'Good Anorexic' through Bodily Thinness

3: A. 1   Patrolling & (Re)Producing Bodily Perimeters

I suggest that only in tandem with exploring how good anorexics are made socially can we begin to conceptualise the thinness of the 'anorexic body' in ways that take account of informants' experiences of, and desires for, anorexia. Grosz argues that "the body must be seen as a series of processes of becoming, rather than as a fixed state of being" (Grosz 1994: 12). This echoes Haraway, who writes, "bodies as objects of knowledge are material-semiotic generative nodes" (Haraway 1991: 200) whose "boundaries materialize in social interaction" (ibid. 201). And, Shilling suggests that Bourdieu's analysis of practice gives us ways to think also about "bodies as unfinished entities which are formed through their participation in social life" (Shilling 2003: 113). Drawing on these ideas of process, and being and becoming unfinished, in this part of the chapter there will be an interplay of thinness and relationality. Such oscillations and reflections are intended to echo how each of these illuminates, but also problematizes, the other's role in making good anorexics.

During her interview Milla pinched herself, encircled her arms with her hands and pressed bruisingly hard on her hipbones to demonstrate how she checks every day how thin her body is. Milla described such palpating as enabling her to:

"…always know where the perimeters of my body are."

Milla, inpatient

Similar patrolling of bodily "perimeters" is advocated by pro-anorexia websites:

"Take a shower. Paying attention to your body will remind you why you are starving in the first place."

"Videotape yourself and watch it to see how fat you look whenever you want to eat."

Tips

These Tips, alongside Milla's narrative, do posit bodily thinness as important to being good at anorexia. But they also expound another narrative about such thinness.

In her interview Kyra described a good anorexic as

"Someone who has maintained a skinny, often visibly bony body over a length of time, perhaps even for years and years."

Kyra, Facebook Pro-Anorexia Research Group participant,

interviewed online

This idea of "maintaining" is important. It has been suggested that the body in western culture is "an entity which is in the process of becoming; a *project* which should be worked at and accomplished as part of an *individual's* self-identity" (Shilling 2003: 4 - *italics in original*). Conceptualising bodies as "becoming" does resonate with being good at anorexia. But, I take up the idea of the body as project only cautiously. I suggest that the "surveillance over, and against [herself]" (Foucault 1980: 155), seen in Kate's menu collecting - and re-evoked here by Milla's bodily patrolling - is an active modality of being good at anorexia. These acts are not merely secondary to the thinness they produce; their enactment in itself makes you good at anorexia. The 'project' of being a good anorexic is thus not acted on the body but produced *with* the body on a daily basis. This suggests that to informants, anorexia may be done *through* the body, but it is not *about* the body. As such, thinness which has been regarded in much previous literature as the essence of anorexia does not entirely align with being good at anorexia; it emerges here as fractured and mobile – as something both aspired to in the future *and* that necessitates continual reproduction in the present. This is illustrated by informants' self-weighing.

Two *Thin Commandments* state:

"What the scale says is the most important thing."

"The numbers on the scales become both friend and enemy, and the frenzied thoughts pray for them to be lower than yesterday."

Drawing a parallel between her daily self-weighing at home and her equally frequent weigh-ins on the EDU, Gillian recounted how the weight she registered determined her entire mood for the day, engendering elation or guilt. This is echoed in Maureen Dunbar's memoir of her daughter Catherine's illness and death. A cited entry from Catherine's diary reads: "I weighed 30 kilos this morning, that really made my day" (Dunbar 1986: 46). Such is the importance of Catherine's morning weight that even when she records the death of her grandfather this too is preceded by "my weight was 30.8 this morning which pleased me" (ibid. 45[74]). Yet, Catherine and Gillian's continual weight checking illustrates that to be good at anorexia the numbers on the scales must not only go down, but stay down. In the EDU I often witnessed the extreme distress caused by gaining even a fraction of a kilo; this would render informants self-loathing and tearful. Miriam said:

> "If you put on any weight it's like….'what did you do wrong? What did you do yesterday? What's gone wrong? Why are you putting on weight? Why, why are you doing this? What's going on? How on earth…Why, why…why did you have that? What was wrong with you? What's going through your mind? You don't need that! Now your weight's gone up and you know, you're giving up and you're just being weak and pathetic' and… you know, you've got to be strong, you've got to keep going, keep ploughing on."

Miriam, inpatient

Fear of gaining weight is part of the diagnostic criteria of anorexia nervosa in DSM IV (APA 1994) and it is suggested that for anorexics "weight gain can be a terrifying experience, not just mentally but also physically" (Treasure & Ward 1997: 107). But, in terms of being a good anorexic it takes on particular resonance; the power of weigh-ins, alongside Kyra's earlier suggestion that good anorexics "maintain bony bodies," suggests that being a good anorexic involves always being 'better than yesterday' – over and over again. Thus, these modalities of patrolling, which are not only surveillances but also productive, make you a good anorexic only one day at a time. They illustrate that being good at anorexia is relentless. 'Relentless' is a word that is not infrequently used to describe anorexia in various literatures. Yin Lim and Agnew, for example, state that it is "a complex psychological and multi-dimensional

---

[74] Also, Garrett 1998: 154 – 156.

disorder in which the individual deliberately and wilfully starves in a *relentless pursuit* of thinness" (Yin Lim & Agnew 1994: 309 - *italics mine*). That anorexia is multi-dimensional and complex can hardly be denied. Yet, here the authors use 'relentless' to describe the "*pursuit* of thinness" and it is this teleological defining of a goal that is, arguably, problematic.

Weighing oneself not only makes you a good anorexic, it can also unmake you. Outward expansion of corporeal contours breaches informants' sense of self as much as food entering the body ruptures from the outside in; both fracture the boundaries of body and self. Fear of gaining weight in my informants' interviews is thus entirely enmeshed with the pro-anorexic subjectivity of making and maintaining oneself a good anorexic on a daily basis. As such - with each located in the other here - both thinness and being good at anorexia are perpetually unfinished and precarious, which imbues being a good anorexic with, following Victor Turner, "liminality" (Turner 1967); informants balance between being a better anorexic and being a bad anorexic and, in between, being good shifts continually out of view and reach. Being good at anorexia is thus as much about staying anorexic– about stasis and holding onto anorexia as getting better at it. Good thus comprises *being* as much as becoming and both require continual effort.

The next section will suggest that recognition of this "liminality" casts new light on frequent discussions of competition between anorexics. Competitiveness is driven less by a wish to be a better anorexic than others and more by informants' desires to make themselves better anorexics when they turn their gazes on other anorexics and find themselves comparably wanting.

3: A. 2   'Motivating' Oneself by Turning One's Gaze on Others

Pro-anorexia websites advise that participants:

> "Find a buddy online and do fasts with them or have competitions. Or email them when you are craving."
>
> *Tip*

Such competition between anorexics is well documented[75] and is a particular focus of press discussions of pro-anorexia websites. In her memoir of anorexia, *Good Girls Do Swallow,* Rachel Oakes-Ash says of this:

> "Some anorexics flaunt their body for The Gaze. Look at me, look at me, look how much I am suffering. Look how my ribs stick out, bet yours don't do that."
>
> *Oakes-Ash 2001: 68*

Here, Oakes-Ash frames competition as invited – directing another's gaze to affirm oneself as a good anorexic. However, during my fieldwork, competition was more usually described as flowing in the opposite direction. Warin writes of her own anorexic informants that in EDUs "anorexic practices were challenged and confronted, yet these were the places where the hierarchy of anorexia was most evident, as some competed to be the best anorexic within the group." (Warin 2010: 86). This suggests that competition is a process in which anorexics strive to be better at anorexia than they perceive others to be. About this, Charlene, an informant from the EDU, sent me an email in which she offered her thoughts on pro-anorexia websites. Describing these as "bloody awful," she said:

> "I have personally looked, because as you know this illness is highly competitive, the need to see if someone is worse makes you work harder, or even better if you are worse you feel that sense of achievement. People like me dont need any more ideas."
>
> *Charlene, inpatient, by email*

Charlene's words suggest that competition is not as straightforward as making oneself a better anorexic than others. By saying she 'does not need any more ideas', Charlene suggests that competition is rather the using of others' anorexia as a motivational tool to make oneself a better anorexic. As such, others' thinness could be argued to act as a *Thin Commandment*, visually defining what it is to be a good anorexic and thus against which one must measure oneself. In her interview Laura discussed this:

---

[75] cf. Shelley 1997.

"Pro ana sites motivate me to keep starving myself and as a fairly competative person (which is common amonst anorexics) by looking at these sites and reading what other people have eaten encourages me to "beat" them and eat less. Also all the really skinny photographs motivate me to aim to look like them and so i continue to starve myself."

Laura, Facebook Pro-Anorexia Research Group participant,
interviewed online

Kyra recounted how every time she used to visit a new pro-anorexia website she searched for biographical information about the website's creator to check how much they ate and weighed. She described feeling:

"Like I needed to be able to 'compete' with them, feeling either inferior because they had managed to maintain lower weights or superior because they weighed more than me."

Kyra, Facebook Pro-Anorexia Research Group Participant,
interviewed online

These quotations highlight how competition is as much intra- as it is inter-subjective. Informants describe how perceiving others to be better anorexics engenders desire not only to be better than them, but also to make themselves better at anorexia. This relational "reproduction of the self from the reflections of others" (Haraway 1999: 272) is described by Libby:

"It's not so much a competition with the other girls but a competition within myself as well, to stay as anorexic as possible."

Libby, inpatient

Yet, since almost all my informants described motivating themselves by turning their gaze on others, the gaze surely flows both ways - others must also be looking at you. In her memoir, Nikki Grahame writes of her stay in an EDU:

"A characteristic of this eating disorder is the competitive urge to be the thinnest and most celebrated anorexic in a particular place. So the other

girls were already jealous because I was the thinnest and the illest. I was top-dog anorexic."

<div align="right">Grahame 2009: 190</div>

A gaze that might both unmake and motivate self-re-making of the viewer here affirms Grahame as a good anorexic. Yet, interestingly, it became clear in the EDU that even the admiring gaze is usually not experienced as such by the receiver; many informants felt themselves to be bad anorexics in the eyes of others despite sometimes being lauded as good anorexics in other informants' interviews. This introduces the sense that another's gaze has the power not only to make one a good anorexic but also to unmake. Like Plato's Pharmakon (Plato 2005; Derrida 2004), this gaze is at once both remedy and poison. In a discussion of the importance of recognition to identity, Carl Elliott points out that "others can refuse to recognize your identity, refuse to grant it equal moral status, or insist on seeing you in a way other than the way in which you see yourself" (Elliott 2004: 41). The next section will explore the refusing gaze and address the tension between being a bad anorexic *in the eyes of* others and being *made* a bad anorexic *by* others.

3: B   The Unmaking Gaze of Others
3: B. 1   Be(com)ing A 'Bad Anorexic' *in the Eyes of Others*

During fieldwork on the EDU a new rule regarding Cooking Group was introduced. To take part patients now needed a BMI of 16 or over. Lists of those taking part in the coming weeks' Cooking Groups were always posted on the board outside the Nursing Office. After the rule change, these lists served to publicly proclaim that anyone taking part now had a BMI of over 16. They therefore created a divide between the patients; those who were too thin to take part became 'good' anorexics, rendering those on the other side of the line 'bad' anorexics. Staff argued that this new rule encouraged patients to regard a higher BMI as praiseworthy and 'healthy'. But, amongst the patients there was widespread frustration.

Because many patients had just left and some new ones had been admitted, at that time Claudine happened to be one of the few patients with a BMI above 16, having already spent months in treatment. Aware of her potential to be perceived as a bad anorexic by others due to her sense of having a larger body anyway,

Claudine did not want her permission to take part in Cooking Group to confirm this by rendering her body doubly visible. Claudine said that although she "knew" her BMI was "too high," and she already struggled with not being as good at anorexia as she wanted to be, she was particularly terrified of being labelled a bad anorexic by others. Claudine told me during one of our interviews that she intended to lose as much weight as possible in order to not meet the new criterion for Cooking Group.

It is clear from Claudine's story that bodily markers such as BMI or weight, which, as we saw above are performed and enacted daily by informants to make themselves good anorexics, can instantly unmake them if open to public view. Like another's gaze on your thinness, these markers allow the label of a good anorexic to be bestowed and revoked by others as well as yourself. Erving Goffman describes how stigma "refer[s] to bodily signs designed to expose something bad and unusual about the moral status of the signifier" (Goffman 1963: 11). Although Goffman is here discussing marks scored onto the body, like cutting and branding, it is clear that the visibility of thinness and, if revealed, BMI and weight, can also transact stigma. Rather than marking the body after an individual's moral status has been called into question, here the body draws the individual's moral status into debate in the eyes of those who look at it. Because, arguably what other anorexics judge through such markers is not the body in and of itself, but rather your moral resolve against hunger – whether you practice *enough* food refusal to be a good anorexic; if anorexia is *through* not *about* the body, thinness is indexical. For my informants, being good at anorexia was thus rendered doubly relentless and precarious; as well as balancing between making and unmaking themselves by eating and self-weighing, they were also under continual threat of being unmade by others. This threat of being socially unmade illustrates that being a good anorexic is not always – or perhaps, hardly at all – under one's own control. The next section will explore two ways in which informants attempt to influence, subvert and block the gaze of others and so reclaim agency and control.

3: B. 2   Reclaiming Agency from Another's Gaze

In her memoir, Mandy Allison writes:

> "Intrinsically I believed that my body could betray me"… "the danger of exposure was potentially great, as my body was something that could be seen."

Allison 2009: 87

Anorexics' covering of their bodies can be sometimes attributed to a desire to hide one's anorexia from carers and clinicians, as advised by *Tips & Tricks*. Some informants also described covering up because of bodily shame.[76] But hiding one's body from other anorexics serves a very different purpose. In the EDU some informants did this to block the social making and unmaking of their anorexia. Ultra-concealing clothes served, essentially, to close the body to the gaze, performing it as, to echo Bourdieu, "finished" (Shilling 2003: 113).

Yet, this suggests that being good at anorexia and *appearing* to be may not be the same, or even aligned. A *Thin Commandment* advises website participants:

> "You must buy clothes, cut your hair, take laxatives, starve yourself, do anything to make yourself look thinner,"

The blurring of *making* oneself thinner through starving/laxatives that actually alter bodily perimeters and cutting hair/buying clothes that *appear* to do so is interesting here. It suggests that appearing *is* making and that being a good anorexic is something that flows in and out of the body. In relation to the unmaking gaze of others, thinness and being good at anorexia thus exist in an unstable relationship, each producing but also problematizing the other. We could say that thinness as a signifier of moral resolve and being 'good' also comes to signify something more than – or other than – a description of bodily boundaries; it too is dislocated from the body. The next account suggests that the importance of *appearing* to others to be a good anorexic also dislocates starvation from the body.

During one airless and silent lunchtime sitting next to a patient, Julia, I suddenly realised that she continually repeated the same action as she ate. Every

---

[76] See Burney & Irwin 2000; Goss & Gilbert 2002.

time Julia put food on her fork she passed it over the top of the opening of her opposite sleeve as though dispatching her meal down her arm. Yet, each time no food left her fork and it continued on its reluctant trajectory to her mouth. The first half of the fork's journey to her sleeve was a slow one, with expansive movements; Julia held her head up as she performatively hovered food over her open sleeve. But, when the fork moved from sleeve to mouth, Julia thrust down her head and hunched her shoulders forward so her hair hid her face as she quickly put the food in her mouth. Julia would then put her head up, look around to see who was watching and the sequence of actions would occur again. This continued until Julia was challenged to empty her sleeve by a staff member who had been convinced by her performance and of course, it contained nothing.

Julia's performance of not eating underlines the centrality of food refusal to being a good anorexic as discussed in Part One. But paradoxically, that it *can* be visually performed also seems to undermine the importance of not eating as an embodied action. This perhaps privileges appearing to not eat over actually not eating. This performance is key to Julia's reclamation of agency to determine her own making and unmaking as a good anorexic. At that time Julia, a very reluctant patient, was on section and had carried out a number of actions to resist and disrupt her treatment. A link between resisting food and resisting treatment noted in relation to Lola in Part One suggests that, like "la Perruque" (de Certeau 1984), Julia's performance was an oppositional act. However, I also suggest that seen to be not eating was important as a practice that constituted her own sense of self as a good anorexic. In the highly regulated Dining Room in which being discovered not eating would lead at least to a high calorie drink, if not an assisted feed, it was important to Julia to eat and yet to appear to not do so. Julia's actions performed the food refusal of being good at anorexia in circumstances in which it was difficult to embody anorexia, to 'actually' be a good anorexic. They aligned Julia's "presentation of self" (Goffman 1959) with her sense of self, protecting that sense against erosion and constraint. Furthermore, we could also reverse this, and say that Julia produced herself as a good anorexic precisely *by* presenting herself as such. Her performance thus reminds us that mimesis is "a capacity that alerts one to the contractual element of the visual contract with reality" (Taussig 1993: 70) and which "implicates reality" (ibid. 11). Thus, instead of "trickery" (de Certeau

1984) Julia's actions constitute an "embodied imitation as a kind of psychological identification" (Strathern & Lambek 1998: 11) with both herself and wider modalities of being good at anorexia; she is "miming the real into being" (Taussig 1993: 105) as looking like is a modality of becoming.

Julia's performance suggests that there is something more complex and subtle to the discussions of the unmaking gaze of others so far not discussed. There is a blurring of boundaries to her performance. We cannot unproblematically assume that this is about *appearing* to be a good anorexic, performed for others – or *making* herself a good anorexic, for herself - or both; this particular articulation of being good at anorexia resists such simplistic delineations. As well as being unmade in another's eyes, which called into question their social personhood, many informants recounted how through the gaze of others they felt themselves to be broken - their own sense of themselves as good anorexics destroyed. This suggests that the gaze of another can unmake you not only socially, but also *to yourself*.

3: B. 3   Be(com)ing Unmade *to Oneself*

One day during fieldwork Milla had an appointment with the dentist. It was generally assumed beforehand that she would be having a filling as she had toothache. In the Patients' Lounge, surrounded by other patients before her appointment, a staff member told Milla of his concern that she would use the filling pain as an excuse to not eat. The staff member said he wanted to make it clear that this would not be acceptable and that she would not be excused from any food. In response, Milla blushed, mumbled that she did not intend to do that and made a swift exit to the dentist's. By the time she returned Milla's discomfort had transmuted into anger. In our later interview, Milla explained that her anger had been directed at herself. She recounted that, until it had been suggested by the staff member, it had not occurred to her to use her dental pain to avoid eating. She described spending the remainder of the appointment day overwhelmed by feeling like, as she put it, a "really bad anorexic" for not having thought of the ploy herself. Moreover, she also dreaded the approaching dinnertime as she was desperately torn about what to do; Milla said that she just wanted to eat dinner and, as she put it, "get the whole eating thing over with for the day" as usual. Yet, she also knew

that having heard the exchange in the Patients' Lounge, the other patients would feel that only a 'bad anorexic' would pass up such a challenge as had been 'issued' by the member of staff. Milla felt that she should at least appear to not be eating or everyone would know what a terrible anorexic she was. She ate that night but did so with even more distress and struggle than usual.

It is clear from Milla's narrative that there are two distinct but enmeshed elements to being socially made and unmade as a good anorexic. Her sense of needing to be publicly seen to not eat evinces her desire to negotiate and curtail the threat to her social personhood. But the incident also makes Milla angry with herself because it reveals her to be a bad anorexic *to herself*. It is useful here to draw on George Herbert Mead's discussions of the social foundations of the self (Mead 1967). Through "social acts" he theorized, we come to see ourselves from the standpoint of others and in relation to them selfhood arises; self can be "both subject and object" (Mead 1967: 137). Mead distinguishes between "the I" and "the me," self as subject as opposed to self as object. Mead argues that "the I" is a response to the attitudes of other people (ibid. 175), whereas "the me" is "the organized set of attitudes of others which one himself assumes" (ibid. 175). "The I" is thus the knower and "the me" the known. With this in mind, we could say that reflecting on herself through the gaze of others, Milla did not just observe herself to be unmade but she also subjectively experienced her unmaking. Or, to put it another way, Milla not only found herself to be an inadequate anorexic, she became one. If, "in Western societies that put a high value on the individual – its freedom, autonomy, creativity, and the expression of its own individuality – we can easily overlook the role that others play in giving us the pieces with which we put together an image of ourself" (Burkitt 2008:1), here Milla's pieces of self are arguably both given and taken away, socially.

But, what this also suggests about being good at anorexia is how much it is always dual - a continual dialogue of social and individual, outside and inside, each shaping and making the other. Moreover, these dialogic transactions may continually journey back and forth with inferences and refractions coming into being on many levels at once. In her interview Abigail discussed her experiences of the EDU Dining Room. Demonstrating how competition with others mingles with self-making, she said of another patient:

> "If I finish dinner before her she's won… and then she's a better anorexic than me!"

<div align="right">Abigail, inpatient</div>

She continued:

> "I feel like I've got hamster cheeks… full, full of food and I just feel so… and then everyone looks at me and they think: 'god, she's eating a lot, she's packing it in, stuffing her little face'."

<div align="right">Abigail</div>

Here Abigail is at once, both "I" and "me" in Mead's terms. But, the I is arguably not necessarily another's gaze. Abigail's sense of herself as a bad anorexic is made as much by her inference of that gaze as its actuality. It is arguably formed both by her knowledge, and thus fear, of the social making and unmaking of anorexics and by her own sense of unmaking herself through eating. These reflect and produce each other. The interaction of food, body, self and other illustrates that Abigail's horror at food cannot be dislocated from her desire to be a good anorexic but, as I argued in Part One, we cannot simplistically attribute cause and effect either. Abigail's unmaking is inferred but the inference itself brings that unmaking into actuality. Abigail is both self and other, knower and known and yet is arguably also trapped inside a circularity produced by her own pro-anorexic desire. As such, Abigail also reminds us here of how desires cannot be dislocated from the frameworks that articulate and reinforce how to be a good anorexic, such as *Thin Commandment, Tips and Tricks*. There is an echolalia or, a "heteroglossia" (Bakhtin 1982), of others' voices; desires comprise others' desires, words and even, bodies. Good anorexics are thus made not just by the desire to be a good anorexic, but also *alongside* that desire as it too is continually reproduced and redefined. Moreover, the process of disengagement and re-engagement that would seem to take place between bodily appearance, desires and being a good anorexic suggests that it is possible not only to look like, but also to *be* bodily a 'good' anorexic yet not to act like one. In reverse thus, it is also possible to be good at anorexia in one's practices and actions, but not to look like one corporeally to others or even to oneself. As such, what it means to be a good anorexic is redefined and

reproduced with each day-by-day reproduction of desire. It might be useful here to call on Haraway's discussions of a "material-semiotic actor" (Haraway 1993) in which "the human being becomes just one material-semiotic actor engaged in complex conversation with other players" (Bolt 2007: 2). Good anorexics are made not only in relation to thinness or food refusal or even, in relation to other people and their thinness and food refusal, but in a network in which all these human and non-human actors are engaged in conversation, and "the object of knowledge [is] an active part of the apparatus of bodily production" (Haraway 1993: 374). As such, being a good anorexic is not static but is composed of, to borrow from Brian Massumi, "interacting vectors" (Massumi 1992: 14).

These ideas of dislocations, resonance and desire will be unpacked later in this thesis, particularly in Chapters Four and Five. However, I have briefly mentioned them here because I suggest that only with such a conceptualisation can we take account of a lingering but pervasive ambivalence in many informants' accounts of being good at anorexia. It is, arguably, both from these relationships and within the spaces between them that broken links, counter-desires and contradictions to being a good anorexic emerge; as such, ambivalence is a *part of* pro-anorexia.

Part Three has explored how being good at anorexia is as much socially as individually enacted and has argued that it is only with this in mind that we can approach bodily thinness and theorise its place in subjectivities of pro-anorexia. I have suggested that being good at anorexia and being thin sometimes overlap but at other times are dislocated or even conflicting. As such, being, and desiring to be, a good anorexic is more complex and foliated than it might have been assumed before the start of this chapter. **Part Four** will now end this chapter with a discussion of ambivalence. Although seemingly brief for such a complex subject, this next section serves to introduce an idea of ambivalence that will be further explored, layer-by-layer, in the chapters that follow.

Part Four   The Emergence of Ambivalence

4: A   Other People: Competition *and* Care

During fieldwork it was discovered by staff in the EDU that one of the older more experienced patients had lent one of the youngest a calorie counting book so that she could continue to enact mechanisms of anorexic control whilst in treatment. When the older patient was challenged by staff, she explained her actions as friendship. She argued that enabling her friend to calculate what she was consuming would make her feel safer, allowing her to reclaim some autonomy, and that she might subsequently engage with treatment more willingly. Yet both patients also admitted that they pored over the calorie charts wanting to count and really, to avoid, calories because, "that's what we do." This act of giving the book constituted a formalisation and concretisation of many of the interactions that took place in the quotidian life of the EDU. When filling in their menu choices for the week, patients would ask one another which choice was "better." As well as some reference to taste and/or consistency, "better" here took on the meaning of containing less fat or fewer calories. Such interactions therefore also (re-)established anorexic meanings to words like 'better' that are in opposition to the "narrative emplotments" (Mattingly 1998: 5) of the clinic. Such a mix of motivations and values runs through many of my interview transcripts. Many informants expressed a lucid and, often, tortured understanding of others' pro-anorexic desire and, in particular, their wishes and attempts to be good anorexics. In her interview Lia, an inpatient, discussed her mixed feelings on witnessing other patients hiding food and vomiting. She did not know whether it was 'right' to stop them or leave them to it; she felt that both actions signified help and hindrance in different ways and recognised that her motives for each would be mixed.

During her interview Tara candidly described how if, on the EDU, another person ate their dinner when she had been able to avoid eating or to dispose of hers, she was thrilled because this made her a better anorexic, for that moment at least. But, Tara's narrative had a further dimension to it that was not present in parallel narratives in Part Three. Tara directly linked this competition to her care and support of other patients. She described the thrill she got if her comforting and support of another patient in the Dining Room helped them to eat, particularly if

she avoided food in the process. Tara described thinking, "ha ha, you ate your dinner!" This is echoed by Grace Bowman's memoir of anorexia. She recalls of her past anorexic self:

> "She is reassured when others eat; she likes to feed them – watching them place every crumb in their mouths, filling with fear if their plates aren't empty. She wants them to be weighed down, heavy and full, then she can be lighter and she can float above them."
>
> *Bowman 2007 A: 45*

Yet Tara was also very kind and supportive to other patients; there were many times, both in the Dining Room and outside it, when she was generous with time, comfort and advice and she was much liked. With very real empathy for others' suffering, Tara described how she looked around at other patients and was "horrified." She said:

> "They all look so poorly."
>
> *Tara, inpatient*

Tara wanted to "tell them to take the weight off," as she put it, while she made them dinner. This encapsulates a duality of competition and care, about which Tara was very frank. These exist side-by-side in many informants' accounts and do not efface each other.

Tara's recognition of others' suffering was echoed by, amongst others, Elle. Stating that after four months of treatment she did not want to get better any more than she had on admission, Elle said:

> "I don't think anything's going to work because I don't want it to. I do want to get worse because 'worse' to other people is 'better' to me"
>
> *Elle, inpatient*

But, she also said:

> "Whoever designed the Peer Pressure System was really really clever because without it I'd be dead."
>
> *Elle*

Elle argued that it was necessary because *other* people should be "helped to recover" and "not suffer." Especially, she argued, they should not be allowed to die. But, as we saw in Part Two, she should. This was echoed by Josie, who said:

> "I want you to know that I have never actually used the message boards of any of these sites but only look at other people's comments but have never commented myself because personally I find it really difficult to understand how people can encourage others to continue to starve themselves. I think it is different if you choose to starve yourself but I could never live with myself if I encouraged another person to do so because you are effectively assisting in their suicide (in my opinion)."

> *Josie, pro-anorexia website participant,*
> *interviewed online*

These quotations illustrate how ambivalence towards anorexia emerges in relation to other people's anorexia. Although conceptualising the relative thinness of their own bodies only in terms of how 'good' they are at anorexia, Tara, Elle and Josie's gaze read into others' bodies a subjectivity of suffering that made them want to help. This help was apparent in many different contexts in both field spaces and was often indicative of relationships of care, compassion and support between informants. Hearing others say in the EDU, or write on the web, that they were 'struggling,' did 'not want to carry on' or might be 'better off dead' for example, provoked on many occasions enormous outpourings of support and encouragement that the interlocutor could 'beat this' and 'had to keep fighting anorexia.' In these exchanges anorexia contextually lost its desirability.

This recognition of one another's pain was often cited as a reason to participate in pro-anorexia websites. In her interview Galina echoed informants in the EDU, like Lia above, who described understanding the pro-anorexic desire of others. She said:

> "Often at work people mention how much im eating or what im eating and about how dangerous it is to diet in such extreme ways these people understand why Im doing it and allow me to do things even if they themselves don't approve such as a friend through one board thinks purging

is very very wrong and dangerous but she understands that i need to do it so doesnt keep going on and on about it to me telling me 2 stop."

Galina, pro-anorexia website participant,

interviewed online.

Galina made it clear in her interview that such understanding was a prime motivation for visiting the sites. But, in this motivation there is a complex enmeshment of wanting care towards herself but also towards anorexia – these, Galina feels are not so easily distinguishable. Galina's words suggest that she wants support to beat her anorexia to the point where it is, she feels, balanced with personhood – 'under her control' - but not support that would take anorexia away from her. The co-extensivity of a *specific* 'desirable anorexia' and personhood and how boundaries between these are continually repositioned by informants to leave outside this relationship an 'undesirable anorexia' will be unpacked in Chapter Four. However, for now, Galina like other website participants, also said that, despite wanting to be a good anorexic, she was saddened to see others going down the same path.

Although pro-anorexia websites have been widely regarded in the press as spaces in which people are actively recruited to anorexia by others, as I noted in Chapter One, this is almost always untrue. Participants do encourage others to continue starving but they also actively discourage those who are not anorexic from beginning to starve. Two website taglines read:

"We certainly aren't out to convert healthy individuals into anorexics or share our "tricks" with innocent girls looking to lose a few pounds"

"If you aren't disordered but wish you were, fuck off, go count your blessings and eat a sandwich. Wannarexics will not be tolerated."

Homepage Taglines on two pro-anorexia websites

Echoing the mingling of motivations described by those in the EDU, these taglines perform anorexia as both dangerous and 'not for sharing.' There is in these sentences a wish to protect others from such pain. About the websites Jumela, said:

"The websites are very much supportive of people who are in recovery and if anyone shows the slightest hint of possibly wanting to try and recover, everyone gives their full support and advice. There's no sort of 'cult' thing involved where once you start using the websites you HAVE to stay anorexic because we all know how life-destroying it is, and to see someone get their life back is so lovely."

Jumela, pro-anorexia website participant,
interviewed online

She continued:

"Pro-ana sites also offer tips on re-feeding for those considering/undergoing the recovery process. In-fact the main site I visit is run by a recovered anorexic trying to help others."

Jumela

In her interview, on the other hand, Laura said about the sites:

"Often they are very derogatory of recovery."

Laura, Facebook Pro-Anorexia Research Group participant,
interviewed online

When I asked Nora during her interview what she valued about pro-anorexia websites, she said:

"I get both support and motivation…. if someone is going too far the community would say something…. but what is too far?"

Nora, Facebook Pro-Anorexia Research Group participant,
interviewed online

If pro-anorexia websites, the desiring spaces of *Thin Commandments* and *Tips & Tricks,* are pervaded with ambivalence, then ambivalence requires attention and unpacking. Although suffering and desire seem to exist simultaneously in many informants' accounts of their own anorexia, in relation to their perception of other people's, these are less compatible. But, the next section will now explore how one's own desire to be a good anorexic is also often mired in ambivalence.

4: B   Desire to be a 'Good Anorexic,' but not an Anorexic

4: B. 1   Competing Desires

Likening anorexia to criminality in her interview, Paula said:

> "I hate it, I absolutely hate it…. You're doing a wrong thing all the time."
>
> *Paula, inpatient*

She continued:

> "It's something that I feel guilty about. Erm, I always describe it as… it's the same as if I had a prison record. It feels the same sort of thing. It's the same as saying you're a convict or you're on parole."
>
> *Paula*

Turning the discussion to pro-anorexia websites, Paula said:

> "It's not something to be proud of or, you know, or to have a website."
>
> *Paula*

Yet, in her interview Paula also discussed how something shameful is a source of pride. A dualism of shame and pride at being good at anorexia occurred throughout many informants' interviews. To not only resist treatment but to also actively want to be a good anorexic is a desire often shrouded in shame, secrecy and silence; I am grateful that informants felt sufficiently comfortable with me to admit this mingling of desires. When the idea of being a good anorexic arose on the EDU in conversation and interviews, patients would often echo Abigail's words that:

> "We don't usually talk about that - we don't admit that that's what we are doing."
>
> *Abigail, inpatient*

Both Paula and Abigail discussed how admitting wanting to be good at anorexia seems to suggest to others that one wants unequivocally to be anorexic and thus to desire the havoc that the diagnosis wreaks on friends and family. Yet in my transcripts the desire to be anorexic and wanting to be a *good* anorexic do not seem to be necessarily aligned. In fact it is possible concurrently *not* to want to be anorexic and yet to desire to be a good anorexic.

During her interview, Libby said:

> "I find it really hard to improve, because part of me feels like I shouldn't be improving cos it's wrong to improve, it's not anorexic to improve."
>
> *Libby, Inpatient*

Libby then stressed how strong her desire to "be a good anorexic" is, but she qualified it with:

> "…And I know that's completely wrong to think that and it's completely… it doesn't help me at all, and I know that, but it doesn't stop me thinking it."
>
> *Libby*

Libby's statement echoes my discussion, above, of motivation in which competing with others was as much a competition with oneself to be a better anorexic than with others. Here that intra-subjective competition re-emerges but with a sense of a relentless struggle *against* oneself. In her interview, Nancy stated that

> "Being an anorexic means that I'll have to battle every day of my life, battle with myself."
>
> *Nancy, Inpatient*

And Lia said:

> "I get the guilt from the anorexia for eating and get the guilt from the other side of me if I don't eat"
>
> *Lia, Inpatient*

Defined as "conflicting motivations" and "feeling two ways about something" (Miller 1998: 123) ambivalence pervades these narratives. It has been suggested that ambivalence "is part of eating disordered behavior" (Treasure et al. 2007: 86) and that "at the same time as receiving positive, egosyntonic effects from the behaviours those with anorexia may also acknowledge the negative effects, causing strong feelings of ambivalence" (Williams & Reid 2009: 1). Williams and Reid suggest that "ambivalent feelings will also play an adverse role in treatment resistance" (ibid. 1) and to support this they draw on Vitousek et al's discussion of *Enhancing Motivation for Change in Treatment-Resistant Eating Disorders* (Vitousek et al. 1998). This latter paper describes how "deeply ambivalent anorexics become adept at manipulating

their apparent weight, disposing of food surreptitiously, and distracting professional attention from their physical status (Vitousek at al. 1998: 392). But in these discussions of ambivalence there is fluidity regarding the focus of the ambivalence in question – and thus the subject-positioning from where that anorexia arises. Vitousek at al. 1998 are discussing ambivalence towards *treatment* amongst some anorexics.[77] In contrast, Reid and Williams discuss ambivalence towards *anorexia and treatment,* as do Colton & Pistrang 2004. Pro-anorexic desire to be a good anorexic in which informants may exhibit ambivalence towards recovery does not preclude ambivalence also towards anorexia. In the interviews just cited informants' desires to not only both recover and yet maintain anorexia but also to reject anorexia *and* yet be a *good* anorexic are fluctuating, fluid and often concurrent. As such, I suggest that a good and a bad anorexic represents, each in its own way, "spoiled identities" (Goffman 1963); neither is a temporally fixed category and many informants would seem to move from one to the other throughout their daily lives experiencing guilt in either state as desires shift and conflict.

In her interview Elle described "two different betters." The first she labelled "idealistic better," which she described as:

"Having a life and not caring about weight"

Elle, inpatient

The second, "real better," she described as "fatter than I'd like to be." She said this would involve:

"Having these thoughts but fighting them and living at a weight that I despise. I can't do that. Better is constantly fighting. It's too strong to constantly fight. It's a lot less painful to give in to it"

Elle

Elle concluded that she would continue trying to be a good anorexic. Her interview introduces a sense of inevitability, which was frequently echoed particularly by older informants; the next section will explore this.

---

[77] See also Davies & Lipsey 2003; Fox et al. 2005.

4: B. 2   When Desire Becomes Need

One afternoon when I was hanging out on the Ward's back steps in the autumn sunshine with Victoria and Charlene, we glimpsed a patient from the EDU running vigorously around the hospital grounds. On noticing her, Victoria said:

> "I just can't do all that running stuff, I'm not really a good anorexic at all."
>
> *Victoria, inpatient*

To which Charlene replied:

> "No, nor am I."
>
> *Charlene, inpatient*

Both women's voices were wistful. When Charlene did not reassure Victoria that she was a good anorexic and instead agreed that she herself was not either, Victoria glanced at Charlene with disappointment. The conversation that followed, about how they were such bad anorexics that even if they visited the local swimming pool they only bothered with the sauna, was full of self-deprecating humour and conveyed palpable regret on the part of both. Yet in her interview Victoria said:

> "This illness is nothing to be proud of, I am so embarrassed I can't even say the 'A' word, it makes me shudder."
>
> *Victoria*

And she said:

> "They keep telling me that I just have to choose to be better. But it isn't like that, it isn't a choice. Do you really think I'd choose to leave my family like this?"
>
> *Victoria*

Victoria's vehement denial in interviews that she had any control over anorexia or even liked it competed against the desire she expressed on other occasions to be a good anorexic. I suggest that Victoria's desire for anorexia was fuelled by necessity borne of a sense of limited choice.

Victoria was one of the patients on the EDU with the recently termed "severe and enduring eating disorder (SEED)" (Robinson 2009). She was in her late thirties and had been anorexic for over twenty years. Amongst the group of patients on the EDU whose anorexia was longstanding, attitudes to being good at anorexia can perhaps be conceptualised as less about desire and more about necessity and a sense of the impossibility of change. In her interview Charlene said:

"I think, what gets me I think is that after such a long period of time I still find it very difficult to hang on to any kind of hope that it's [recovery] going to be sustainable. And that was my really big thing at the beginning as well… why make me go through this again just for short-term gain? You know, is there really a point to that? And I had at that point made my decision, you know, that it had been a long time and that nothing had ever worked and so we won't delay the inevitable… you know, I … leave it alone, sort of thing. And I felt, and I feel in many ways, I still feel whatever people's problems or illnesses or whatever, if they make a decision and it's their life, it should be respected if they are an adult… not so for a child, but if you're an adult, yes."

Charlene, inpatient

Likewise, Lois said in her interview that she did not want to go to the Relapse Prevention Group on the EDU because, as she put it:

"I don't want to prevent!"

Lois, inpatient

But, Lois also said that trying to prevent was an unrealistic goal and that after over twenty years of anorexia it was, as she worded it, "too late." She said she just wanted to be "kept alive and let out." I asked in our interview whether her opinion had changed at all during the months of treatment. She replied:

"I don't know. I don't really want to get my hopes up but I don't feel exactly the same as the way I did."

Lois

Transcripts of interviews conducted with anorexics, on the Internet and in the hospital, who had had the illness for a number of years, are poignantly full of "biographical disruption" (Williams 2000). Social consequences such as broken relationships are recounted alongside biological sequelae such as osteoporosis. Each is imbued with a sense of there being 'no way back,' that the damage has already been done. And yet many of this group of informants, such as Victoria and Paula also described a desire to be good anorexics. This is not as much of a contradiction as it may seem; I suggest that their desire is precisely strengthened by this recognition of irreparable damage to lives, selves and bodies. It is this damage that transforms wanting to be a good anorexic into needing to be, as they find ways of being within compromised conditions of possibility. Many felt that all else they had once been good at, and wanted to be good at, had gone and they therefore *had* to be good at anorexia. Or rather, as Lois, put it:

"Well, I have to be good at something."

Lois, inpatient

And to Lois, anorexia was that something. Lois, Charlene, Paula and Victoria here counter the sense of failure engendered by a life of anorexia by striving to be very, very good at anorexia. This shifts ideas of struggle and achievement that were seen to emerge particularly in informants' accounts of starvation earlier. Struggle here is still about achievement but an achievement framed, tarnished, and also strengthened, by the need to be a good anorexic.

Conclusion

In exploring the protean desires and relationships, gazes and tactics, that make and unmake good anorexics, this chapter has traced what being good at anorexia entails, attending to specific embodied subjectivities of pro-anorexia, as argued for in Chapter One. It has addressed individual struggle, the gaze of others and ended on ambivalence. An exploration of practices that constitute informants' "ways of operating" (de Certeau 1984: xi) has suggested that pro-anorexia is as much about stasis and protecting one's anorexia as it is about becoming better at it. But, as Mead reminds us, being is always necessarily a process of becoming (Mead 1967) because "the present is characterized by emergence" (Flaherty & Fine 2001: 150), as well as by, in the context of being a good anorexic, a relentlessness "liminality" (Turner 1967). Ideas around being and becoming are linked to the incessant interplay between embodied subjectivity on the one hand and visual appearance on the other. The bodily practices explored, such as food rules and vomiting have at once both emphasised and yet problematized the centrality of bodily thinness to being a good anorexic. The *Tips & Tricks* shared by participants to websites both aid and yet undermine the draconian *Thin Commandments* that grasp uncompromisingly at thinness. Notions of an 'end result' and how these might relate to being a 'good anorexic' are blurred and negotiated; anorexia, it has emerged, is perhaps done *through* the body, but is not centrally *about* it. Informants' practices relate, instead, to making anorexia day-by-day. The chapter also explored an emergent sense of ambivalence. I argued that it is possible both to dislike anorexia and also to desire to be a good anorexic. Each viewpoint shifts in and out of the other in informants' accounts in a way that suggests pro-anorexic desires are as much constituted by ambivalence as they are undermined by it. However, it is a specific understanding of patients' ambivalence towards anorexia that informs a therapeutic notion of "the anorexia talking." This distinguishes between the two viewpoints of wanting and not wanting anorexia, assuming the former to be engendered only by illness and the latter to arise from the 'authentic self'. The next chapter will therefore explore *"That's the Anorexia Talking:" Exploring Anorexia & Personhood in Multiple Uses of a Clinical Phrase.*

Chapter Three *"That's the Anorexia Talking:"* Exploring Anorexia & Personhood in Multiple Uses of a Clinical Phrase

"In hospital and in outpatient treatment it is common practice for healthcare workers to try to encourage the anorexic person to try and distinguish between "the anorexia talking" and you as a person. For example if I say to my counsellor, 'I'm fat and disgusting' she will reply with 'no you're not that is the anorexia talking' and I am aware that she is trying for me to disconnect from those harmful thoughts however, it sometimes makes me a little frustrated because i feel like she is talking to me as a mad person who has voices in her head. I know for many anorexics that it is common knowledge to have another 'voice' in their head telling them not to eat and some anorexics even have names for them, however, I have never experienced having a definitive and separate voice, the only person I hear is myself so to be told that it is the anorexia talking frustrates me and can enforce the feeling of being different and abnormal."

Josie, pro-anorexia website participant,
interviewed online

When inpatients spent a little too long in Community Group debating which brand of margarine the Ward Manager should order, staff said their "anorexia [was] talking;" when one patient wore an outfit in which a gap between her skirt and top revealed glimpses of emaciated hips on sitting down in the Dining Room, her nurse described her choice of clothes as "anorexic;" when another patient screamed at me that she 'could not get out of the hospital swimming pool until she had done a certain number of lengths,' bashing her head against the sides until a blue bruise spread across her cheek, I heard "it's ok, it's her anorexia talking" inside my head; when a patient lay outside the Nursing Office pleading to be let out for a cigarette, her Primary Nurse said "not to worry," that her tears were because her "anorexia [was] raging" that day. In both clinical literatures and practices "the anorexia talking" is sometimes used to describe treatment refusal amongst anorexics (see

Tan 2003); and, when the Mental Health Act (1983 & 2007) enforces treatment against an anorexic's wishes it does so on the basis that not only is this refusal - this "talking anorexia" - not a patient's 'real wishes,' but also that the patient's competence is impeded.

Thus, the phrase "that's the anorexia talking" features in debates regarding competence and autonomy in relation to treatment refusal and enforcement. It is, furthermore, a concrete part of some treatment therapies whilst also paralleling the therapeutic rationales and frameworks of others.[78] In both these contexts "that's the anorexia talking" is most frequently used to refer to anorexics' articulations of pro-anorexic desire, such as a wish to be a good anorexic, or expressions of treatment refusal. But, as the paragraph above suggests, during fieldwork on the EDU I also heard the phrase in many different situations on a daily basis. It ran like a leitmotif through treatment interventions and the intangibilities of daily life during which staff informally talked to each other and to patients. Particularly in this conversational usage, the boundaries of the phrase stretched and "that's the anorexia talking" was utilised to describe many objects, actions and behaviours. In this widening, the phrase itself also often became malleable; "talking" sometimes interchanged with "raging" or "strong," for example, and these enacted particular ontological conceptualisations of personhood and illness.

This phrase is therefore present on many levels in 'the clinic' (Foucault 2003), from 'theoretical' debates to both pragmatic 'therapeutic' interventions and 'conversational' interactions. This common usage rests on an assumption that there is a unity across these three levels. I suggest, however, that they do not fit so easily together; perhaps we could say that they "share a space but cannot be mapped in terms of a single set of three-dimensional coordinates." (Mol & Law 2002: 1). And, as each level is different, each alters the phrase. It will be seen that as "that's the anorexia talking" traverses spaces and contexts and, importantly, comes into contact with patients themselves, shifts in its meaning bring with them unintended and, perhaps, harmful consequences. But, although unpacking the uses of this phrase across these levels might be a worthy undertaking in itself, within a thesis about pro-anorexia it serves a wider purpose. Taking up Marcus's call to "follow the metaphor" (Marcus 1998: 92), which I discussed in Chapter One, this chapter

---

[78] See Epston & Maisel 2009; Treasure et al. 2007.

traces "discourses and modes of thought" (ibid. 92). In contrast to the last chapter's emphasis on materialities and practices, this one treads a more semiotic path, focusing on voices and metaphors. I use diverse conceptualisations of how, when and (from) where "anorexia talks" to reflect on ontological paradigms of personhood, illness and agency on the parts of informants and the clinic.

An attention to informants' practices to maintain and enhance anorexia in the last chapter revealed a burgeoning sense of ambivalence and complexity. Not only was being good at anorexia sometimes enforced by informants' fear of being unmade by others, but some also expressed hatred towards anorexia even whilst desiring to be good at it. It is the ambivalence with which that chapter ended which is also central to this one. This chapter suggests that across the levels of clinical usage of "that's the anorexia talking" patients' frequent ambivalence towards anorexia is utilised to construct a particular binary model of the relationship between personhood and anorexia founded on notions of authenticity and "inner depths" (Taylor 1989). Conceptualising pro-anorexic articulations as just their "anorexia talking" posits others - and *only* these others - as 'authentic.' The phrase thus not only becomes "evidence" (see Latour 2005) for particular claims of personhood and pathology but also performs these into being; there is circularity to these enactments. The chapter therefore asks how these clinical performances of personhood and anorexia relate to those articulated by anorexic informants, as explored through how they too use the phrase "that's the anorexia talking." Despite frequently expressing misgivings about the phrase, informants in both field sites do also describe their anorexia as talking, or even as "acting." But, in contrast to the phrase's malleability in the clinic, the chapter argues that informants tend to use *"talking"* or *"acting"* in more literal ways to describe their intimate experiences of, and relationships with, anorexia.

Part One explores clinical uses of the phrase "that's the anorexia talking." Tracing the phrase across the levels of the clinic I start by looking at the phrase against a background of discussions of treatment refusal and enforcement. I then explore how the phrase forms part of, and reflects, a range of therapeutic interventions on the EDU that are designed to motivate patients to recover. The chapter then unpacks the conceptualizations of personhood on which both the

'theoretical' and 'therapeutic' levels of usage rest and which they re-enact. These discussions travel back and forth across the levels of the clinic in a mirror of the phrase's movements; I intend to show that the paradigms embedded in and performed by a notion of "the anorexia talking" are not linear or one-directional. Rather, usage of the phrase on each level informs conceptualisations in the others and vice versa, in a circular process. But, addressing the conceptualisation of anorexia as in control of the anorexic, I show how as the phrase travels from clinical literature to both therapeutic interventions and general conversation on the EDU, not only does it rupture the very paradigm of personhood on which it is based, but its usage also has unintended consequences.

It is these consequences that are the focus of the first half of **Part Two.** Tracing anorexic informants' reactions to being told that their anorexia is talking, this part of the chapter suggests that because informants experience the relationship between anorexia and personhood differently from clinical models, they also hear the phrase in ways other than how it is intended; informants' rejections of notions of authenticity and their reluctance to regard the anorexia as in control of all 'bad behaviour' render the phrase shaming rather than exonerating. Such discrepancies between intention and reception are recounted by some informants as a reason for seeking company and support from other anorexics on the Internet. The chapter then turns to explore anorexic informants' own articulations of the phrase "that's the anorexia talking" in both field sites. Finding themselves entangled in clinical teleologies, informants undertake alternative emplotments.[79] Sometimes these assert different relationships between anorexia and personhood. At other times they reflect those of the clinic, often flowing between these two models. Hence, the multiple and sometimes-fractured ways informants negotiate and appropriate the phrase often fit neither with clinical uses nor with their own articulations in other contexts. Thus, although this part's discussions take up the threads of Part One, these now resonate with juxtaposition and fragmentation, which the more broken structure of this half of this chapter seeks to reflect. Informants' conceptualizations of a talking anorexia not only offer alternative answers to questions already posed in the chapter, but also proffer different frameworks arising from situated, and importantly, "partial," ways of

---

[79] See Mattingly 1998; Ricoeur 1992.

seeing and being (see Haraway 1991). As well as forging new paths of questioning, these alternative visions can, as Donna Haraway suggests, "be good for avoiding binary oppositions" (ibid. 188) such as those enacted by clinical usage of "that's the anorexia talking."

In relation to the thesis's central themes and questions, this chapter particularly engages with **relationships between personhood, agency and illness.** In tracing the overlaps as well as contrasts between the clinic's and informants' uses of "that's the anorexia talking," it also begins to investigate **overlaps and disjunctures between pro-anorexia and treatment resistance**.

Part One   The Clinic's Uses of "That's the Anorexia Talking"

1: A   Dividing Anorexia from Self

1: A. 1   Holly & Treatment Refusal

I was introduced to clinical usage of the phrase "that's the anorexia talking" in the first hours of fieldwork in the EDU when I was ushered straight into Ward Round; in the large but stuffy Conference Room that March morning the phrase was used frequently by members of the multi-disciplinary team. They described anorexia as talking in, arguably, the narrowest sense of the phrase, to delineate patients' discussions of food and/or weight and their resistance to recovery and cure. This reflected the equally narrow focus of the patients themselves, who tended to use Ward Round to discuss their diets, weights and admissions. But this was, to a certain extent, its purpose; in a typical Ward Round, alongside discussion of the patients' needs and therapies, the team also introduced such 'anorexic' topics as food, BMIs and weight. They would discuss how a patient was doing well or how they could eat more or put on more weight. If the patient in question responded to these suggestions positively the team congratulated them; if resistant, they were told their anorexia was talking. One patient who was told her anorexia was talking that day was Holly. Through her I will trace the rationale of not accepting opposition to, or refusal of, treatment as anything but "the anorexia talking," before turning to explore the conceptualisations of personhood and illness on which this usage rests.

After arriving for her ten-minute slot with the team, Holly remained in Ward Round for over an hour. During that time she tearfully argued with clinicians about her target weight, which she described as "too high," and her diet, which was "too much." Holly articulated her desire to maintain her anorexia and reject recovery. In response to being told by her team that she "needed to eat" and "must put on more weight," Holly said she "[did] not want to get better," "[did] not want to put on weight" and "[did] not want to eat." She appealed to all those present to "leave [her] alone." In response to these articulations Holly was told repeatedly by those around the table, including the clinicians and her parents, that "that's just the anorexia talking" and that her "anorexic minx" was in the room with her and was "not letting [her] speak;" the team stated that she'd be listened to on a later

occasion when the anorexia was "less strong." As the hour progressed Holly became increasingly distressed and frustrated until eventually she was carried, crying, from the room by a member of staff so that Ward Round could continue with other patients.

Holly was frequently alleged by staff to be "the worst anorexic" on the EDU. This appellation described not only a severity of emaciation that saw Holly weighing only 28 kilos, but also expressed the fervour of her articulations of desire to maintain anorexia. Holly had enormous beautiful eyes but they were set in gaping grey sockets above extremely sunken cheeks. At times during fieldwork Holly was lively, cheeky and very good company. At other times, however, Holly was incoherent, unable or unwilling to talk about anything but food and weight and utterly preoccupied with getting rid of what she had eaten in any way conceivable, by vomiting in communal washing machines, under cushions and, even, on her plate in the communal Dining Room, to the tearful horror of the other patients. Holly had been making herself vomit in treatment for so long that she could regurgitate at will, bringing food up to fill her cheeks, holding it there, re-chewing it and then swallowing it again. When her weight dropped to a critical level Holly, who was on Section, was assisted fed against her will in order to prevent her from dying.[80] At times Holly became critical and there were days when staff, feeling that she might pass away in her sleep, rang her family to request that they stay with her overnight. However, Holly hung on each time and still remains in hospital, where she has been, under duress, for over half her life.

It is likely that I would never have met Holly if anorexics could not be sectioned under the Mental Health Act (MHA 1983[81]). Her clinicians argued that in all likelihood she would have died on reaching adulthood the moment treatment was no longer enforced by her parents, as demonstrated by her intractable vomiting and extreme emaciation. Holly's continual precarious balancing on the edge of death illustrates that "the persistent extreme behaviours associated with eating disorders are frightening and confusing" (Treasure et al 2007: 9); "few symptom patterns evoke stronger reactions from treatment professionals" (Vitousek, Watson & Wilson 1998: 391 – 392), such as "both impatience and fear"

---

[80] For a discussion of assisted feeding see Chapter Five.
[81] See also NICE 2004 esp. paragraph 6.5.7.

(Howlett, McClelland & Crisp 1995: 39 [82]) and cause "therapist burn-out" (Treasure & Ward 1997: 103) than anorexia. Greeted with Holly's perpetual refusal to engage with recovery, it is perhaps unsurprising that clinicians might experience tension between desire to "force-feed or withdraw" (Howlett, McClelland & Crisp 1995: 39). It has been argued that "anorexia nervosa is not inevitably a progressive terminal illness. For this reason, it is preferable that treating physicians focus on the preservation of life" (Melamed et al. 2003: 621[83]), although it has also been pointed out that saving patients like Holly's life in the short-term may have a negative impact on their survival in the long-term (see Rathner 1998[84]). As such, anorexia presents to professionals a matrix of complex issues that often require speedy decisions given the physical risks and high mortality rate associated with the illness. Deciding whether or not to respect Holly's treatment refusal is not only a matter for legal experts and medical ethicists,[85] it is also about appropriate care. Jacinta Tan argues, "on the one hand, psychiatrists risk dereliction of duty of care by allowing patients to come to harm; on the other, they risk medical paternalism by overriding patients' choices" (Tan 2003: 1246). Simona Giordano, moreover, suggests that whether or not one accepts a patient like Holly's refusal to eat or gain weight does not entirely depend on debates of autonomy versus paternalism within care, but also "to an important extent, on one's sense of empathy and compassion for a person's suffering" (Giordano 2005 A: 261). About this she says, "whether or not anorexics should be allowed to die depends not primarily on their competence, as many claim, but on the extent of their suffering and on whether it can be alleviated" (Giordano 2010: 143). Such compassionate intent also comes into view if we think about Holly in terms of models of "relational autonomy" (Mackenzie & Stoljar 2000) and take account of "carer distress" (Kyriacou, Treasure & Schmidt 2008). It is therefore clear that to claim that "anorexic patients' refusal of treatment hardly represents a straightforward, genuinely free choice" (Sato 2003: 1937), to see their competence and desires as impeded by anorexia, and to carry out assisted feeds on this basis, saves the lives of patients like Holly. As such, the labelling of her

---

[82] See also Tan 2003.

[83] See also Draper 1998.

[84] The current NICE guidelines state that "little is known about the outcomes of those who are compulsorily treated; they have a poorer outcome than those who are not compulsorily treated, but this may be due to the initial severity of illness on admission" (NICE 2004: 6.5.7.3).

[85] See, Draper1998; Gans & Gunn 2003; McSherry 1997; Tan, Hope & Stewart 2003 B; Tan, Hope, Stewart & Fitzpatrick 2003.

treatment refusal in Ward Round as "the anorexia talking" illustrated just how much the phrase both reflects, and forms part of, the architecture that permits and justifies enforcement of treatment through sectioning. It also discursively re-enacted Holly's section through the day-to-day interactions of the EDU.

In the face of the stark realities of anorexia embodied by Holly, it is emotionally difficult to disentangle the phrase "that's the anorexia talking" from these overarching debates for which it seems to stand and which it performs. Yet, it is arguably imperative to do so; to focus on these wider issues in critiques of "the anorexia talking" would disallow analysis of both the assumptions that are embedded in the phrase and also, of the ramifications of the phrase's usage by professionals in contexts such as the EDU. This latter analytical thread will be explored in Part Two. But, for now, I will begin unravelling the ontological conceptualisations of illness, personhood and agency in "that's the anorexia talking" by looking at interventions on the EDU in which it features and which it parallels.

1: A. 2   Motivational Therapies: Using Ambivalence to Construct Authenticity

Telling Holly that her anorexia was talking in Ward Round was intended to illustrate to her that she is, as her parents and clinicians put it, "more than her anorexia," thus helping her find motivation to recover. On the EDU not only were patients who attempted to engage a staff member in conversations about food or weight told they would not be listened to because their anorexia was talking, but the phrase was also often accompanied by sentences like, "you can do better than this" and "this is not you." Using the phrase in this way enacts a therapeutic stance that emphasizes the possibility of cure and imbues that cure with a positive value - anorexia is harmful and cure is desirable. This clinical usage therefore aims to give a patient the desire to discover more to her/his life than anorexia, hence finding motivation to recover. As a 'plot' to "convince others to see the world in a certain way" (Mattingly 1998: 5), "that's the anorexia talking" thus propounds an unambiguous teleology from a present state of illness to a future state of recovery. Used as a motivational device in this way, an idea of the anorexia talking both reflects and reproduces wider discourses and practices of eating disorders therapy.

The NICE Guidelines suggest, "the aims of psychological treatment should be to reduce risk, encourage weight gain, healthy eating, and reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery" (NICE 2004: paragraph 4.4.2.3). As Epston and Maisel suggest, the most literal way in which the phrase is tied to treatment is how the phrase forms part of treatment transactions in Narrative Therapy (Epston & Maisel 2009[86]). But on the EDU Motivational Enhancement Therapy (MET) and Occupational Therapy (OT) most mirrored this future-orientated teleology of motivation.

On the EDU there are many OT groups, including Relapse Prevention Group and Canteen Group, as well Cooking Group, mentioned in the previous chapter. All these aim to equip patients in practical and psychological ways for a life spatially beyond the Ward and temporally beyond anorexia.[87] I also spent some time with an Occupational Therapist who worked on the Acute Psychosis Unit in the same hospital. She described OT there in starkly different terms. She explained that patients came to the Psychosis Unit often straight from police cells after 'anti-social' or, occasionally, violent incidents ensuing from the sudden onset of a psychotic episode. The therapist described the primary aim of OT on that unit as calming patients and helping them deal with their current situation and mental state on a day-to-day basis. Although, during fieldwork, OT on the EDU also involved some relaxation exercises and guided imagery to ease anxiety, this was not its primary aim. This other ward's emphasis on dealing with the present led me to realise how future-orientated Occupational Therapies on the EDU were, how each emphasised the possibility and attraction of a life after anorexia. This is a particular feature also of MET.

MET comprises a series of interviews over time undertaken with a patient by a treatment professional;[88] in the EDU this professional was usually the patient's Primary Nurse. As Treasure, Smith and Crane put it, MET employs "strategies that help [an eating disordered patient] move towards greater readiness to change by

---

[86] See Gremillion 2003, particularly 193 – 210 for an anthropological analysis of Narrative Therapy in eating disorders treatment. In the context of her critiques of other treatment modalities, Gremillion's discussion of clinicians' encouragement of patients to externalise, and separate from, their anorexia both intersects with but also offers interesting alternative viewpoints to mine.

[87] For explorations of Occupational Therapy with Eating disordered patients see Breden 1992; Harries 1992; Rockwell 1990; Shearsmith-Farthing 2001; Yin Lim & Agnew 1994. I'd like to thank the Occupational Therapist on the EDU for suggesting these texts.

[88] For a general discussion of MET see Rollnick, Miller & Butler 2008 and on its use with eating disordered patients see Feld et al. 2001; Treasure & Schmidt 2008; Treasure & Ward 1997.

creating questions in his or her mind between the status quo - in which the eating disorder forms the individual's identity - and their own deeper ideals, values and ambitions" (Treasure et al. 2007:74). MET thus aims to engender recognition by the patient of the consequences of maintaining and desiring anorexia and thereby motivate behavioural change. But it does this by utilising patients' ambivalence in a particular way. Through this usage of ambivalence we can very much begin to glimpse the tenets on which a notion of "the anorexia talking" rests.

At the end of the last chapter I discussed how even those anorexics desiring to maintain and enhance their anorexia often also express ambivalence towards their illness. My portrait of Holly, above, which set up the chatty lively Holly alongside the Holly who vomits in her plate, illustrated my own desire to distinguish Holly from the illness and represent her as "more than her illness." But, such a clear-cut binary structure does not reflect the fluidity with which Holly travelled between desire for anorexia, desire for recovery, ambivalence towards anorexia and ambivalence towards recovery; she often experienced more than one at once, as informants also did in the last chapter. But I suggest that MET co-opts patients' ambivalence and moulds it into a shape that resembles my erroneously binary portrait of Holly.

MET is based on the *Transtheoretical Model of Behaviour Change* (see Prochaska and DiClemente 1992) which theorises change as occurring in demarcated stages. Each stage encourages the patient to think about why they do or do not desire change, thus inciting ambivalence towards the behaviour pattern or addiction. Likewise, a patient's ambivalence - both towards treatment *and* towards anorexia – is engaged with by the MET therapist with the aim of "emphasizing the negative effects of the illness and finding alternative solutions or sidestepping the positive benefits" (Treasure & Ward 1997: 112). Treasure and Ward suggest to professionals undertaking MET that the patient "should be encouraged to identify her difficulties, her reasons for concern, her readiness for change, and factors that might be helping or hindering this process. It may be helpful to structure the problem with open questions about how each area of life is affected by the anorexia nervosa; for example physical health, psychological health, social and romantic life, family life, and finally education and career" (Treasure &

Ward 1997: 106[89]). Moreover, it is not only MET that draws on patients' ambivalence; in an article subtitled *Capitalizing on Ambivalence*, it is suggested that "understanding ambivalence and identifying ways to enhance readiness to change is a critical step in effective treatment" (Cockell et al. 2002: 84) as a whole. Likewise, in a study engendered by "a need to understand more about ambivalence in patients with eating disorders" (Blake, Turnbull & Treasure 1997: 190), it is argued that "therapeutic interventions might be targeted to maximize the level of motivation to promote change in eating behaviours" (ibid. 190). This hitching of motivation to ambivalence both rests on and strengthens an idea of the anorexia talking. Central to its praxis is that motivation can only be encouraged by disregarding half of a patient's feelings and desires in favour of the other half. MET, OT and allied therapies take only the dislike of anorexia as representative of a patient's 'real' desires, denigrating any pro-anorexic or oppositional articulations as just a product of illness itself – as "just the anorexia talking." Moreover, such acts of dividing and categorising do not stop only at articulations and feelings; from here they also translate onto a larger scale.

To find a way into a patient's anorexia – to cleave a conceptual space into which therapeutic interventions can be fitted - motivational therapies like MET and OT posit a wholesale division between the anorexic and their illness; telling Holly that she is "more than her anorexia" is very much about allowing her to dislocate herself – or dislocating her – from her anorexia. What is particularly interesting, given that this technique is about aiding motivation, is *how* MET and OT aim to "facilitate change" (Harries 1992[90]) through division. They, like "that's the anorexia talking," encourage patients to externalise anorexia and hence re-find - literally recover – an illness-free self that is conceptualised not only as having been trapped in, or shrouded by anorexia, but also as having preceded anorexia and which can follow it. What is advocated, thus, is a change 'backwards' - back into what one once was and, perhaps, *should* be again. In his discussion of the intersections of identity and illness in psychiatric patients (Hope 1995), Tony Hope points out that making use of a concept of "an 'authentic self' which depends on the logically prior notion of illness" (ibid. 143) is problematic, not least because it involves claiming that one expression of a patient's self "stands in the identity making relation to the

---

[89] See also Rollnick, Miller & Butler 2008.
[90] See also Geller, Cockell & Drab 2001.

historical [patient] and that the other does not" (ibid. 142). However, in line with my discussions above, Hope also cautions that to attribute equal validity to these different states of self without establishing one as authentic may allow the patient to "cycle destructively between the two states" (Hope 1995: 141). As such, respecting autonomy may not be in the anorexic's interest. However, what this has highlighted is that underpinning these constructs of division and externalisation is a pervasive discourse of authenticity. Although, as Hope suggests, a notion of authenticity that validates one of a patient's articulations rather than another may (be the only way to) render treatment possible in highly exigent circumstances, it also requires unpacking.

In the "hypostatisation via excessive commemoration" (Lambek & Antze 1996: xix), to borrow a phrase from Michael Lambek and Paul Antze, of an assumed previous self prior to anorexia, not only are there tropes of division, but also of authenticity. A notion of authenticity has crept quietly through this section's discussion. It was there when I described staff members telling patients "this is not you" and it was also present when Treasure et al. described anorexia in relation to a patient's "*own* deeper ideals, values and ambitions" (Treasure et al. 2007:74 - *italics mine*). The framework of division on which "that's the anorexia talking" rests, and which it articulates, therefore conceptualises anorexia as only an inauthentic current and temporary addendum to a patient's "authentic self" (cf. Tan 2005). This division between, and hierarchy of, an anorexic's "authentic self" and the illness has been a recurring trope in various literatures regarding anorexia since Hilde Bruch discussed the "person within" (Bruch 1974) in the 1970's. It also features in popular texts on eating disorders and memoirs. In *The Best Little Girl in the World* which, according to the publishers "broke through the silence of anorexia" in 1978, the author (a therapist) recounts the fictional story of Francesca (Levenkron 1978). The eponymous heroine begins the story as Francesca but on becoming anorexic she shortens this to 'Kessa' with the words "Francesca was fat. Francesca was dead" (ibid. 11). Kessa is not only anorexic but also has character traits that Levenkron suggests are antithetical to those of the 'real' Francesca. Francesca was good at school and her parents described her as a delight. Kessa, on the other hand, does not care about school; she is devious, she lies, shouts, screams and is surly. In contrast to this is *Wasted: Coming Back from an Addiction to Starvation* (Hornbacher

1998). In this memoir Marya Hornbacher recounts her life with anorexia, bulimia and EDNOS.[91] Hornbacher charts her difficulty in framing her narrative in the temporal and conceptual constructions of biomedicine that trace a linear trajectory from external adversary/ity to cure because, as she states, "the adversity was, um, me" (ibid. 285). She describes her "identity –being" as wrapped up in "my ability to starve" (ibid. 199). Intriguingly, the French title of Hornbacher's work is *Piegée* ('Trapped:' Hornbacher 2000), which translates the more neutral *Wasted* into something resembling Levenkron's external aggressor or possessor. These two books, both of which were exchanged by patients in the EDU and are recommended on pro-anorexia websites as sources of *Tips & Tricks*, indicate the tension between two conceptual models of eating disorders: anorexia as external and inauthentic versus anorexia as intrinsic and part of the self of an anorexic.

This division between anorexia and an authentic "person within" (Bruch 1974) arguably draws on a paradigm of identity as founded on "inner depths" (Taylor 1989) and assumes these to pre-date anorexia. This notion of "inner depths" links to philosopher Carl Elliott's discussions of how a discourse of authenticity "has come to suffuse contemporary life" (Elliott 2003: 29) in western society. Also drawing on the work of Charles Taylor, Elliott argues that authenticity has become a "moral ideal" (ibid. 29) - "as much an ideal as a self-description" (ibid. 38) and a "crucial part of modern identity" (ibid. 29). In framing anorexia as, following Pinel, a "partial madness" (Pinel, discussed in Appignanesi 2008), recovery from which will enhance and not threaten a patient's sense of self, clinical paradigms of anorexia and personhood arguably reflect, re-enact and, perhaps, forcibly implement these wider discourses of authenticity. Moreover, dividing the person from their anorexia not only renders anorexia an inauthentic, expendable illness that *must* be removed from the self; it also suggests that the anorexia makes the anorexic express themselves in 'inauthentic' ways. As such, it lends to such articulations a morally objectionable quality and this moral undertone also then feeds back into uses of the anorexia talking across clinical levels; it arguably resonates through the scenarios that I quoted at the beginning of this section in which staff suffixed their articulations that a patient's anorexia was talking with "*you*

---

[91] EDNOS: Eating Disorder Not Otherwise Specified (see NICE 2004: section 2.3; Fairburn & Bohn 2004)

can do better than this.'' There is a suggestion to this that such talk signifies a kind of 'giving in to anorexia' that, according to staff, must not be done.

Thus, by tracing manifestations of the phrase "that's the anorexia talking" from overarching debates of treatment enforcement and refusal to motivational therapies, this first section has shown how a particular understanding of patients' ambivalence alongside a notion of authenticity are used in mutually-legitimating ways to frame personhood and anorexia as separate. Keeping in mind a notion of the 'morality of authenticity,' the next section explores how and why the idea of division is also used to separate behaviours into those controlled by anorexia and those that are 'authentic;' this usage of "that's the anorexia talking" paradoxically collapses the division on which it is founded.

1: B   From Food to Persons: Anorexia Takes Over Personhood

1: B. 1   Eating Behaviour - Any Behaviour

A manual for carers of eating-disordered people advises:

> "Divide and rule are the operating principles of this 'minx' who has taken over your loved one. A consistent approach is essential, otherwise it will do its best to take over your home and family."

Treasure et al. 2007: 40

That anorexia 'takes over' and controls an anorexic is embedded in a conceptualisation of anorexia as talking. It is illustrated, for example, by a conference workshop manual entitled *Alienating patients from the 'Anorexic Self': Externalizing and related strategies* (Vitousek 2005). This suggests it necessary to tell an anorexic that their anorexia is talking because:

> "The individual doesn't really want to restrict her eating, lose weight, or resist treatment - her Real Self has been invaded/infected/colonized by an Outside Force."

Vitousek 2005: 3

Vitousek's writing of "Real Self" in capital letters reflects adherence to the discourses of authenticity discussed above. She describes this "Real Self" as locked in battle with anorexia, drawing on military terminology like "invaded" and "colonized."[92]

The belief that anorexia controls anorexics was frequently propounded in the EDU, recounted between staff and by staff to patients. It was part of informal conversations between nurses as well as more formal discussions in multidisciplinary meetings. It also manifested in the mechanisms of counter-control to prevent vomiting or over exercising, such as locking bedrooms and toilet supervisions, particularly during Rest Periods after meals. Yet particularly as it moves from the therapeutic level of clinical interactions to these more general spaces and mechanisms, a conceptualisation of a controlling anorexia begins to seep and expand; suggesting anorexia controls anorexics the phrase takes on meanings beyond clinically recognised 'anorexic behaviour' to describe an anorexic's personality and/or behaviour. This is also illustrated by Vitousek's manual:

> "The construct [that's the anorexia talking] can be used to alienate patients from egosyntonic symptoms
> - we can speak ill of the patient's symptoms without insulting her
> Which sounds better?
> - 'You are selfish … you are dishonest … you are thoughtless'
> - 'The disorder has made you selfish … the disorder has made you dishonest … The disorder has made you thoughtless'
> 'Anorexia is selfish … Anorexia is dishonest … Anorexia is thoughtless.'"
>
> *Vitousek 2005: 3*

The therapeutic rationale of moving in the space of one page from suggesting that "restricting eating" is controlled by anorexia to designating character traits as anorexic is to remove blame for manifestations of, for example, selfishness or dishonesty; it emphasises that an anorexic is "medically unwell; their behaviour is unintentional" (Treasure et al. 2007: 35). The importance of this distinction to those caring for an anorexic is poignantly illustrated by Maureen Dunbar's harrowing memoir of her daughter Catherine's battle with, and death

---

[92] See Martin 1994; Sontag 2002.

from, anorexia (Dunbar 1986). It is also vividly apparent in an interview I conducted with Judy about her recovered anorexic daughter, Zoe. Judy described watching anorexia take an increasing hold over Zoe in the weeks before she was admitted to hospital when Judy "desperately tried to manage her at home." Judy said:

> "That's when things went really haywire; it all just fell apart at that point. Zoe would wake up in the mornings and as soon as she was awake within fifteen seconds she'd start crying and saying 'I don't want to live, I don't want to eat'. It was awful. And then you'd get her up and you'd try and make her some breakfast and she just couldn't really eat it. She'd start crying and getting angry. And then all this sort of extraordinary stuff would come out that I…that I didn't expect of her, you know. The things that she'd say just weren't her - there was this sort of other person talking. And I think that the throwing things had also started by then. She'd throw food across the kitchen…and she'd scream… and she'd kick things. Oh and she'd bang her head endlessly… she'd bang her head on the table and on the wall and she had this quite large lump on her head. At one point she took a knife and threatened me… threatened me with a knife and, erm, I remember feeling just sort of, erm, so unsure…because she was so different and so psychiatric by then…about actually what she was going to do with the knife, you know? Was she actually going to knife me? Because it was a possibility."
>
> *Judy, mother of a recovered anorexic.*

Use of the phrase in the hospital did align with this sense of explaining 'bad behaviour' as 'just anorexic,' such as if someone shouted at a member of staff. Given the high levels of conflict, trauma and frustration that continually ebbed and flowed on the Ward throughout fieldwork, this usage of the phrase was also a self-protective mechanism on the part of staff. It allowed staff members who had come under verbal fire from a patient to tell themselves that they were not really being shouted at, that the patient 'did not mean what they said.' This enabled them to maintain their own selves as unharmed in the midst of some quite traumatic conflict. As such, this phrase helps to maintain relations of care within what Helen Gremillion terms "the therapeutic family" (Gremillion 2003, particularly Chapter 3) and reinstates therapeutic moral order. As I noted in the introduction, I admit that

the one and only time that I was shouted at by a patient, the phrase jumped to my mind too before I pushed it away and reconceptualised the event. Nursing staff frequently argued that telling a patient their anorexia was talking in such contexts was compassionate; it meant that only the anorexia was chastised and their 'authentic self' was expunged, idealised and left 'intact.'

The link between what we could, for the sake of simplicity term 'bad behaviours' and anorexia is historically situated; its clinical perimeters hold within them, to quote Sontag, "lurid metaphors" (Sontag 2002: 3). In first classifying anorexia, Gull and Lasègue termed it a "mental perversion" (Gull 1874, referred to in Hepworth 1999), with "the nineteenth century use of 'perversion' [being] related to obstinacy and stubbornness" (Hepworth 1999: 30). Anorexia is "unpopular with clinicians because of the perception that clients habitually deny, deceive, and rationalize to protect their symptomatology" (Vitousek et al. 1998: 392). The moral overtones of this are highlighted by Judith Fathallah in her novel *Monkey Taming*. The protagonist, Jessica, says of her treatment team in an EDU:

"One by one they, made their reports on me: all drear, all dark, all damning. I was not adhering to my meal plan, I was not following unit policy. I was, in general, doing very badly and was in fact very bad."

Fathallah 2006: 159

However, when we think about this conceptualisation of anorexia as controlling an anorexic's 'bad behaviour' and its usage in practice to respond to and reorder behaviour on the EDU, we are confronted with a paradox; as behaviours such as dishonesty, or indeed obstinacy, become anorexic *"symptoms,"* the distinction between the authentic self and anorexia, which "that's the anorexia talking" was seen to rest upon, is paradoxically collapsed by this usage. As blame is shifted into the diagnosis so too, paradoxically, is the self of the anorexic. In the shift in context from instilling motivation to responding to 'bad behaviour,' the paradigm of division and authenticity is altered and lost. To claim that anorexics are controlled by their anorexia is thus not to visualise a division between anorexia and personhood but rather to frame personhood – whole personhood – as taken over by and subsumed into anorexia – and importantly, as will be seen in Part Two, to

treat anorexics accordingly. The next section addresses clinical conceptualisations of friendships between anorexics to explore this paradox.

1: B. 2 Friendships: "Just the Anorexia Talking?"

Drawing on Marcel Mauss's classic work on selves and persons (Mauss 1985), J. S La Fontaine suggests, "if the self is an individual's awareness of a unique identity, the 'person' is society's confirmation of that identity as of social significance" (La Fontaine 1985: 124). La Fontaine further argues, "in Western Europe the notion of friendship is defined as a relationship between two unique individuals, not by virtue of any socially defined relationship such as neighbour or kinsman, but as social persons in the Maussian sense" (ibid. 129). I suggest that clinical usage of the phrase "the anorexia talking" renders anorexics non-persons precisely by calling into question not only their autonomy, but also the social significance of their identity. This ensues very clearly from a conceptualisation of anorexics as entirely controlled by their anorexia. This became apparent during fieldwork on the EDU through staff's frequent conceptualisations of friendships between patients as "just the anorexia talking."

Discussion in one afternoon's Staff Group focused on a single patient, Aditya. Aditya had just returned to the Ward after absconding for 24 hours. The day before, on a pass to walk around the grounds, Aditya had gone to a nearby high street and been caught shoplifting. After liasing with the EDU, police had not pressed charges but had also been unable to escort Aditya back as she was no longer on Section. She had then promptly disappeared overnight. During the time when she was missing, Aditya was in touch with friends, a number of them ex-patients. Many telephoned the EDU to express their concern for her welfare. Although staff were also concerned for Aditya, many strongly contrasted their own concern with that of the ex-patients. This act of contrasting precipitated a more general discussion in which many staff members described it as "so weird" that the ex-patients should keep in touch with one another. Their continuing contact was characterised as "anorexic." One nurse argued to general agreement:

"Anorexics only keep in touch to be anorexic. If they wanted to get better they wouldn't keep in touch."

Martin, psychiatric nurse

Here Martin would seem to be suggesting that the friendship between patients is that of, to put it simply, anorexia with anorexia; any notion of personhood beyond, behind or, even within anorexia is absent. There is thus no sense here of division. Not only is anorexia regarded as having taken over aspects of personhood in relation both to food/weight concerns and also to outward behaviour but something else too. Martin's statement suggests that anorexia controls anorexics' desires and decisions-making in aspects of their lives that might otherwise seem to be unrelated to anorexia.

Friendships between anorexics formed in, but lasting beyond, inpatient stays are discussed by Megan Warin (2006 & 2010). Warin conceptualises these as part of the relatedness that may be produced by anorexia. She states of her own fieldwork, "the commonality of anorexia, and the world of secrecy and belonging it engendered, meant that it not only became a vehicle for relatedness with oneself, but also with other patients" (Warin 2006: 50). In highlighting the production of relations through common desires such as those found amongst any group sharing the same interests, Warin goes some way to refuting that friendships are "just the anorexia talking." Yet, she arguably also leaves the idea that anorexia is their central, albeit chosen, bond intact. In the first introduction of an informant perspective to this chapter, this extract from Eva's interview questions this assumption. Of getting to know people by meeting them as inpatients she says:

"It is very comforting. But it's a weird way of forming friendships too! … I think, going back to the personality trait thing, if anorexia is a personality trait, when two people have a personality trait in common, they often make friends. And there are probably other people in here that are typical high achievers or typical perfectionists and I am probably drawn to them for that reason, rather than drawn to them because they are anorexic. It does help also that they can understand and can give you hugs and stuff."

Eva, inpatient

Moreover, although the "commonality of anorexia" as Warin puts it, is of course, evidenced by the very existence of pro-anorexia websites, these sites also contain a multiplicity of social relations formed both through and importantly, in spite of, anorexia. That the sites are spaces of shared desire for anorexia in which participants help one another become better anorexics is irrefutable. But, as I noted in the previous chapter, participants described visiting the sites also for support and advice around recovery, as well as for understanding and friendship. Galina wrote in her interview:

> "I wanted to let you know they r not all bad they have offered me a place to escape to. when im feeling so low i can go there and talk to people who understand I suffer from depression and self harm as well as an eating disorder and these people understand about those things as well they have been there for me when i didnt see a point in living any more. We dont just talk about the ed's[93] either we talk about pop stars things off the telly we form very strong relationships with each other and we also support each other."
>
> *Galina, pro-anorexia website participant,*
> *interviewed online.*

This plurality of interactions, ranging from seeking understanding for suicidal ideation to discussing "things off the telly," illustrates that not only can all talk engendered by anorexia not be characterised as just "the anorexia talking" but also that there are other focuses and relations beyond anorexia. These myriad relationalities were also apparent on the EDU where inpatients lived in close proximity with one another for months at a time, often forming close friendships based on shared interests in clothes, art, films, humour, as well as anorexia. That there are layers of desire and subjectivity that perhaps cannot be understood or even reached without ways of seeing that are not founded on binaries of whether or not the anorexia is talking will be explored in the next chapter. However, these contrasting conceptualisations of friendship between the clinic and informants suggest that now it is time to address informants' responses to being told that their "anorexia is talking."

---

[93] "ed's:" eating disorders.

Part One has explored ways in which "that's the anorexia talking" is used across the various levels of the clinic. I have argued that patients' ambivalence to their anorexia, discourses of authenticity and the compassionate impetus to save lives triangulate anorexia and personhood into a particular relationship. This both underpins the architecture that permits treatment and is continually re-enacted through the praxes of treatment interventions like MET. But, I have suggested, the central clinical paradigms of authenticity versus illness is itself blurred and ruptured by using the phase to describe an anorexic's 'bad behaviour' as though it were a symptom of an all-encompassing anorexia. This suggestion that anorexia not only has agency but that this supersedes the person's, controlling their behaviour, conceptualises the personhood of the anorexic as subsumed into illness; as such it is no longer viewed as separate from anorexia. This was particularly explored through the responses of staff on the EDU to friendships between anorexic patients. **Part Two** now offers a rejoinder to Part One by addressing anorexic informants' conceptualisations of "the anorexia talking." It will first explore informants as interlocutors of the phrase, looking at how they experience being told that their anorexia is talking. I will suggest that because many informants do not experience the relationship between their personhood and anorexia in terms of division and authenticity, they receive the phrase in ways different from its intentions. The second half of Part Two will then turn to address anorexic informants as speakers, by tracing how they use the phrase "that's the anorexia talking." The particular configurations of agency and alterity embedded in, and enacted by, informants' uses respond to the clinical conceptualisations of authenticity and control discussed in Part One. But they also forge new paths of exploration, which lead into the next chapter.

Part Two   Informants' Conceptualisations of "the Anorexia Talking"

2: A   Informants' Responses to being told, "That's Your Anorexia Talking"

2: A. 1   Revisiting the Discourses of Division and Authenticity

The conceptualisation of anorexia as external to, and distinct from, an "authentic self" was discussed as alien by many of my informants. Some inpatients interviewed described the happiness they experienced at being given hope of a future without anorexia through OT and MET, even if they could not yet feel the possibility or desirability of change. However, others felt frustrated that talking about a future that they could neither envisage nor wanted discounted their current desires and sense of self as being attributable only to the effects of illness – as "just the anorexia talking." In her interview Kate, an inpatient, said of her sessions of MET:

> "I find the MET a nightmare cos you have to separate the 'you' and 'anorexia' and I can't do that, I can't. Someone was saying the other day: 'Oh, my anorexic minx is here and I'm here and it's holding on to me like this'. And I thought, God I don't…I just thought, you weirdo! What? You know, there's only one of you like there's one of me!"

Kate, inpatient

She continued:

> "I feel it's [anorexia] so a part of me. It's… and that's what makes it hard because I don't know what I'm fighting…I don't know what I'm fighting. I'm getting, I should be getting, so angry and so… angry and fighting and confrontational with something … but it's me. And you think: but I like me. Sometimes. You know? And people say 'be yourself, be yourself, don't be anorexic'. But that *is* me. That's the thing cos people say 'but you're not anorexia'. I'm not no, but it is me..… I find it very hard when people say, 'this is you' and come out with all this anorexia talk. I think: no it's me, just

me! I don't feel different. I don't feel like there's something different inside me, so it's just me."

<div align="right">Kate</div>

Causally linking what she regarded as anorexia's innateness with both her desire not to recover and her feeling that it would be impossible to do so anyway, Eva, another inpatient, drew me a Venn diagram. She stated that each circle was a personality trait, such as "high achievingness" or "perfectionism." Pointing to each in turn, Eva said that there was "a bit of anorexia" in each circle. She said of staff usage of the phrase:

"I find it quite frustrating to be honest. You know, you're sitting at a meal and they're saying 'don't let it… you know… don't let it get the better of you' sort of thing and then again you feel like, you feel like saying: 'look, this is part of my personality, how can you tell me to…Because you feel like… I do feel like it's part of me and I suppose, maybe, when I get better it'll be less of a part of me. But it's always going to be a part of my personality. That's how I feel. I feel it's always going to be a part of who I am. Because, at the end of the day that's why I find it so hard to accept it's an illness I think, because, like, I just see it as a personality trait rather than an illness. Because there's things like, when people say to me, 'you're a perfectionist, you're this, blah blah blah', all those stereotypical clichéd little things that are meant to be so common in anorexics or whatever, well I just step back and say, 'well that's just a personality trait then, isn't it?' That's… how is that an illness? So when people are saying 'that's your anorexia talking' you just kind think: so?! [laughs], it's part of me! I find it…just find it so frustrating. Yeah, it just seems like such a cliché to me that you'd have this anorexic voice sort of thing, which people just… I don't know… it makes you… again, it's another way of making you lose your identity in here because they seem to think that there's this little person inside you that's taken over, kind of thing, and they're like, 'that's that per… that's your anorexia talking', so your anorexia's a little dot, you know, a little man, 'that's your anorexia talking' and I'm like 'No! It's me. This is part of who I am'. I find it really frustrating. But people say [assumes patronising voice:] 'but that's your anorexia talking'

and you just think: don't identify me by that person, that anorexic voice. It's more than that and they make it sound so simple, like, dividing it in half like that, like – that's your anorexia and that's you – they make it sound so simple. And it's like: no! There's a hundred million ties between the two and a hundred… it's so deeply connected."

Eva, inpatient

Eva went on to reformulate the clinical perspective of a division between self and other to conceptualise both as parts of herself:

"I always see it as two separate, like, parts of, parts of you. I suppose that's actually doing the clichéd thing of you having sort of split personality cos it is like you have two sides to your mind. It is part of my personality, it's not some invasion of some foreign body, if you know what I mean, which people always seem to think anorexia is. It's part of me. It's just what… it's who I am. And it's horrible and it's unfortunate but I suppose, that's just, that's part of my personality and that's why I always find it so difficult when people say 'you've got to cure it, you've got to get rid of it' because it feels like an ingrained part of my personality really, in a weird sort of a way…rather than just an illness. […] It's like saying: 'that's this and this personality trait talking, don't listen to it'. Well, it's me, I'm going to… I have to.'"

Eva

These quotations suggest that the split between anorexia and personhood on which the phrase "that's the anorexia talking" rests is problematic. Informants do not entirely reject ideas of anorexia as a separate entity but this 'other' entity also does not necessarily fall outside the boundaries of themselves; there is a sense, perhaps, of alterity within the self. Eva, for example, does conceptualise anorexia and non-anorexia as "two separate, like, parts" but she regards each of these as part of her. To her their separation mirrors the multiple boundaries that differentiate her personality traits from one another, each one containing a bit of anorexia and each forming part of her. This illustrates the difficulty in singling out and investing with value only one entity amongst the many described by Eva and hints at complexities that belie assumptions of authenticity. Given that informants do not experience the clinical model of authenticity and division, as the phrase travels from clinical speaker

to inpatient interlocutor its meaning shifts; informants do not hear the phrase as it may be intended. I will now explore this by revisiting the clinic's notions of anorexia in control from the point of view of informants.

2: A. 2   Anorexia in Control?

That notions of anorexia as controlling an anorexic are not entirely problematic is indicated by informants talking of *needing* to vomit and feeling they *should* exercise. I noted in the last chapter the liminal position of vomiting in relation to being a good anorexic and this is important here. I argued that vomiting had the power to unmake as well as make one (as) a good anorexic precisely because it is seen by informants as not entirely controlled. Many informants also regarded exercise as being similarly liminal; it too demonstrates anorexia's control. This was poignantly articulated by Jenny, an inpatient on the EDU. Jenny described how she felt forced to do a certain number of exercises in a specific order within a limited time every night. If she was not permitted to carry out this routine on the EDU or was interrupted before the end she would panic and become very upset. Through her tears Jenny would describe the "hell" inside her head; her suffering and sense of not being in control were very apparent.

Furthermore, the elision of food-related behaviour and wider personality changes ensuing from anorexia was also recognised in interviews by some anorexic informants. To return to Kate, she said:

> "I think…I think it would be totally a lie if I said it hadn't changed me, it has. Erm, on a day-to-day basis… not necessarily now, but before I came in, I would have screaming, ranting, slanging matches with my parents. I actually got quite hoarse because it was…and I'd be getting to the point where I'd almost be being sick because I was getting so angry…and it would be over…erm…two tubes of pasta…seriously, two of those little penne tube would set me off. That, that's changed because I'm not, not an angry person, not someone who shouts, not someone who screams, that's not me. And so, in that sense it has changed me but then, yeah… no, you can't say that

something as big as this hasn't affected you…. That would be, would be wrong."

Kate, inpatient

However, whilst acknowledging that anorexia has some agency and hold over their thoughts or actions in relation to 'anorexic' concerns such as food and weight, informants frequently argued that anorexia did not therefore necessarily control other aspect of their personhood. As such, many were reluctant to delineate 'bad behaviour' as simply "the anorexia talking." In her interview Leila said:

"I always used to, erm, externalise it and think of it as the anorexic minx, like a lot of people, because it's a horrible thought to think that something so evil and like, the things that it does to you and how you treat other people through it, is actually you. So, it's easier to externalise it so that it isn't a part of you and that's just something else. But then, at the end of the day it is in you and like, there's reasons why you've got it."

Leila, inpatient

Leila's use of the term "minx"[94] echoes its usage in clinical manuals and does, in line with these, construe her behaviour as controlled by anorexia. Yet, the last line of this quotation attests to Leila's difficulty in fully espousing that paradigm of her relationship with anorexia. This difficulty was echoed by other informants, such as Laurie:

"Yes I try to say it [that's the anorexia talking] because if I think about it like it's myself doing it all the time then… erm, very much, you feel guilty cos you've caused all the problems around you. Erm, you just, you have to separate it so it's like an illness and then there's you. That's what I've been told to start doing and so that's why I'm trying to do it now."

Laurie, inpatient

Laurie's interview demonstrates a strange paradox: He explained that his attempts to describe what he termed "problems" as anorexia talking did not ensue from a belief that anorexia did control his behaviour, but rather from a desire to escape a

---

[94] cf. Treasure 2007.

sense of shame that was produced not just by that behaviour but also *by the phrase itself*. He experienced being told that his anorexia was talking as shameful because he felt that it suggested he *could not* control himself. And yet, he recounted that it was precisely this shame that underlay his attempts to use the phrase; he thus found himself using the phrase to refute itself in a strange and endless tautology. It is therefore clear that it is necessary to unpack how the phrase is experienced by informants in ways very different from the intentions of clinical usage.

2: A. 3   Ramifications of a Clinical Phrase

In the previous chapter I noted in my discussion of ambivalence the shame that existed alongside desire to be a good anorexic in many informants' accounts. There, Paula described anorexia as criminal, like having, she said, "a prison record," evincing a sense of "anomie" (Durkheim 2002). Paula wished to conceal from others the pro-anorexic desire that felt acceptable to her, but that she regarded as being socially unacceptable. That being told that her anorexia was talking heightened this sense of shame was also apparent in Paula's interview. Paula regarded the phrase as "blaming" and "shaming" because she felt that it made the anorexia within her "public," and more visible to others. It was that visibility, Paula felt, which in turn rendered her pro-anorexic desire too shamefully apparent. Josie, a pro-anorexia website participant, also said that being told that the anorexia is talking can:

> "Enforce the feeling of being different and abnormal."
>
> *Josie, pro-anorexia website participant,*
> *interviewed online*

Josie recounted how it was as a result of hearing the phrase in outpatient treatment that she had first visited pro-anorexia websites to "feel ok again."

Arguably the phrase's potential to heighten shame ensues, at least partly, from clinical usage's reproduction of an existing linkage between the sorts of 'bad behaviour' it is used to describe on the EDU and the biomedical criteria of anorexia, as noted in Part One. Jenny described her anorexia diagnosis as engendering assumptions in family and friends. She said:

"And they're never nice ones!"

Jenny, inpatient

Jenny was particularly upset by an assumed correlation between anorexia and deceit. She argued that it was so accepted that "anorexics are liars" as she put it, that her family had been told to look out for this by medical professionals at the point of diagnosis. Jenny recounted, with visible pain, how family members had suddenly started to view her as dishonest. She argued this to be unfair as, she said, she had never been a liar before and was not one now. Likewise, Leanne, a pro-anorexia website participant, described how assumptions provoked in family and friends rendered her 'just anorexic':

> "When we wear this label we're put in 'a box' where our voices can no longer be heard. We lose control of our lives because our families and friends abandon us citing the misconceptions about who and what we are. They start treating us like freaks and we can feel them distancing themselves from us."

Leanne, pro-anorexia website participant,
interviewed online

Leanne, like Josie above, described this as a key reason why she visited pro-anorexia websites for support and understanding and as such, in their way both the clinic and the Internet may propel anorexics towards the other. However, as well as this paradoxical effect of causing feelings of shame and isolation, there were also two ways in which informants' reception of the phrase not only differed from its intention but was completely opposite to it. I suggest that this contrast ensued from the way in which a belief that a patient's anorexia was talking on the part of members of staff often had very practical impacts on their behaviour in the EDU.

Many informants argued in interviews that staff's adherence to a conception of a talking anorexia made them more likely to chastise harshly a patient because they regarded themselves as chastising only anorexia and thus not dealing with a person. This claim on the part of informants does perhaps make sense if we return to Mead's writings on the self, introduced in the previous chapter. He argues that when one is going to say something "the effect on himself of what he is saying

checks him; there is here a conversation of gestures between the individual and himself" (Mead 1967: 141). Therefore, "one controls the address to another person by the response made to one's own gesture" (ibid. 142). In order to check ourselves we need to think that we are talking to a self like our own and not only holding a conversation with the voice of illness. In this conversational clinical usage thus, the phrase becomes dislocated from its philosophical underpinnings of division; again, anorexia is regarded as having taken over to the extent that the person is no longer acknowledged.

Furthermore, it was almost a mantra in the hospital amongst staff that a patient seeking reassurance over food or weight should not be answered as it was 'just the anorexia seeking reassurance.' This, again compassionately, was intended to allow patients to distance themselves from what was perceived to be 'anorexic' distress about food or weight, and to express 'real' emotion. This latter was characterised as arising from the "authentic self" and was thus underpinned by the assumed division between self and anorexia. That it was specifically food and weight-related distress that was described as the anorexia talking by staff would seem to indicate that they regarded some distress as within anorexic parameters and some as outside them. Yet, many patients recounted that on articulating any distress they were told that their anorexia was talking; they felt staff's adherence to a belief that a patient's anorexia was talking led them sometimes to ignore a distressed patient.

Frustration at this denotation of all manifestations of distress as "anorexia talking" was a frequent topic of conversation particularly during cigarette breaks and Group Walk. About this Libby said:

"It's the most frustrating thing in the world to have someone… and it always seems to be if you try and express how you're feeling, and it's 'that's the anorexia talking'. You think: you tell me to express how I feel and then you tell me that's anorexia and you don't want to listen! You think: what am I supposed to do, I do one thing and that's wrong, another thing, that's wrong and it's so frustrating! And then and then… you just think: but it's me! It really is me. And even if it, you know… fine, ok, I will accept that sometimes maybe it is coming from an anorexic perspective but it's still me

saying it, it's still me. I'm still left in my body and I don't… I don't hear one person here and one person here, it's just me you know? It's really… it drives me absolutely mad!"

Libby, inpatient

She continued:

"And it seems to be easy for them to just go 'that's anorexia, I'm not listening' and just walk away. And then if you're genuinely distressed, you are genuinely distressed and you… need something back as opposed to 'whatever'."

Libby

I asked, "would it make treatment easier if the phrase wasn't used?"

"Oh yeah! Just to listen to me and to go 'ok, that's how you feel, that's how you feel'."

Libby

Libby, like many other informants, did acknowledge above that sometimes her distress related to issues of food and weight and hence came "from an anorexic perspective." These she described as "not genuine." As such, she would seem to differentiate between authentic and inauthenthic in a way mirroring the clinic. But, Libby discussed how sometimes, even around food, her emotions were "genuine." In often-tearful narratives many patients on the EDU described the flood of distress they experienced on starting to eat again when it was enforced by inpatient treatment. Many informants regarded this distress as not necessarily *about* eating but simply as *prompted by* eating; informants often differentiated between the catalyst and the articulation, claiming the latter to be "genuine." In order to understand this distinction and its subtle but crucial rupturing of clinical conceptualisation of the anorexia talking we need briefly to note the relationship of anorexia to distress *outside* and *before* the clinic, as conceptualised by informants.

Many informants described not eating as having helped them to alleviate distress, which is also documented in existing psychiatric and psychological literature.[95] This links back to Chapter Two in which we saw that practices of eating

---

[95] cf. Fox & Leung 2008; Serpell et al. 1999.

and starving were dual; they signified both modalities of making and mediating informants' everyday lives as well as continually (re-)making anorexia day-by-day. That these two outcomes are inextricably two parts of the same equation relates to the way in which key to the making and mediating of the everyday is the use of anorexia to control emotion; this allows informants to 'get by' day-by-day. They therefore need to continually reproduce anorexia so that it may continue to control their emotions.[96] On one pro-anorexia website on which I carried out participant observation and interviewing there is a *Letter from Ana*; it says:

> "I make it possible for you to stop thinking of emotions that cause you stress. Thoughts of anger, sadness, desperation, and loneliness can cease because I take them away and fill your head with methodic calorie counting."

> *'Letter from Ana' on Pro-Anorexia Website*

Likewise, in her interview Libby said:

> "You can see that there's this magical Holy Grail which made everything go away."

> *Libby*

This statement offers a second reason why Libby, like many other informants, objected to her articulations of distress being described as "the anorexia talking." Given that anorexia helped her to *not* express, or indeed not feel, distress, Libby conceptualises *not* expressing emotion as "anorexic." As such, articulations of distress signify the gaining back of a voice and the act of eating makes her express 'authentic' distress that is not necessarily about food as such. This is echoed by recent psychological discussions which argue, "being able to talk openly about issues" puts in place alternative coping mechanisms to the anorexia's quelling of distress (Reid et al. 2008[97]). But the question thus remains whether this open talking is 'anorexic' or not.

By charting informants' responses to the labelling of their articulations of distress as anorexia talking, this section has briefly hinted at how notions of agency

---

[96] See Chapter Four for further discussion of this 'need' for anorexia's continued 'help' with emotions.

[97] See also Cockell et al. 2004; Le Grange & Gelman 1998.

and authenticity embedded in clinical usage of the phrase are co-opted by informants to express more complex relationships to food and eating in which agency is dispersed and food, anorexia and bodies constitute one another in intriguing ways. These will be more fully explored in the next chapter. But it has also opened up a way to listen to anorexics' own conceptualisations of the anorexia talking. In her denial of distress as just or rather always, the anorexia talking, Libby did not just reject a notion that anorexia talks; rather, she moved it elsewhere – altering its boundaries and ideas of how, why and where it talks. There is a burgeoning sense here that there are layers of complexity in informants' relationships with anorexia that cannot be either conceptualised or contained by clinical usage of "that's the anorexia talking." The next chapter will more fully explore these. But, for now, the last section of this chapter will explore how anorexic informants themselves use the phrase "that's the anorexia talking." The relative fragmentation of this last section, particularly compared to the solidity of Part One, reflects the multiple and sometimes fractured ways informants negotiate and appropriate the phrase.

2: B   **Anorexic Informants' Uses of "That's the Anorexia Talking"**

2: B. 1   **When Anorexia *Does* and *Does Not* Talk about Food and Weight**

I will now trace when informants do and do not regard anorexia as talking in relation to food and weight. Focusing on the intricacies of these 'anorexic themes' provides a way into the complexities of informants' uses of the phrase and thus into their conceptualisations of anorexia and personhood. In her interview, Leila, an inpatient, used the phrase to articulate how anorexia mediates her relationship with food. She said:

> "Last weekend my mum came up …and there were so many opportunities where I could have done something that would have reduced the amount of calories…like I could have put less on my plate, I could have done this, that and the other – I could have played it completely but then I had, I had to

stop myself from doing that because I knew it wasn't me doing it. I was thinking: oh that's the anorexic doing this."

Leila, inpatient

Leila's usage of the phrase echoed informants' explanations of the avid watching of cookery programmes on the EDU. Watching *Master Chef* on the vomit-stained sofas of the Patients' Lounge with Elle one evening I asked her why she liked the programme. She replied:

"Well, that's just anorexic, isn't it!" *Elle, inpatient*

Likewise, in a particularly mirth-filled OT pottery session to which I escorted Miriam, she and I spent an hour's session making burgers and chips out of clay. Light-heartedly discussing our actions throughout the session, Miriam said of her fast-emerging clay meal:

"Oh, the Ward would think this was so anorexic! They'd totally tell us our anorexia was talking if they saw us making clay burgers. Maybe it is I guess. But it sort of isn't as well, you know?"

Miriam, inpatient

The doubled awareness of Miriam's statement is clear not only from the ironic simultaneity in the last sentence of this quotation but also from her inclusion of me; she says "they'd tell *us our* anorexia was talking," thereby framing her actions as equally unrelated to anorexia as mine were. Miriam also pointed out that if a member of the EDU staff had walked in they would have "admired" my clay doodlings and "called [hers] anorexic." Whilst making a valid point about how "the logic of diagnosis" (Corin 2007: 275) works, this did not stop Miriam from saying that her anorexia was "sort of" talking through her clay food. That it might be and *also* might not be, even in relation to food, was illustrated by another informant, Maba.

Maba, returned from woodwork in the hospital's Occupational Therapy Block with a recipe book stand she had made. Showing me her fine craftsmanship Maba said laughing:

> "Yes I know, a recipe book stand, so anorexic!"
>
> *Maba, inpatient*

And yet, another conversation with Maba illustrated the problem with assuming that relations with food and weight are *always* or *just* anorexia talking. One afternoon Rest Period on the EDU Maba recounted having found a hair in her lunch. She told those of us assembled in the Patients' Lounge that she had not bothered to complain to staff as:

> "They wouldn't have believed me anyway; they would have just thought it was the anorexia talking."
>
> *Maba*

This provoked discussion amongst the assembled patients of all kinds of bits of plastic, hairs, moulds and fluff they too had found in their hospital food. After an animated conversation that had uniquely drawn together the patients during the habitually socially awkward Rest Period, the room fell silent. The lull ended with a flurry of wry comments, such as:

> "Enough talk about food!"

And:

> "Oops, that's anorexic!"

The sudden break in conversation and ensuing utterances illustrate the patients' recognition of how, even whilst bemoaning staff usage of "that's the anorexia talking," they had slipped into a talking anorexia; anorexia had taken over, and in fact animated, the conversation. Yet, slipping into anorexia and then removing oneself from it by proclaiming "oops, that's anorexic" suggests an ambiguity; even around food anorexia only sometimes talks. This was also discussed by Leila; in her interview Leila intricately delineated between times she felt anorexia to be talking around food and when she did not:

> "Being told that 'that's the anorexia talking' is so annoying because there are certain things that is very anorexic behaviour and that is anorexia coming out like… erm, not having sponge cake and that. Yeah I don't want it

because it is painful and that is the anorexia. But, then there's other things that's actually you talking and that's where you lose your voice. Because, like, when I first came in I'd never had butter in my life, not margarine or spread or anything and I had to have it here…a piece of bread in the morning with butter on. I'd just never ever had it but they just didn't believe me. My mum rang up and…but they were just like 'no, no you have to have it' but I've never liked it. And it's just things like that; you do have genuine likes and dislikes but the dislikes you just, you have to have anyway."

Leila, inpatient

Leila illustrates both the fraught relationship with food embedded in anorexia as well as how that does not always hamper agency. Co-opting discourses of authenticity discussed in Part One, Leila distinguishes between what she categorises as anorexic – a painful relationship with food – and what she terms "genuine likes and dislikes;" importantly, these "genuine" predilections may also relate to food. Leila's alternative use of the authenticity discourse suggests that since informants' conceptualisations of whether, how and when anorexia talks cannot simply be linked to subject matters of food or weight, it may relate not only to what anorexia speaks *about* but also where it speaks *from* and *to.* This distinction becomes clear when we examine use of the phrase as reassurance between anorexics; an articulation that both *is* and *is not* related to food and weight.

2: B: 2   From Food to Voice: Using the Phrase as Reassurance

On one eating disorders message board on which I was conducting fieldwork a participant asked:

"I know I am underweight but do you think I really need to gain weight? Or would it be ok if I just maintained?"

To which another participant replied:

"That's just the anorexia talking when you say you're getting fat. Maybe you could try building muscle, it wouldn't look like fat."

Conversation on an eating disorders pro-recovery website

This usage of "the anorexia talking" as reassurance over food and weight concerns is widespread on pro-anorexia websites, as it also was on the EDU. Specifically, if someone was distressed that they had "eaten too much" they might be told by another patient not to worry because the anorexia was talking. In light of the discussion of distress, earlier, this usage may seem straightforward. In contrast, and perhaps in response, to staff's unwillingness to reassure patients over food or weight, patients enact that role of comfort giver instead. Indeed, such recognition of, and support through, suffering aligns with my discussions of friendships between anorexics, above. Yet, informants' utterances of the phrase as reassurance often strayed into conversations outside the delineated boundaries of food and weight; this trespassing would seem to be paradoxical given informants' frustration at the clinic's denotation of all distress as "just the anorexia talking." However, it became clear during fieldwork that in the situations in which "that's the anorexia talking" was offered and received as comfort, the idea that anorexia really was talking was usually not believed by the speaker or their interlocutor. On a number of occasions after hearing the phrase I later asked the speaker about their usage to receive the reply that "of course, it wasn't *really* the anorexia talking!" This suggests that it is not the words themselves that create meaning in this context. The phrase acts not as a vehicle for reassurance as such but rather as a reassuring 'object' of friendship and comfort.

It is useful here to revisit ideas of mimesis introduced in relation to Julia's performance of not eating in the previous chapter. There, I argued, Julia "mim[ed] the real into being" (Taussig 1993: 105), bringing her "presentation of self" (Goffman 1959) closer to her sense of self and vice versa. Ideas of closeness and distance are also woven through informants' use of "that's the anorexia talking" as reassurance. Here the phrase distances the interlocutor both from their distress and from the clinic. Clinical usage of the phrase in response to patients' distress arguably elided distance from distress with distance from anorexia; it set up two distinct subject positions for patients to choose - *either* distress/anorexia *or* reassurance/authenticity. The phrase thus failed to sufficiently fit informants' own

experiences of anorexia to be reassuring. Here, the mimesis embedded in informants' usage of the phrase works to rupture the boundaries of these distinct subject positions. This usage of the phrase reassures that one can be *both* anorexic and *not* distressed. Although the words suggest that someone's anorexia has arisen, that it is out of control, the actual exchange of the phrase belies this; it would seem to be reassuring the opposite. As such, "the distancing effects of copying" (Taussig 1993: ix), also engenders a space between words and meaning. This is a space that also emerges in Leila's discussion of lying as "the anorexia talking."

2: B. 3 Lying as "The Anorexia Talking"

During her interview Leila said:

> "All throughout anorexia you never have a voice: your voice is lost cos you can play the system easily. I went to lots of doctors you know, for this that and the other. You just get told to eat three meals a day. And you're like [laughing]: 'yeah, yeah, I will. Mmn, I'll start that tomorrow!' And they believe you! You just blag your way through it basically. You just sort of like…portray the right emotions and…. Oh yeah anorexia, you're lying constantly. That's why I can understand why they don't believe you."

> *Leila, inpatient*

Leila uses the phrase "the anorexia talking" here to describe articulating to clinicians that she will eat when she does not intend to. It refers thus, to a performed compliance. This is a reversal of clinical usage of the phrase in Holly's Ward Round where it referred to Holly's spoken refusal to eat and gain weight. Leila instead situates *not* opposing treatment, as "the anorexia talking" – or rather, *appearing* not to oppose treatment. This usage suggests that the anorexia talking is a medium through which Leila conceals, and hence protects, her own pro-anorexic desires and intentions. In performing a lack of resistance Leila creates a protective space between words and self. Leila uses the phrase to suggest a self-aware deception – an enactment of anorexia that is *in her control*, not that controls her and yet which may concomitantly *not* actually be her *"voice."*

Leila's use of the phrase to describe the lies she tells clinicians is ironic. Her words would seem to be antithetical to her intentions; this echoes the phrase's use as reassurance. Yet, attending to this ironic usage also allows us to move away from ideas of binary opposition. In his exploration of Socratic irony, Alexander Nehemas argues, "irony does not consist in saying the contrary of, but only something different from, what one means. In the former case, if we know that we are faced with irony we also know what the ironist means: all we need to do is to negate the words we hear in order to understand what the ironist has in mind. In the latter, even when we know that we are confronted with irony, we have no sure way of knowing the ironist's meaning: all we know is that it is not quite what we have heard" (Nehemas 2000: 12). As such, Vincent Crapanzano argues, irony lies in "the conversational strategies by which the interlocutors indicate at once their engagement with and disengagement from what they are saying" (Crapanzano 2004: 140). An attention to irony therefore indicates that informants' conceptualisations of the anorexia talking are more complex than simply being antithetical to those of the clinic. They may refute aspects of the clinic's assumptions whilst concomitantly reproducing others. As well as hinted at in informants' uses of the phrase as reassurance, this emerges in Leila's description of lying as simultaneously *both* agential *and* a loss of voice.

I argued in Part One that clinical discourses of authenticity rely on notions of inwardness that are, Taylor suggests, "intrinsically linked to our understanding of ourselves as expressive, as articulating an inner source" (Taylor 1989: 390). But I agree with philosopher Peter Binns that "it is a mistake to identify persons from what is inner, or to contrast it to what is outer" (Binns 1994: 97) and Leila demonstrates why here. Leila's lying could perhaps have reintroduced discourses of authenticity by setting up a hidden "inwardness" against performances of compliance. However, an attention to irony, as called for in Chapter One, instead suggests that neither the voice Leila described as "the anorexia talking" nor the intention not to eat which it concealed is arguably more 'authentically Leila' than the other. In many ways this chapter has been about antithesis and antinomy, about the construction, and also rupture, of opposites. Irony allows us to navigate these and recognise how informants are affected by illness without making generalisations from fragments of experience. Kenneth Burke discusses irony as a dialectical

"perspective of perspectives" (Burke 1969: 512), necessarily involving the voices of others. This ambiguous "multivocality" (Turner 1967), to borrow from Turner, takes on particular resonance in the next section's exploration of informants' uses of the phrase "the anorexia talking" to refer to a variety of voices and actions - of self, other or both at once.

2: B. 4 Good Anorexics & The "Internal Bully:"[98] The "Inside Voice"[99] of Anorexia Talking

In her interview Josie said:

> "I know for many anorexics that it is common knowledge to have another "voice" in their head telling them not to eat."

Josie, pro-anorexia website participant,
interviewed online

Some informants in both field sites recounted hearing a voice inside their head speaking to them, or rather, giving them commands. All informants, whether or not they experienced it themselves, referred to this "anorexic voice" (Allison 2009: 252) as "the anorexia talking." Grace Bowman's memoir *Thin* (2007 A) was passed around in the EDU and is also listed on pro-anorexia websites. Bowman writes in her memoir of anorexia about her voice:

> "Inside a little voice has started to take hold. A constant pressuring, pulsing voice."

Bowman 2007 A: 26

Informants' accounts of this talking anorexia ranged from the more frequent sense of the voice only arising in relation to food or exercise, to tell them not to eat for example, to the less common experience of the voice being always present. Some informants talked of "anorexia *describing*" them as worthless and encouraging self-harm or suicide. In *Monkey Taming* Judith Fathallah describes anorexia as a "monkey" who "snarls" in an "awful voice" (Fathallah 2006: 58). A sense of intrusion and torturing alterity is clear here. The voice is not only other, but makes

---

[98] Allison 2009: 250
[99] Bowman 2007 A: 35; Bowman 2007 B.

you other to its pervasive commands. Earlier in the chapter I noted that Jenny described having to do a certain number of exercises in a particular order every night; Jenny recounted how part of the reason it so upset her to be prevented was that the voice inside her head would shout at her, calling her a "bad anorexic" and "lazy." Jenny's account of feeling, as she put it, "tortured" by the voice was echoed by other informants who described its commands as causing pain, restlessness and frustration.

In the previous chapter I quoted Kyra as saying that the concept of being a good anorexic is engendered by:

"Sufferers want[ing] to be better than others at starving themselves."

But she also said:

"The anorexic voice inside your head does have a large part to play also."

Kyra, Facebook Pro-Anorexia Research Group participant,

interviewed online

This inside voice of anorexia talking could perhaps be assumed to cast a new, and problematically alternative, light on being a good anorexic. The voice seems to problematize claims to agency in relation to practices to make oneself good at anorexia. Yet, it is necessary here to pay attention to the distinction drawn by many informants between this "inside voice" of anorexia talking and their pro-anorexic desires to maintain and enhance their anorexia. Bowman writes some sections of her memoir in a play format to portray her anorexic voice. Here, Grace is in the pub eating only soup with friends, including 'Girl 1,' who are all eating meals:

"Girl 1 [*bravely*]: Grace, I don't know how to say this, but do you think that you might see a doctor about things? I could come with you to see a counsellor?

Grace (INSIDE VOICE): *Soup Only. Liquid Soup. No bread roll.*

Grace (OUTSIDE VOICE): Yes, maybe. That is very kind of you.

Grace (INSIDE VOICE): *Not even one mouthful."*

Bowman 2007 A: 35

Although Grace's "outside voice" would seem to evoke Leila's use of "the anorexia talking" to mean a performed compliance, above, we cannot assume from this that, in turn, Grace's "inside voice" is the same as, or even aligned with, Grace's own desires to maintain or reject anorexia. Many informants who described the voice in negative terms also felt that if it were removed they would still want to be anorexic, but that anorexia would not be such a painful experience. Eva experienced the voice as "taunting" her but said:

> "It's not even a voice you can rationalise…or…understand. It's just kind of… it's just there. But then, it's difficult because that's part of you as well isn't it?"

> *Eva, inpatient*

Eva conceptualises this inside voice of anorexia talking as *part of* anorexia, which she said above was *part of* Eva; there is a sense of layering. The voice constitutes only part of Eva's experience of anorexia as well as only part of her desire for it. Thus, that the voice arises from the pathology of the illness is irrefutable and admitted by informants. But, in contrast to clinical assumptions above, this "inside voice" and informants' pro-anorexic desires cannot be assumed to be the same or even aligned. Informants would often describe this "pressuring, pulsing voice" (Bowman 2007 A: 26) as 'other' or "someone/thing else" whilst simultaneously describing their desire for anorexia as "genuine" or "real" – thus again fragmenting - or perhaps rather, differently situating - the clinic's binary notions of authenticity. The voice and pro-anorexic desire can at once both mirror or overlap each other and also be in conflict. As such, many informants described how, when the voice told them what to do to 'become a better anorexic' they might be reluctant to act on its particular commands, whilst also engaging in other ways to maintain and enhance their anorexia in line with *Tricks* and/or *Tips*. Informants' agency is thus not perhaps as problematized as we might have assumed on first introducing discussion of this voice. In her interview, Laura said:

> "For me, when i admit i have a problem and talk to people about it i find that the anorexia has less of a hold over me and i tend to eat a little bit

more and therefore become a "bad" anorexic so for me i think i try to hide it because i lose more weight."

<div align="right">Laura, Facebook Pro-Anorexia Research Group participant,</div>
<div align="right">interviewed online</div>

Here, Laura's desire not to be a 'bad anorexic' is de-linked from the hold over her that she feels anorexia has. Thus, recognising the distinctions often drawn by informants between a talking anorexia and their pro-anorexia actually highlights their sense of agency, albeit perhaps complex and sometimes fractured, within their pro-anorexic desires. I suggest that this agency relates, at least partly, to contrasting conceptualisations between informants and the clinic regarding if and where there may be boundaries between self/other and anorexic/not anorexic. Clinical usage of the phrase assumes the 'boundaries of the self' to be breached by anorexia as it takes over personhood. As such, anorexia is conceptualised both as entirely circumscribing the anorexic as well as continually seeping out through behaviour to become uncontained and public. Instead, the inside voice of a talking anorexia is seen by informants to remain inside. Dialogue and struggle with the voice are intra-subjective and self and other are blurred and overlapping. Like Eva said, above, and Milla here reiterates:

"People do talk about the anorexic voice… but you know it's just yourself."

<div align="right">Milla, inpatient</div>

As such, the inside voice may be both you and yet not you at the same time.

Furthermore, agency is claimed by some informants in their descriptions of deliberately "using" this inside voice of "anorexia talking" to trigger themselves into being better anorexics. In the previous chapter I briefly touched upon "triggering" in relation to informants' frequent uses of memoirs. I noted there that reading the memoirs of other anorexics was described as treading a fine line; such texts are used to self-trigger both anorexia and pro-anorexic desire in order to become a better anorexic, but they can also trigger one or both of these against one's will. In an interesting twist on this, here, informants take the inner voice that could, in the context of this discussion, be argued to trigger them – or at least, to attempt to trigger them - against their will and they reclaim it as a device of self-triggering. For example, Shanice, an inpatient, echoed other informants in describing herself as too

"weak" to be good at anorexia by herself. She felt the voice "helped [her]." Like hunger in the previous chapter, this feature of illness is co-opted as a modality of motivation. This is particularly clear on exploration of how this voice breaches the seeming boundaries of inner and outer to spill onto pro-anorexia websites.

2: B. 5   Anorexia Talking on the Internet: The Figure of *Ana*

Chapter Two was framed by *Tips & Tricks* and *Thin Commandments* from pro-anorexia websites. These signified, respectively, guidance on making oneself a good anorexic and the ideal parameters of the construct. Given the linkage between the "inside voice" of anorexia talking and being good at anorexia (although not necessarily *wanting* to be) it is clear that *Thin Commandments* resemble that "inside voice" in an echolalia of cajoling, bossing and undermining. Some informants in both field sites even described pro-anorexia websites as a montage of public renderings of this anorexic voice. In her interview Aurelie said:

> "I believe that the internet and in particular pro-anorexia sites has created its own use of language and terminology. If talking face to face then a person might say that it is the anorexia talking but over the internet it has been given a name e.g ana or mia and I think sufferers feel more comfortable using names because they don't feel so abnormal if they talk about it as a person (if you understand my meaning?) It is easier to hide behind the internet than having to talk face to face and I think the type of language used on pro-ana sites reflects this because by giving anorexia a personal name makes it more acceptable to the rest of society and not so strange."

> *Aurelie, Facebook Pro-Anorexia Research Group participant,*
> *interviewed online*

Here Aurelie echoes other informants by drawing a parallel between the inside voice of anorexia talking and the personified figures of *Ana*, short for anorexia and *Mia*, short for bulimia.

   Ana, represented discursively and pictorially both as an angel and a harridan, is, on some sites, written and prayed to. It is to her as well as each other that participants address requests for help in becoming better anorexics. There are also

many writings across the Internet that are purportedly from *Ana.* As noted briefly in the last chapter, *Letters from Ana* echo the central tropes of *Thin Commandments* in commanding participants to exercise and avoid food. However, the pronouncements attributed to the voice of *Ana* are also often very graphic. They warn bleakly of suffering, death and loss of control. As such, this particular voice of anorexia talking embodies the sense of ambivalence that echoes throughout my informants' accounts of anorexia; it mingles a stark recognition of suffering with desire for anorexia. In telling participants how horrible the illness can be - how frustrating and relentless - these letters signify a mirroring of form and content; they both describe and incite this relentlessness, which I discussed in the previous chapter. These elements all feature in this excerpt:

> "I expect a lot from you. You are not allowed to eat much. It will start slowly: decreasing of fat intake, reading the nutrition labels, cutting out junk food, fried food, etc. For a while, the exercise will be simple: some running, perhaps some crunches and some situps. Nothing too serious. Perhaps drop a few pounds, take a little off of that fat tub of a stomach. But it won't be long before I tell you that it isn't good enough. I will expect you to drop your calorie intake and up your exercise. I will push you to the limit. You must take it because you cannot defy me! I am beginning to imbed myself into you. Pretty soon, I am with you always. I am there when you wake up in the morning and run to the scale. I am there when you figure out the plan for the day: 400 calories, 2 hours exercise. I am the one figuring this out, because by now my thoughts and your thoughts are blurred together as one."

> *Extract from a 'Letter from Ana' on a pro-anorexia website*

Also drawing a parallel between their pro-anorexic website informants' descriptions of an inside voice and the personifications of *Ana*, Williams and Reid argue that using the term *Ana* "goes beyond a simple pro-anorexic convention and expresses participants' beliefs about anorexia as something capable of performing actions and having emotions of its own. Here, anorexia is seen as something that is able to take control of the individual and to enforce behaviours upon them" (Williams & Reid 2009: 10) However, Katie Ward notes that as well as having

"suffocating clutches" (Ward 2007: paragraph 10.2), *Ana* provides both "power and control" (ibid. paragraph 10.1). Some informants in both field spaces described how making their inside voice public through the act of writing on pro-anorexia websites quietens it. Sharing one's inside voice is thus a strategy to cope with one's own anorexia and gives website participants, at least a sense of, agency. Unlike the incessant noise of the anorexic voice described by Bowman, above, *Ana* signifies a voice with which participants can choose to engage or not. Interestingly though, in this figure of *Ana* lie ideas of performance echoing those of the previous chapter. Just as both Eva and Milla, above, described the "inside voice" as part of them, the figure of *Ana* and *Thin Commandments* are all at once both inside as well as outside, both self *and* other. These Internet manifestations signify not only an externalisation of the inside voice of a talking anorexia but also a performed anorexia – as we remember that they do not necessarily align neatly with pro-anorexic desires. Yet, Taussig (1993) reminded us that miming can produce the real and I suggest that this element of performance is not, to co-opt the language of the clinic, 'inauthentic,' but rather, is one way to maintain one's own anorexia through taking on the role of *Ana,* and thus *becoming anorexia,* for others. That in writing *Letters from Ana* or contributing to lists of *Thin Commandments*, participants take on the role of a cajoling and torturing "anorexia talking" for others is suggested by *Wintergirls*, a novel which contains one of the few literary portrayals of pro-anorexia websites. In this the protagonist, Lia, discusses the "shrieking chorus" (Halse Anderson 2009: 175) of participants "screaming through their fingers" (ibid. 112). She says:

> "I scroll through our confessions and rants and prayers, desperation eating
> us one slow bloody bite at a time."

> *(ibid. 112)*

Like the gaze of others in the previous chapter, being subject to others' clawing, commanding, and sometimes violent anorexia talking can thus relationally make or unmake you as a good anorexic. This "heteroglossia" (Bakhtin 1982) of voices, alongside a sense of alterity, invites comparison to anthropological approaches to spirit possession.

2: B. 6 "That's The Anorexia Acting:" A Final Troubling of Discourses of Authenticity and Control

Given that, as Ellen Corin argues, "the heuristic potential of spirit possession for understanding the notion of person is based on the fact that a diagnosis of spirit possession indicates that the person's problems are understood as involving the person's identity and her permeability to some kind of Otherness which has come to dominate her" (Corin 1998: 88), the lack of discussion of spirit possession in Part One may have seemed marked. Mentions there of the 'minx' controlling behaviour may have evoked images of possession for the reader. Yet, that lack was deliberate; it would have been difficult to discuss spirit possession without implicitly entangling it in clinical frameworks of illness versus self that frame alterity as intrinsically undesirable. Introducing spirit possession would, I suggest, have implicitly emphasised a one-dimensional idea of 'possession,' undermining the intellectual nuances present in existing literature. But, the emergence of ideas of agency and alterity as simultaneously present in informants' experiences of an inside voice and their strategic use of the figure of *Ana* has engendered a new space of comparison to spirit possession that draws nuances to the fore. The mingling of alterity and agency that such a comparison allows takes on particular resonance in a discussion of how one informant, Lia, describes her anorexia as acting.

During fieldwork a number of informants recounted incidents in which they felt their anorexia to have been acting. In her interview Lia described how at lunch that day she had spilt her milk, causing it to be replaced by a nurse. Despite assuring staff she had drunk some before spilling it, the cup had been refilled to the top again. Lia claimed that she "like[d] milk," that she "ha[d] no problem with it" and she argued that even at her lowest weight at home when she could not eat, she had drunk milk. It is possible that this claim was itself an enactment of Leila's definition of "the anorexia talking" as a performance of compliance, but I wish to take Lia at her word. Lia recounted how she felt on principle that she should protest at being given too much milk. Believing her only mode of protest to be, as she termed it, "anorexic," due to the lack of other outlets in the EDU for expression, and feeling that such expression "would be seen as anorexic anyway," she acted out a protest to the milk by refusing to drink it. This, Lia described as her "anorexia acting."

Although Lia's narrative exhibits a tension regarding whether agency is located in her or in anorexia, it does not invite assumption that these claims are in opposition. Instead, it solicits an understanding that takes account of performance and alterity without claiming that if anorexia is talking, or rather acting, Lia is not; each, perhaps, shapes and produces the other. This is because Lia describes her anorexia as enacting desires she could not achieve alone. It acted, she said, not *on* her, but rather *for* her. As such, alterity is, as Taussig argues, "every inch a relationship, not a thing in itself" (Taussig 1993: 130). Spirit possession, it has been argued, "raises questions that are provocative for all of us as human beings, questions pertaining to such things as the sources of human agency, or the relationship between action and passion, or autonomy and connection, in selfhood." (Lambek 1998: 104). Thus, drawing on discussions of spirit possession allows this particularly situated vision of alterity as potentially invited - as something that constitutes Lia's sense of self as much as undermines it. It permits us to follow Lia's lead in recognising her embodied actions as simultaneously both agential and other. Corin writes of the Zebola idiom of spirit possession, that in enacting bodily practices to please the possessing spirit, "the person is transformed from a passive – chosen – object into an active object-subject of the relationship" (Corin 1998: 91). She continues, "a first embodiment responding to an external force, the possessing spirit, is complemented by a second embodiment, deliberately shaped from within. As she engages in active communication with the spirit, the woman moves from a relationship trapped in an imaginary and unmediated world in which she feels captured by the others' power (people or spirit), to a position of dialogue in a symbolic space where she becomes the subject" (ibid. 91 – 92). This is particularly interesting when we note that Lia's refusal to drink the milk could be framed as an example of the 'bad behaviour' discussed in Part One. Given the clinical linkage between such 'bad behaviour' and an anorexia diagnosis, in order to claim anorexia as part of herself - as she did during her interviews - it is necessary for Lia to claim, reconfigure and embody the behaviour that is linked to it. By conceptualising the anorexia as acting Lia claims the diagnosis as part of herself whilst also rejecting some of the responsibility for behaviour regarded in negative terms by staff on the EDU.

Furthermore, as Lambek argues of spirit possession, "one of the questions it inevitably touches on has to do with the relationships between mind and body" (Lambek 1998: 104). Anthropological approaches to spirit possession enable us to discuss Lia's conceptualisation of the anorexia acting without asking what, or rather whom, she is bodying forth. And yet we are still left with a question regarding what, if any, comprise the differences between anorexia talking and anorexia acting – why is it that Lia talks of acting? That voices are "constituted or 'articulated' into being in material arrangements which include social, technological and corporeal relations" (Moser & Law 2003: 2) suggests there to be no difference perhaps; the body is always present since it is continually produced and reproduced by the diverse utterances of the phrase "that's the anorexia talking." Yet, there is something more here too, something that offers key answers to the binary tropes proffered by clinical usage of the phrase in Part One. Lisa Blackman suggests that "non-verbal communication or body language is usually framed within a contrast between the authentic and the manipulated, the honest and the deceptive, where body leakage is judged according to the extent to which the person is revealing their feelings, which might be at odds with what they are saying or doing" (Blackman 2008: 26). Borrowing ideas of "body leakage," I suggest that it is precisely these bounded notions of authenticity that Lia's anorexia acting disrupts. Bodies may seem to challenge voices but in conceptualising anorexia as sometimes talking, sometimes acting, and often both, Lia instead challenges assumptions of authenticity and dualism; her actions are no more "body leakage" than her words could be termed 'mind leakage.'

Only by having disrupted binary assumptions of authenticity embedded in, and performed by, clinical usages of "that's the anorexia talking" can we understand the intricate ways in which informants conceptualise agency in pro-anorexic desire. Instead of claiming that *either* anorexia *or* self holds control, as we saw in Part One, Lia's discussion of her anorexia acting hints that agency may be dispersed; it perhaps ebbs, flows and arises across spaces and times and in relationships between selves and foods, anorexias and bodies. The next chapter will suggest that paying attention to such alternative relationalities is crucial to understanding informants' pro-anorexia.

Conclusion:

This chapter has explored the myriad ways in which both treatment professionals and anorexic informants conceptualise anorexia as talking. The phrase has shifted from standing in for overarching debates of autonomy, through enacting both strategy and metaphor, to describing the experience of hearing anorexia talking as an inside voice. Despite being used both by treatment professionals and anorexics, their usages are so diverse that the phrase does not perform linkages between these two groups as might perhaps have been expected. Although frequently said by staff to patients, the phrase is never uttered by patients to staff; it only flows one way. Connections between groups are thus fragmented and curtailed as the selves, bodies and even, anorexias, produced by articulations of the phrase fail to map onto and fit with one another. Thus, Part One's discussion of a division between self and anorexia based on ideas of authenticity versus pathology was followed in Part Two by more intricate conceptualisations of agency and alterity related to specific actions and voices. Discussions of spirit possession and irony engendered an understanding of informants' usages as simultaneously echoing and refuting clinical usage. Most informants fully acknowledge that anorexia is an illness which does exert some control over them. Yet, in their conceptualisations of when, and indeed whether, anorexia talks, informants articulate desires for, and ambivalence towards, anorexia without frequent recourse to binaries. To return in conclusion to Haraway, whom I cited in the introduction, I "do not seek partiality for its own sake, but for the sake of the connections and unexpected openings situated knowledges make possible" (Haraway 1991: 196). Through discussions of the interplays of illness and personhood, desire and ambivalence in informants' accounts, this chapter has begun to invite analysis of partiality and complexity. In so doing it has opened up potential spaces in which to explore subjectivities and practices that both constitute, and are constituted by, pro-anorexic desires, and has offered ways of addressing such desires as neither "just the anorexia talking" nor fully agential. As such, this chapter has laid the ground for the next one, *"Anorexia Won't Trick You Like Food Does:" Following the Many Threads of Pro-Anorexic Desire.*

Chapter Four *"Anorexia Won't Trick you Like Food Does:[100]"* **Following the Many Threads of Pro-Anorexic Desire**

"My hope was always that Catherine would overcome her anorexia and so, with her special knowledge, be able to help others, but she was trapped, trapped in a *maze* of agony and delusions."

Extract from Maureen Dunbar's Memoir of her daughter Catherine's life with, and death from, anorexia (1986: 10 – 11)

"The *maze* is in fact the best model for allowing moving bodies to pass through while at the same time retracing their steps as much as possible."

Michel Serres, 2008: 2

One afternoon during Snacks in the EDU's Dining Room, with her back rigid against the window bars, Chloe suddenly burst out:

"I'm not eating this shit again!"

Chloe, inpatient

Slamming her untouched doughnut onto the communal table so hard it disintegrated into a stodgy squash of jam and sugar, Chloe ran from the room. Because of the EDU's Peer-Pressure System, all of us in Snacks were asked by the nurse in charge that afternoon to leave our plates and file into the corridor "to support Chloe." Wide-eyed with the tension of being interrupted during their own doughnuts, the patients silently watched Chloe scream with frustration and smash her head repeatedly against the corridor walls. After some minutes, when Chloe's sobbing had abated, the nurse asked gently:

"Shall we go back in [to the Dining Room] Chloe? Do you think that you can eat now?"

---

[100] Quotation from a pro-anorexia website.

Chloe responded:

"Of course I can bloody eat, I just don't want to!"

Chloe then led the way back to the table and stuffed the doughnut into her mouth. Half swallowing, half gagging, she glanced around to meet the many eyes gazing at her before putting her face in her hands, where it stayed until the end of Snacks.

Afterwards, Chloe and I sat together in the Patients' Lounge. There Chloe expressed shame that she had, as she put it, "made such a spectacle of [her]self" but she reiterated the anger underlying it. Chloe lucidly argued that being made to eat against her will was "barbaric" when she had no wish to recover. Although she admitted that anorexia had "messed-up [her] life," ruining her relationships with friends and family, Chloe said:

"Anorexia is just the way I do things."

Chloe, inpatient

Having been in enforced treatment for some months, Chloe was now at a medically normal BMI. Pointing this out to me she said:

"I was always told that when I put on weight my thinking would change, that I'd suddenly want to get better. But I don't. I can't see any point in that at all. I'm just as anorexic now as I was… and I'm staying that way!"

Chloe

During fieldwork Chloe's discussions of wanting to keep her anorexia were echoed in the EDU by informants at various stages of treatment and recovery, as well as by pro-anorexia website participants. This similarity between field sites also extends further; I have argued in this thesis that pro-anorexia websites offer valuable glimpses into the not infrequent complexities of anorexics' subjectivities of their illness, in particular by revealing the ambivalence found in spaces that are ostensibly *pro*-anorexic. In the EDU too, interviews revealed that informants' desires for anorexia were often juxtaposed with, nestled in, and even constituted by, dislike of their illness. Now that the previous chapter has forged ways of addressing contradiction, partiality and overlap, this chapter will explore desire in

the context of pro-anorexia. By listening to informants' articulations of wanting to keep their existing anorexia, this chapter investigates what fuels and shapes their desires to hold onto the illness, whilst also recognising how anorexia may hold onto them. As such, the chapter not only explores *why* anorexia is valuable; conjoining the emphasis on practice in Chapter Two with that on voice in Chapter Three, I follow the myriad productions of that value through informants' accounts. This reveals desire to be both active and passive, doing and done to and it enables exploration of informants' ways of desiring and of the anorexia(s), selves and bodies these ways enact.

I suggested in Chapter One that addressing pro-anorexia requires a shift in vision away from the emaciated body to subjectivity. This focus is both central to, and yet challenged in, this chapter. Paying attention to subjectivity, João Biehl argues, "holds the potential to disturb and enlarge presumed understandings of what is socially possible and *desirable*" (Biehl 2010: 217 – *italics mine*). Situating itself in the present of those already diagnosed with anorexia, the chapter addresses the 'gap' between a past 'authentic self' and an imagined future recovery in which, according to the clinic, 'anorexia talks.' The difficulty of escaping this paradigm when thinking about desire has already emerged; my claim that Chloe "lucidly" railed against treatment may seem to clash with the description of her thrashing her head against the wall and binary notions of authenticity versus anorexia may once again seem seductive. However, as Emily Martin argues, "most of the tidy dichotomies that float in the wake of the separation between rational and irrational (sane/insane, controlled/uncontrolled, responsible/irresponsible, reasonable/unreasonable) are inadequate to the task of capturing complex experiences" (Martin 2007: 8). The challenge for this chapter is therefore to hold all elements of informants' articulations together without (re-)producing polarities and assumptions; I take up this task by reflecting on the *possibility* of desire.

Through the chapter's ethnography I question whether pro-anorexia and desire share a space; are they the same, different or overlapping? I ask if desire is a useful, adequate or, even, appropriate word to describe informants' articulations of wanting anorexia. Does thinking of pro-anorexia as a desire take account of aspects of subjectivity left out by binary notions of anorexia talking? Or, is desire a term that insinuates *too much* possibility? It perhaps takes too little account of the very

lack of possibility engendered by living with a psychiatric illness that may be "not under conscious or wilful control" (Treasure et al. 2007: 19). I explore anorexia as "something both animated and inhabitable" (Stewart 2007: 2), which is shaped by, and shapes, informants' subjectivities and possibilities of experience. This permits discussions of desire as undesired and how want slips into need without these narratives disallowing others to share their space. As such, I keep in mind an image offered by one informant, Eva, who described her anorexia as a "maze." Simultaneously encapsulated by the term 'maze' are entrapment and closure, but also "lines of flight" (Deleuze & Guattari 2004) and possibility. It is these juxtapositions that the chapter addresses.

Part One explores informants' friendships with anorexia; it follows the threads of desire which lead from and to these existing relationships of belonging, which many informants describe as central to their wish to maintain anorexia. I ask how informants "move across those relationships, where [they] can and cannot invest, where [they] can stop/rest and where [they] can move and make new connections, what matters and in what ways" (Grossberg 2010: 313). I explore how agency and, even, personhood are shared with anorexia and how this balance centrally underwrites friendship. Informants suggest that anorexia "helps" them by 'coming out' to take control of aspects of their lives and/or selves when needed. Instead of contradicting informants' conceptualisations of anorexia as a part of them that has 'always' been there, heard in the last chapter, friendship comprises a dual temporality in which an existing or past relationship with anorexia produces friendship in the present and is reproduced by it. Furthermore, holding onto one's anorexia is at once both static and mobile; it *requires* a constant active reciprocity towards anorexia on the part of informants. This interplay of stillness and dynamism reveals that the model of desire which emerges in pro-anorexia is simultaneously productive and also a response to (sometimes projected) lack; these manifestations are, I suggest, co-constitutive. Engaging with the sense that "desire is something that is mobile in character, shifting and displacing itself, never easily pinned down" (Law & Moser 1999: 249), this half ends with a discussion of how desires can be both desired and undesired. In response to undesired desire, it will be seen that informants self-produce alternative desire for anorexia within themselves. This

process ambiguates anorexia's agency and reinstates its friendship. Thus, not only is ambivalence often engendered by the same aspects of anorexia as desire, but also, informants continue to desire anorexia after becoming ambivalent towards it.

However, **Part Two** focuses more intricately on what happens to pro-anorexic desire when anorexia reveals its 'undesirable' aspects over time. Anorexia's agency, which underscored friendship earlier, now undermines it; where informants were, or at least seemed to be, the centre of agency, even if they shared this with anorexia, in Part One, this half of the chapter explores a pervasive loss of agency both to anorexia and, also, to food. Part One has shown that anorexia's friendship engenders "hard-won attachments that can be hard to get out of once you're in" (Stewart 2010 A: 7). Part Two explores how these both contribute to, but also cut across, illness progression. It becomes clear that it is because of the precariousness of anorexia's friendship that this relationship is so worked at by informants. This realisation lends the chapter a shadow-structure of circularity in which each half follows the other and both reveal the creative and circular triangulations of pasts, futures and presents in informants' accounts. These temporalities are particularly clear when unpacking anorexia's entrapment. I explore how informants improvise to reconfigure being trapped in anorexia as desirable. However, when such improvisations reach their limits of possibility and anorexia is deemed too difficult to live with/in, informants also rupture existing relationships with anorexia, creating new ones in the present and past. Some agentially produce anorexia by harnessing the other agent in relation to which they experience a loss of agency - food; they pit the agencies of food and anorexia against each other. Others discursively dis-assemble anorexia into elements, leaving those that are unwanted outside its boundaries, thereby performing alternative desirable anorexia(s). All these processes allow, albeit temporarily, the illness to remain in a valued relationship with informants' personhood despite the suffering it causes. They also dispel any assumptions we might have held regarding relationships between anorexia(s) and bodies, which will be further explored in the next chapter.

In terms of the thesis's central themes, if Chapter Two set out the case for **an analytical focus on subjectivity and materialities rather than emaciation and visuality** to explore anorexia, it is the current chapter that most acts upon

this suggestion. It does this by engaging with **intersections of desire and ambivalence in pro-anorexia** with the aim of forging new ways to address **relationships between personhood, agency and illness.**

Part One   Relationality: Holding Onto What One Is and Has

1: A   Friendship: (Re-)Productions of Desire through Relationality

1: A. 1   "My Friend Anorexia:" Personhood, Shared Agency & "Help"

Informants in both field sites offered friendship with anorexia as the first, and often *the,* reason why they wanted to maintain, and sometimes enhance, anorexia. Anorexia's friendship was described variously:

"It's been a friend to me for a long time."

Tara, inpatient

"With anorexia I'm not alone."

Miriam, inpatient

"It's a friend, definitely a friend. It keeps me company… and it helps me…you know? It does help me."

Laurie,   inpatient

"It sort of stuck by me and helped and that's my idea of what a friend would do."

Kyra, Facebook Pro-Anorexia Research Group participant,

interviewed online

Descriptions of anorexia as a friend amongst anorexics in treatment have been noted in literatures from the anthropological (Warin 2006) to the psychological.[101] Likewise, a study of pro-anorexia websites states that anorexia "is often described as a 'special friend'" on the sites (Ferreday 2003: 283). If not always explicitly called a 'friend,' discussions of "my relationship with anorexia" (Bowman 2007 B: 64[102]) also abound in autobiographical accounts and memoirs of anorexia. In her memoir, Nikki Grahame recounts:

---

[101]cf. Colton & Pistrang 2004; Serpell et al. 1999; Williams & Reid 2009.
[102] Also, Lipinski 2007.

"Anorexia was my best friend, my only friend"

To comprehend informants' narratives of 'wanting anorexia' this relationality requires exploration. Not only do accounts of friendship illustrate that relationships between informants and their illness engender pro-anorexic desire, they also show how this desire is remade within friendship's mechanisms. By tracing contours of desire through friendship, this chapter begins where the last one ended. Discussing informants' uses of "that's the anorexia talking," I suggested that anthropological approaches to spirit possession aid our understanding of an invited alterity within the self; these discussions problematized notions of self and other enacted by clinical uses of the phrase, which, I argued, rest on more linearly binary delineations of inner/outer, self/other. Lia's account of anorexia acting for her when she spilt her milk and refused to drink the overfilled replacement is echoed now by Cally. Here Cally also describes anorexia as acting but, she says, it does this because it is a friend.

On admission to the EDU Cally had recently separated from her husband and was seeking a divorce. One November evening, perched on the cold concrete of the back steps in the preternatural glare of security floodlights, Cally expressed frustration at the staff team's attitude to her marriage breakup. This she compared to anorexia's "reliability" to be there when, as she put it, "I need it." Cally recounted having been "coerced" into meeting her husband with her nursing team present. She described how during this meeting the team had agreed with her husband that Cally's "anorexia had made [her] leave him" - that it had been talking. Cally was incensed that the EDU staff accepted his version of events. She, in contrast, saw her marriage as having caused her illness because it had long been unhappy. In evidence, Cally recounted how on the day she left she went to buy food thinking to herself, "now I can start getting better." Until then, she said, she had not wanted to recover as anorexia was her "only ally." Cally said that this alliance was revived by the "awful meeting" on the EDU. She described feeling "trapped," "ignored" and "backed into a corner," made to go through the motions to save a "dead marriage." Thus, anorexia came back to help her through. Cally said:

> "In that session I was so anorexic…so anorexic! I could feel it coming. But it was there so I didn't have to be… like a friend would be. It just took over."
>
> *Cally, inpatient*

She continued:

> "I shouted and screamed. I must have seemed mad! I don't know what they thought of me…. Well, I do, they just thought it was the anorexia talking. They didn't know what to do with me. It was the anorexia. It helped me. I was more anorexic there than anywhere else."
>
> *Cally*

Here Cally rejects both her husband's claim that anorexia made the decision to divorce him and that it was 'just the anorexia talking' (as staff conceived it) during the meeting. Yet, she also says that anorexia "just took over" and that the screaming "*was* the anorexia." As such Cally, like informants in the previous chapter, fractures a clinical conceptualisation of anorexia talking, to embrace or reject it at different times. This again evinces the necessity of an ethnographic vision of anorexia that goes beyond antinomies. Moving beyond the last chapter's focus now, Cally also, importantly, suggests that it is precisely because she can relinquish control, and even her whole public presence, when she needs to that she sees anorexia as a friend. Anorexia and self in Cally's narrative emerge as simultaneously fixed but mobile – imbricated but also fluid; each moves around a fixed point of contact with agency dissipated and exchanged along their connecting thread. Moreover, Cally felt her anorexia to be particularly "present" and "strong" during the sessions because her desire for it was. In this correlation not only are desire and anorexia co-extensive but so too are anorexia and personhood; their overlaid boundaries, within which agency is shared, underscore a conceptualisation of friendship as a desired relinquishing of agency. In her interview, Shanice echoed Cally's words:

> "The first thing that comes to my mind about anorexia is it's like a friend. It's like sort of… I dunno… yeah, more of a person rather than an illness. It's more of a friend, a close friend, rather than having an illness. Because, when it came along I was going through a really bad time and I was feeling

quite depressed and it just sort of came along and rescued me in a way. It's always there for me. It doesn't abandon me, when the going gets tough. It'll always step in for me in a fight."

Shanice, inpatient

In Cally and Shanice's narratives agency is mobile, episodically flowing between self to other. But, some informants described anorexia as a constant companion to which agency over *particular* things is *always* given. Its desirability and, paradoxically, its lack of threat arise from this continuity.

Michelle described how anorexia helped her:

"One of the things that my anorexia is about is feeling overwhelmed by life and the world. It really helps me by limiting choices and it helps me keep control"

Michelle, inpatient

Likewise, recounting how "anorexia holds my hand," Jumela said:

"Speaking as someone with anorexia, I can say that anorexia is in no way connected to wanting to look like models or movie stars. Ana provides the only way I can find of holding some control over my life. It's a disease not a fashion statement."

Jumela, Pro-Anorexia Research Group participant,
interviewed online

In many informants' accounts, being helped out and 'having one's hand held' by anorexia on a more than episodic basis was most associated with anorexia's blanking of emotion, which I also touched on in Chapters One and Three. As noted in Chapter One, this "use of anorexia nervosa to avoid dealing with other problems" (Cockell et al. 2002: 77) has been widely discussed in psychiatric and psychological literatures. However, that handing control to anorexia to 'look after' one's emotions both ensues from and also re-enacts anorexia's friendship is hardly recognised at all.

In her interview, Elle said:

"It sort of helps to relieve feelings and stuff. It does its stuff so I don't have to feel them."

Elle, inpatient

Likewise, Claudine described anorexia's blanking of emotion:

"It's like you're telling yourself to shut up. So you don't eat and it shuts up… for a bit anyway."

Claudine, inpatient

Another informant, Charlene, described having gone through a time before treatment when she was plagued by many debilitating panic attacks a day. About these she said:

"You know, I can cope with one, two, three a day, whatever, but not constantly all day long because then there wasn't any point in having a life because I had to keep cancelling all my friends, I couldn't get through the day at work. The only thing that I know that numbs all that down, and works brilliantly, is not eating. It works, which is why I didn't want to give it up… even though it's horrible in its own right. I suppose it's like taking a medication that has zillions of side effects but it's still better than what you're taking it for."

Charlene, inpatient

Charlene here conceptualises anorexia as something that helps her to be other to her panic attacks; it removes them, allowing her to be(come) herself. As such, Charlene externalises and absents herself from the panic attacks, perhaps by melding herself with a contextually external anorexia. This leaves emotion inhabiting a tensely liminal position; it is at once both disposed of and yet also locked 'inside' in informants' accounts. Notions of inside and outside are once again blurred and mobile. There is an echo of the clinic's notions of authenticity here but, importantly, one's 'authentic self' in Charlene's narratives is not who one is without anorexia but rather who one can be with anorexia's help – a self *through* anorexia. The illness emerges as both something that agentially mediates and makes

informants' everyday lives, and also which 'allows' them to make their own everyday lives 'through' it. As such, being good at anorexia, thereby maintaining this possibility of an alternative everyday life, takes on, as we will see later, a sense of necessity for informants.

Thus, we have seen in this section that informants externalise anorexia not as an enactment of disconnection, but rather of connection; this mirrors and ruptures clinical paradigms of externalisation in the last chapter. Here, by locating anorexia beyond the bounds of selves and bodies in a self-created 'public' space, informants give anorexia, to draw again on Taylor's discussions of selves (Taylor 1989), its own symbolic personhood - a position from which it can "help." Just as alterity was discussed as a condition of selfhood in the last chapter, here friendship signifies a claiming of anorexia not as a part of self, as such, but rather as intrinsic to self. Friendship with anorexia is both inter- and intra-subjective; it reaches outwards and yet also encloses and constitutes the self, evincing, to borrow from Michael Jackson, "intersubjective fusion" (Jackson 2002: 340). Intersubjectivity, Jackson argues, comprises "the ways in which selfhood emerges and is negotiated in a field of interpersonal relations, as a mode of being in the world" (Jackson 1998: 28) but it also "embraces centripetal and contrifugal forces, and constructive and destructive extremes" (ibid. 4), thereby being always ambiguous. Matei Candea has recently argued that anthropology's discussions of relationality could be enriched by ideas of "mutual possession" in Gabriel Tarde's work (Candea 2010; Tarde 1999). This, like that of later theorists of networks, highlights "the relational constitution of entities" (Candea 2010: 125) and how "every question of possession leads to another question of possession" (Candea 2010: 126), which offers a way of talking about the ambiguity of belonging to anorexia. Like Candea, Deleuze and Guattari (2004) and Latour (2002) have also returned to Tarde. Latour, discussing how Tarde foreshadowed actor-network theory, suggests that for him "a brain, a mind, a soul, a body is itself composed of myriad 'little persons,' or agencies, each of them endowed with faith and desire, and actively promoting one's total version of the world" (Latour 2002: 119). Yet, although recognising multiplicities of agency is important, we also need to acknowledge tensions around this multiplicity in informants' accounts. I asked Nora, a participant to the *Facebook* group, why she

used an online pseudonym that, like those of some other informants, was a version of *Ana.* She replied:

> "It's kind of like your alter ego... it's something you don't want your regular facebook page friends to know."
>
> *Nora, Facebook Pro-Anorexia Research Group participant,*
> *interviewed online*

Whilst highlighting the shame with which many informants viewed their anorexia, as previously noted, Nora also said it was "nice" to become this alter-ego; there is a sense of partiality and also fluidity here. In this latter, Nora's interview also foregrounds a tension that has simmered under this first section. Anorexia's 'coming out' and informants' becoming self and/or other in these accounts of friendship have evinced dynamism and mobility that might seem at odds with narratives of having always been anorexic offered in the last chapter. The next section will explore this tension.

1: A. 2   Temporalities of Friendship: Desire in the Present & Past

In her interview Gillian put her conceptualisation of anorexia as a friend in context. She said:

> "The reason you develop food issues changes as you go through life. Because when you're eleven it might be because, you know, you're scared of growing up for example, though that wasn't my reason… but you know, that might be a reason…I guess. When you're fifteen it's because of exam pressure, when you're eighteen it's because you met some horrible guy in the street who did something nasty, when you're thirty… so it changes. But now it's very linked to quality for me… how I cope when my quality of life is shit. It's helpful."
>
> *Gillian, inpatient*

Here Gillian not only links anorexia's "help" to friendship, as we have already seen, she also de-links anorexia's initial onset from the many recurrences/relapses of anorexia throughout her life. Gillian also dislocates all of these multiple onsets from

why she *values* anorexia *now*. As such, not only is the initial onset of illness not linked to anorexia's value, each life event that has caused Gillian to turn to anorexia thereafter is also not given as a cause of present value. And yet, Gillian turns to anorexia every time, she told me, because of her existing relationship with anorexia which was formed and re-formed by each of these previous occurrences; the precipitators change, the relationship remains. There is circularity here; by helping her get by in this day-by-day way, Gillian's sense of anorexia's friendship is continually reaffirmed and anorexia is also re-invested with value. As such, echoing discussions of practices enacted by informants to make themselves good anorexics in Chapter Two, which emphasised unfinishedness and process, the relationship between informants and anorexia is perpetually unfinished and mobile. And, desire is made and remade within the present, entangled in and constituted by this relationality.

Therefore, in contrast to the model of personhood enacted by clinical uses of "that's the anorexia talking," which arguably framed both acquiring and recovering from anorexia as singular events in a particular order, there is not a three-step teleology of before, during and after anorexia in informants' accounts. Rather, informants' subjectivities both of anorexia emerging and disappearing in the present, and of partiality in which anorexia controls particular aspects of personhood but not others, suggest there to be befores, afters and durings all within anorexia and between anorexia and self. Demonstrating the distinctness of a desire emanating from outside anorexia to one articulated by informants who are already ill, this model of desire as an on-going process designates the present as "the locus of reality" (Mead 1932) to be explored. To return briefly to Mead's writings on the self on which I drew in Chapter Two, Mead argued that there is "a certain temporal process going on in experience" (ibid. 13). In this, "a self emerges from the dynamic interplay of present, past, and future….Far from being the static and structural entity that is so often depicted, the self is more accurately understood as a momentary stance toward past and future events" (Flaherty & Fine 2001: 157). Thinking about how desire is continually remade in the present has thus introduced a kind of dynamic ontology in which desire – and arguably, selves and anorexia(s) too - are unfinished. Although this clearly fits with discussions of practice and process in Chapter Two on the one hand, it might seem, on the other,

to sit uneasily with notions of anorexia as "constant" in this section and innate/permanent in Chapter Three. However, rather than dismissing this seeming dichotomy as inconvenient contradiction, addressing it reveals it to be of paramount importance to understanding the mechanisms of pro-anorexic desire, as simultaneously fixed and mobile.

Echoing Chloe in the introduction, Kate said:

> "Anorexia's mine. It's just mine. I just think: 'I don't want to share this with you' and you know, it's my little… it's me. It's how I do things. You do it quietly, you do it on your own."
>
> *Kate, Inpatient*

In her memoir of anorexia Nikki Grahame writes:

> "I think maybe it was something that I was born with and that I would have become anorexic at some point in my life."
>
> *Grahame 2009: 309*

And in her interview Bella said:

> "I suppose that it's… it's a part of me that's developed through different stresses in different times… I suppose it's gradually got stronger as… as I grew up. Like any part of you, different parts of you change as you grow up."
>
> *Bella, inpatient*

In her interview Eva described anorexia as so much a part of her that:

> "If a doctor took a scalpel and tried to cut him [anorexia] out, he'd just leave his shoelaces behind anyway."
>
> *Eva, inpatient*

Yet, Eva too layered this permanence with a description of anorexia arising both when she first needed it and episodically thereafter by saying:

> "I've always been anorexic. It just hadn't come out yet and when I needed it, it came out…. and it still does… I mean, every time."

Eva

Eva, echoing the tri-temporalities seen so far - of anorexia being permanent as well as both constant and episodic in the present - suggests that anorexia 'comes out' to help *because* it is *already* a friend. Eva argues that because it is an intrinsic part of her, anorexia is *obviously* a friend. To borrow a phrase that words it better than I can, after – and, importantly, *during* - each of anorexia's appearances, Eva has been "never quite the same but that was nothing new" (Beckett 1986: 390 '*That Time*'). Each time that it helps her, not only is Eva's friendship confirmed and remade, but the past is also reshaped and friendship is thereby produced in both temporalities at once; this 'finishes' the past, rendering it static in relation to coming and going in the present. By creeping backwards into the past, stilling and solidifying linkages, anorexia's friendship also arguably remakes Eva's personhood as desirably 'anorexic,' banishing any notion of becoming anorexic as a one moment singular occurrence. This "reseeing the past," as Anselm Strauss puts it, (Strauss 1997: 69) illustrates that a sense of anorexia's permanence is no more dichotomous with anorexia's ebbing and flowing in the present than anorexia as other *and* self is. In both cases, each constitutes the other. The next section will trace the concomitant stasis and mobility introduced in this section through informants' practices to resist recovery. These comprise the stasis of holding onto one's anorexia *and* oneself, and also the perpetual motion of actively 'looking after' one's friend. This interplay presents us with a particularly nuanced image of pro-anorexic desire.

1: B   Friendship, Treatment & Ambivalence
1: B. 1   Resisting Recovery as Protecting One's Friend

During a fraught Cooking Group, seeing Milla struggling with choosing and cooking her food, another inpatient, Hadia, reassured her:

> "The more you do it, the easier it'll get."

Milla replied emphatically:

"I don't want it to get any easier!"

As well as evoking notions of struggle abundant in the field, as discussed in Chapter Two, this exchange resonates with loss. In her interview Milla described her horror at discovering that things which, as she put it, "aren't supposed to be ok," like eating, had become easier. This, she said, meant that not only was she no longer a good anorexic but also that anorexia was "going away." Milla's words suggest there to be a dual loss in recovery - of herself and of her friend. That many informants experience a loss of self in recovery was particularly apparent in Kate's interview. She described hating therapies such as CBT and MET because:

> "I don't want to open myself up because I don't want people to be able to get…to get to me, if you know what I mean? If I keep it [anorexia] secret, they can't get to me either."
>
> *Kate, inpatient*

Kate's words are reminiscent of cultural theorist Lauren Berlant's discussion of desire as "cruel optimism" (Berlant 2010). Berlant suggests that when describing something we desire, "we are really talking about a cluster of promises we want someone or something to make to us and make possible for us" (ibid. 93). Borrowing from Berlant, we could say that anorexia as the object of Kate's desire "provides something of the continuity of the subject's sense of what it means to keep on living on and to look forward to being in the world" (ibid. 94). Thus, it is clear how recovery "may appear terrifying" (Treasure 1997: 45). Moreover, inside this subjectivity of loss is also ensconced the second element of Milla's narrative above, that recovery means losing one's friend. In interviews wanting to 'feel better,' cause less pain to family members or leave the EDU, for example, was frequently accompanied by a palpable fear of losing a deeply valued relationship. In response to my question regarding why she had told me she wanted to stay anorexic, Elle said:

> "I just don't want to be without it; it's as simple as that really."
>
> *Elle, inpatient*

Likewise, Shanice said:

> "Sometimes I just want to give up treatment now and I don't want to let it [anorexia] go. That motivation isn't there and I think that I'd be better with it than without it. And I think, sort of like….oh my God, what am I going to do if it's not there?…I'm going to be all alone."

Shanice, inpatient

That we cannot dislocate informants' desires for anorexia from their subjectivities of relatedness, or relational subjectivities, challenges conceptualisations of desire as engendered by lack, common in psychoanalysis (cf. Lacan 2001). Rather, accounts of holding onto an existing relationship evoke a vision of desire more in line with that proposed by Deleuze and Guattari (2004; and, Deleuze 2007), extended and challenged by Grosz (1994). Grosz writes, "while psychoanalysis relies on a notion of desire as a lack, an absence that strives to be filled through the attainment of an impossible object, desire can instead be seen as what produces, what connects" (Grosz 1994: 165). As such, she states, "desire does not take for itself a particular object whose attainment it requires; rather it aims at nothing above its own proliferation or self-expansion" (ibid. 165). Likewise, in her discussions of desire, informed by both Deleuze and Grosz, Probyn suggests that it is "the slip between being and longing, that we paste over, that we search to avoid when we erect an edifice of communication based in lack" (Probyn 1996: 44). Instead, desire "produces the pleats and folds which constitute the social surfaces we live" (ibid. 13). Echoing my discussion of temporalities above, these conceptualisations of desire have an intriguing relationship to pro-anorexia; to return to Deleuze, he writes, "desire is a process, as opposed to a structure of genesis" (Deleuze 2007: 130). Holding onto anorexia, as described by informants above, lends to desire a sense of stasis. But, there is also movement and process to the inter-subjectivity of 'friendship.' These are apparent in the practices undertaken by informants to resist recovery. Conceptualised by informants as 'looking after' anorexia, these illustrate that 'holding on' is an active subject position.

On pro-anorexia websites there are many *Tricks*, often jumbled with the *Tips* discussed in Chapter Two. *Tricks* comprise advice on how to conceal and thereby 'get away with' one's eating disorder. They advocate hiding both behaviours such as

starving and purging and also the effects that such behaviour have on the body, such as emaciation and pallor. *Tricks* thus range from behavioural advice:

> "Leave a dirty plate lying around at home so everybody thinks you've eaten."

> "Drink out of opaque cups and spit your food into it while pretending to drink."

To advice on appearances:

> "Wear make-up and paint nails to hide colour and complexion changes and shave any languo [sic[103]]."

Tricks on pro-anorexia websites

I noted in Chapter Two the role concealment plays in modalities of being a good anorexic. Now, Bella illuminates how concealment is also a way of 'looking after' one's 'friend.' In so doing, she frames this protection of relationality as part of being a good anorexic, illustrating the inter- as well as intra-subjective aspects of being good at anorexia.

During her interview on a bench in the sunny grounds of the EDU Bella began to talk animatedly about another patient. Although I felt uneasy, under the guidelines I had set myself of the open informant-led nature of my interviews, I did not stop her talking. The patient in question had recently worn an asymmetric tee-shirt that revealed the extreme thinness of her shoulders. Echoing Chapter Two's discussions of the gaze and competition, I admit that I had already pondered why she had chosen a top that revealed her bones. But I chastised myself in my fieldwork diary for making assumptions: perhaps I was attributing 'anorexic' motives to a choice that was, in fact, related to her extensive interest in clothes, an interest over which we frequently bonded. Yet, in response to turning her own gaze on this off-the-shoulder tee-shirt, Bella firmly stated:

---

[103] This should read "lanugo," which is the downy hair that grows all over the body as a result of emaciation.

"Good anorexics hide their anorexia."

<div align="right">*Bella, inpatient*</div>

I questioned Bella's statement as I thought that the patient's particularly 'spectacular' thinness would make her a good anorexic? Bella responded that although the other patient's emaciation did make her a *visibly* 'good anorexic,' it also unmade her. Bella argued that in revealing the extent of her thinness, the other patient was leaving her anorexia too visible and, as she put it, "too *vulnerable*;" a good anorexic, she said, would not be so careless with something so valuable, but would, "hide it to look after it." Bella's notion of anorexia's vulnerability is intriguing; it suggests that hiding one's anorexia is an active modality of looking after one's friend. And yet, in this dynamic of holding onto and protecting anorexia, we cannot entirely rid ourselves of an idea that desire is formed by lack, especially at these intersections of pro-anorexia and treatment; I turn to Elle, to explore this.

When expressing annoyance at being told her anorexia was talking in the EDU, Elle discussed how clinical uses of this phrase frame informants as deceitful, as noted in the last chapter. Elle did not deny this deceit; describing becoming increasingly secretive about her anorexia, "cleverer at hiding food," and lying, Elle said:

> "So, you go from saying 'no, I didn't eat, what are you going to do about it?' to, 'how do you know I didn't eat? Of course I did!' Deception comes as you become desperate to hold onto it. You don't let anyone see what you're doing in case they stop you."

<div align="right">*Elle, inpatient*</div>

However, contextualising this deceit as protecting her anorexia, Elle argued that she lied not only to resist treatment interventions that would try to "take away [her] anorexia," but also in response to her own feelings of ambivalence towards anorexia, which treatment engendered.

Elle described how staff in the EDU worked to increase her ambivalence towards anorexia, through MET and OT, as discussed in the last chapter. But, Elle argued that this work made her try harder to look after her anorexia. Treatment, she said, had shown her how harmful and hateful anorexia is, but in so doing it had also trapped her; it had disallowed her own rosy vision of, and friendship with,

anorexia to continue but had not removed her desire for it. Elle was thus, she said, "stuck" - left behind by her friend but not fully able to engage with treatment either. Unwilling to relinquish either her long-established desire for anorexia or her new-found ambivalence towards it, Elle recalled feeling guilty about her realisation that anorexia was, as she put it "not such a good friend after all." She felt that this was "the wrong thing to think." There is a sense here that anorexia is *making* Elle think this is the "wrong thing" in order to re-establish the friendship *it* has *with Elle* and Elle herself pointed this out. But, this realisation made Elle want to 'get back to' a less ambiguous, more 'friendly' anorexia. She decided that the best way to overcome her ambivalence was not to distance herself from the aspects of anorexia that she now realised were, as she put it "hateful." Instead, Elle attempted to re-establish her relationship with anorexia by pressing herself further into it. Echoing Stewart's claim about the self that "forms of attention and attachment keep it moving" (Stewart 2007: 58), as Elle's 'friendly' anorexia disappeared, she followed it to re-establish her belonging to it, attempting to make herself more anorexic. Elle's practices to resist treatment and recovery did not only hide, and thereby protect, anorexia as a part of friendship, like Bella's. They also actively made and re-made that friendship. But, it is her subjectivity of real or imagined lack that makes Elle reproduce friendship here.

Elle's projected lack resonates with Berlant's claim that desire can be "an attachment to a problematic object in advance of its loss." (Berlant 2010: 94). She argues, "one makes affective bargains about the costliness of one's attachments, usually unconscious ones, most of which keep one in proximity to the scene of desire or attrition" (Berlant 2010: 94). Elle fills a lack as (or even before) it comes into existence, continually approximating herself to a newly precarious anorexia. Here, desire is simultaneously both a response to lack and also the "lines of connection and communication between beings, ways of being, and things" (Probyn 1996: 42). Moreover, because it is the lack caused by her own ambivalence that mobilises and even, strengthens Elle's pro-anorexic desire, here desire and ambivalence do not just exist together, they move together. With this in mind, the next section will look further at this re-invigorated sense of desire as formed by lack, exploring how the "intensities" (Deleuze & Guattari 2004; Deleuze 2007) of anorexia's friendship produce lack.

1: B. 2   Mutual Productions of Intensity & Lack: Anorexia's Cycles of Desire

In her interview Leila said about anorexia:

"Well, it helps you so you help it."

Leila, inpatient

For Leila, reciprocity makes her relationship with anorexia a friendship. This reminds us that as well as "a profoundly affective manner of being, always performed with the experience of being within and in-between sets of social relations" (Probyn 1996: 13), belonging also comprises "involvement and investment" (Grossberg 2000: 154) and is "a production" (ibid. 154). Given the complex configurations of agency that underpin friendship, this is particularly interesting; the reciprocity of looking after her anorexia renders Leila's pro-anorexia agential and chosen - or at least, it allows her to articulate it as such – by locating agency on each side of the relationship. However, in a paragraph detailing why anorexia's friendship is "better than anyone else's" the figure of *Ana* asks on a pro-anorexia website:

"Who is always there for you? Who else would hold back your hair when you are sick?"

"I follow you throughout the day"

"You are mine and mine alone. Do not fight back"

In the same letter, *Ana* also says:

"I will invest a lot of time in you, and I expect the same from you. I am your only friend, and I am the only one you need to please."

Extracts from a Letter from 'Ana' on a pro-anorexia website

Here, *Ana* not only provides friendship, she also *demands* it back. Such elements of pro-anorexia websites are a valuable glimpse into the ambiguities surrounding anorexia's friendship and, moreover, into informants' enactments to look after it. In contrast to Leila's agential 'helping' of anorexia, these excerpts suggest that informants *need* to look after anorexia so that it will continue to look after them. This melds desire and need, but also suggests that "desires and subjectivities are not given, but rather arise in specific material and corporeal relations" (Law and Moser 1999: 249); they "are made or unmade in the places between the human and the non-human" (ibid. 249) at the multiple interfaces of treatment, personhood and illness. The desire for anorexia's continuing friendship both produces and responds to a potential lack that arises within the mechanisms of that friendship. It is also quelled, encouraged or shifted by informants' experiences of being in, often enforced, treatment. We could say, following Deleuze again, that it is precisely the "intensities" (Deleuze & Guattari 2004; Deleuze 2007) of anorexia's friendship, particularly in difficult circumstances, that produce lack, whether that is projected or experienced. To maintain these "intensities," thus, there is a burgeoning sense of brokering an uncomfortable deal with anorexia in which, perhaps, "the self moves to react, often pulling itself someplace it didn't exactly intend to go" (Stewart 2006: 79); in this not only does anorexia belong to informants, informants, perhaps, also belong to anorexia. This brokering is particularly apparent when we turn to anorexia's production of its own lack.

Anorexia's own production of a lack that only it can fill was particularly related by informants to how it helps with emotions, discussed earlier as one of the bases of friendship. In her interview, Kate said:

> "If you silence the emotions that's when it gets really hard because the way of keeping them down and coping is not to eat but you can't do that because if you keep them down and you're still eating, you mess up. You mess up."

> *Kate, inpatient*

Treasure and Ward describe how anorexics "may develop emotional fireworks after years in frozen isolation" (Treasure & Ward 1997: 107). Like many informants, Kate felt that she had to continue to be a "good anorexic" and not be unmade by

eating – where unmade here takes on a depth only skimmed over in Chapter Two relating to her whole sense of self. Kate's awareness of the potential "fireworks" engendered by treatment instigates a dualism; she holds onto anorexia in the face of threat but, as such, it also holds onto her by being at once both the condition and effect of her distress. Anorexia thus sets up a cycle of "intensities" and lack, with each engendering the other, in which anorexia is at once remedy and poison, filling only the lack that it creates and *making* you follow it.

Describing how anorexia allowed her moments of calm in which she could forget the pain that various life events had caused her, Claudine said:

> "You just sit there and sometimes it manifests itself in a sort of numbness and I'll just lie on my bed, stare into space and I'll sleep a lot or something like that. I just want to stop thinking and you do almost, zone out as it were."

Claudine, inpatient

But, Claudine's smile disappeared when she described how much pain anorexia itself had also caused her. Sometimes on the EDU she was rendered so distraught by having to eat or talk about recovery, for example, that she would repeatedly smash her fist into her head and scratch her face. Discussing this self-harm in her interview, Claudine said:

> "Because that's the physical side of you the pain doesn't almost… almost doesn't matter because you've got this mental bit of you and the physical bit of you and you can hurt yourself so much but that pain just doesn't compare to anything like the pain in your head."

Claudine

But the "pain in [her] head," Claudine was clear, is *also* anorexia. Claudine described using anorexia as a way of attenuating anorexia itself; not eating gives rise to alternative pain which Claudine controls by not eating – over and over. As such, anorexia is simultaneously both the condition and effect of Claudine's distress. It produces informants' need for it, paradoxically, precisely by being so hateful. About this cycle Abigail said:

"…it's [treatment] like having an anaesthetised limb cut off. It's better to keep it anaesthetised so it doesn't hurt. That's why people continue to be anorexic…so they can remain anaesthetised. "

Abigail, inpatient

In Chapter Two's discussion of being a good anorexic, I mentioned Plato's pharmakon (Plato 2005; Derrida 2004). Here we see that anorexia itself is a pharmakon; it is not only both remedy and poison, but, importantly, remedy for its own poison. There is a sense in Abigail's interview that anorexia is *not quite good enough* at dampening her distress; having a permanently anaesthetised leg is not a functional solution. This image therefore illustrates the acknowledgment which pervaded Abigail's interview as a whole that for anorexia to work in overcoming damage and pain, she has to stay in an alternative damaged and painful state. She must refuse herself, and also re-fuse herself with, anorexia. However, although one might assume that these coercive mechanisms of friendship might mire that friendship in ambivalence, this is not the full story.

One of the *Tips* that I encountered on pro-anorexia websites a few times during fieldwork suggested that if participants feel their resolve to be good anorexics flagging, they should:

"Trick yourself into believing your life sucks."

Tip found on pro-anorexia websites

Enmeshed in both the widespread use of anorexia to quell emotion and the dynamic reciprocity of anorexia, so far discussed, this *Tip* is intriguing. In this reclaiming of lack as a part of pro-anorexia, we see that not only do ambivalence and ambiguity not replace desire, but also that desire itself can be produced. Hence, what has been emerging in these last two sections is a dislocation of desire and anorexia. Whereas in her narrative at the beginning of the chapter, Cally felt her anorexia to be strong because her desire for it was, this correlation has broken; here there is a sense that desire for anorexia can itself be both desired and undesired. I suggest that not only did Elle, above, want anorexia, but she *wanted to want* anorexia – and equally perhaps wanted to *not want* anorexia. This latter echoes the discussions of ambivalence in Chapter Two; there informants *wanted to not want* to be good anorexics. The next section will explore undesired desire,

looking at how wanting to want and wanting to not want anorexia are related to each other. Charting informants' co-opting of notions of authenticity to conceptualise 'the anorexia desiring,' will reveal that informants split desires into desired and undesired and also how they agentially self-trigger the former to overcome the latter. Recognising that desire can be produced does not contradict notions of desire as undesired; this production is, rather, a response to undesired desire which serves to ambiguate anorexia's agency and reinstate its friendship. In refusing some desires as not their own, informants re-fuse themselves with both anorexia *and* desire.

1: B. 3   Complexities of Friendship: (Un)Desired Desires

In her interview Kyra said:

> "My anorexia is going through hell as I am doing things not done in 17 years like not weighing and measuring food eg. fruit, cereal, milk, ice cream, cream - not calorie counting - tho it is hard to not be aware."

> *Kyra, Facebook Pro-Anorexia Research Group participant,*
> *interviewed online*

Likewise, Leila said:

> "You know some things you want are just really what anorexia wants."

> *Leila, inpatient*

Shedding an alternative light on the thesis's discussions of anorexia's agency, Leila and Kyra discuss anorexia's *desire*; anorexia "wants" informants to do certain things, "go[ing] through hell" when they do not. Informants in both field sites echoed Kyra and Leila's words and a notion of anorexia desiring was also present in the *Letters from Ana,* as seen above. But, before we rush into assuming that 'the anorexia desiring' means pro-anorexic desire as a whole is not 'authentic' or agential in some sort of absolute sense, we need to look closer; a notion of anorexia desiring cannot be dislocated from the friendship that has informed discussion so far. I found during fieldwork that not only did many informants not frame all pro-anorexic desire as 'the anorexia desiring,' they also actively produced alternative pro-anorexic desire in themselves to claim desire back from anorexia. I return to informants'

relationships with *thinspirational* texts such as memoirs to trace these threads of desire.

In Chapter Two's discussion of being a good anorexic I noted how informants used memoirs as idealised *Thin Commandments* of anorexia, skimming them for *Tips* to "trigger" themselves into being better anorexics. I left the word "triggering" deliberately unpacked there because the thesis was not yet sufficiently equipped to deal with the ambiguity it exudes. Now, we can return to it. In interviews it became clear that it was precisely because informants experienced being triggered 'against their will' that they erected a division between themselves and anorexia, positing some desires as theirs and some as caused by anorexia. Pro-anorexia website participants often warn each other that memoirs are potentially triggering and that if participants do not want to be triggered, they "should not read" texts such as *The Best Little Girl in the World* (Levenkron 1978) or *Wasted* (Hornbacher 1998). About *Wasted*, two participants to a pro-anorexia website wrote:

> "A very raw memoir...actually I haven't got through the entire book yet; affected me way too deeply to the point that it was triggering my own bad habits and impeding my recovery."

> "This was kinda triggering for me. It made me want to embrace my Ana."
>
> *Discussion on a pro-anorexia website*

These quotations suggest that being "triggered" against one's will means to develop undesired desire for anorexia; this is desire that is 'too strong,' felt to be 'out of (one's) control.'

Yet, in her interview, Jumela said:

> "Often pro-ana websites have a section dedicated to 'thinspo'. I have a thinspo file on my laptop. These sections of the website are full of photos of thin women to inspire you and phrases to help you onwards."
>
> *Jumela, pro-anorexia website participant,*
> *interviewed online*

Likewise, Galina said:

"There is usually a page on these sites that claims it does not condone or encourage eating disorders like anorexia and if you dont want to see these images or possibly be triggered into it then to 'click' the 'don't enter button', but lets face it, if youve searched for the site, you are looking for triggers."

Leanne, pro-anorexia website participant,
interviewed online

That *Thinspiration* sections of websites frequently contain words like "motivation" and "inspiring" suggests that what is at stake here is also desire; they are intended to make participants work harder at anorexia by inciting the desire to do so. As Jumela put it, *Thinspiration* aims to:

"Remind you what you're starving for so you starve more."

Jumela

It is therefore clear that it is also to agentially incite desire that informants turn to *thinspirational* materials of memoirs and photographs. As such, these materials are used by informants when they *want to want* anorexia.

That one can self-trigger a wanted desire and yet also have an unwanted desire triggered against one's will are inextricably bound together, not only because this is the same material shifted by context. Informants described using memoirs and photographs to self-trigger a wanted pro-anorexic desire in order to counteract the unwanted desire that they conceptualised as 'the anorexia desiring.' Self-triggering therefore often occurs temporally later than having been triggered but it rewrites the past through the present by blurring cause and effect. Describing anorexia as desiring and then self-triggering desire to overcome anorexia's desire is less a felt experience and more a tactic, I suggest. It allows informants to both attenuate flows of unwanted desire that ebb through them whilst also claiming others, thus splitting their pro-anorexia from anorexia's agency. These processes reinstate binary notions of self and other, as I noted above. But, these binaries are also ruptured by informants' refusal to separate ambivalence and desire or to place these neatly on opposite sides of the division. Rather, desire is located in both anorexia and self, with ambivalence only in the latter. Ambivalence is aimed at the coercive and 'too strong' anorexia that does its own desiring, but not at one's idealised 'friendly' anorexia which responds to one's own desire. Thus there is a

circular process of interaction. It is ambivalence towards anorexia's desire that produces informants' desire (or desire for desire, perhaps). Yet, anorexia's desires and informants' desires are not regarded as necessarily conflicting; at times informants describe themselves and anorexia as (simultaneously) "wanting" the same things and, at others, very different things.

In relation to his informants, also living with psychiatric illness, Robert Desjarlais writes that "agency arises out of a specific set of activities" (Desjarlais 1997: 202). The processes of attributing, claiming, rejecting and producing desire in informants' accounts are arguably not necessarily about entirely unravelling cause and effect in pro-anorexic desires; this is suggested by many informants as not entirely possible anyway. Rather, within the specific context of relationality, and the threads that bind informants to their anorexia, these processes around desire echo Debbora Battaglia's discussions of "agency play." Battaglia writes about "how agency is invoked or ascribed, concealed or obfuscated, more or less strategically" (Battaglia 1997: 506), how it is "placed and displaced, owned and disowned, and in other ways problematized" (ibid. 508). This, she argues, is useful not for claiming cause, control or authority, but rather "for ambiguating authorship or authority." (ibid. 506). Thinking about how desires are multiplied and mobilised in processes of ambiguating illustrates that by attenuating anorexia's desires informants can reclaim anorexia as part of them. Again, this reclamation is at once both active and static, reminding us that "agency can be an activity of maintenance, not making; fantasy, without grandiosity; sentience, without full intentionality" (Berlant 2007: 759). Yet, it is also Berlant who warns us that "the very vitalizing or animating potency of an object or scene of desire contributes to the attrition of the very thriving that is supposed to be made possible in the work of attachment in the first place" (Berlant 2010: 94) and how relations of attachment can be "*too* possible, and toxic" (ibid. 94 – *italics in original*). It is with both an idea of 'ambiguating' and also of desires as potentially 'toxic' in mind that we now turn to Part Two.

Part One has traced pro-anorexic desire through informants' frequent discussions of anorexia's friendship. These friendships produce desire as informants want to maintain an existing relationship. But, desire also continually re-makes friendship. We have seen that informants conceptualise treatment/recovery resistance not only as holding onto themselves but also as protecting one's friend. Moreover, informants also look after anorexia so that it may continue to look after them, thereby showing desire to be inflected by need and coercion. It is productive rather than engendered by lack, but this very production also reinvigorates lack. Desire has therefore emerged as something felt, something employed and, arguably also as something aimed at. It arises at the interstices of anorexia and personhood, both as a part of their relationship but also at the will of one, the other, both or neither, at different times. Anorexia and self are co-extensive and coterminous, with a sense of overlap and partiality at odds with the image of anorexia entirely superseding personhood that were articulated by clinical uses of "that's the anorexia talking" in the last chapter. However, recognising that "intersubjective relations are steeped in ambiguity" (Jackson 2002: 335), **Part Two** now addresses what happens to pro-anorexic desire when anorexia worsens, exploring shifts in, and losses of, agency. Now the relinquishing of agency to anorexia that underscored anorexia's friendship begins to rupture it. Recognising that what was desirable also forms part of what becomes undesirable about anorexia over time illustrates how "the mirage of a straightforward exercise of will is a flag waved in one situation and a vicious, self-defeating deflation in another" (Stewart 2007: 16) and how friendship can be a resignation rather than desire. Clinically, this loss of control to anorexia is where treatment might step in and regard only anorexia as talking. But, I suggest we need to take account of progressions of illness over time without making assumptions about the effects that becoming more ill have on pro-anorexic desire. Looking at anorexia's entrapment, reveals a whole new dynamic of agency and desire within, or perhaps, *inside,* this present space of anorexia's worsening. Even in that space, desire (re-)exists as informants reconfigure anorexia's effects and constraints upon them as desirable conditions of living. But, when such "making do" (de Certeau 1984) with one's anorexia reaches its limits of possibility and anorexia becomes uninhabitable, informants produce alternative relationships with anorexia in the present and past. Informants discursively dis-assemble anorexia into parts, leaving

those that are unwanted outside its boundaries, thereby performing alternative desirable anorexia(s), making specific parts stand for the whole.

Part Two   Relationality Goes Wrong: Still Holding onto What One Is and Has

2: A   Illness Progression & Desire: Intersections & Contradictions

2: A. 1   Reconfiguring Anorexia's Take-Over: From Entrapment to "Positive Withdrawal"[104]

In her interview Tanya described anorexia as "hell." But she also said:

"I just don't want to be without anorexia."

Tanya, pro-anorexia website participant,
interviewed online

Likewise, Jumela described herself as:

"Trapped in something I love and hate."

Jumela, pro-anorexia website participant,
interviewed online

In his interview Laurie said:

"It starts off like a friend and an ally but it's like a person that backstabs you. It… it's a thing…like when you think about anorexia and you're not actually thinking about it as being helpful, it's just dirty. It's just a horrible thing that hits you, it, like, erm, cuts you at your weak points. It's like, erm, it's like somebody what wants to actually kill you; you actually make friends with it so it comes closer. It's a bit like that Julius Caesar plot, you know?…His friend that killed him but became his friend before killing him."

Laurie, inpatient

Here Laurie regards anorexia as getting worse *by itself,* causally unrelated to his relationship with it; in his interview he described feeling betrayed by anorexia because it had destroyed its "cluster of promises" (Berlant 2010). In contrast, some informants posited a causal relationship between friendship and illness worsening. Shanice said of anorexia:

---

[104] Corin 2007 & 2010.

"I suppose it's not a friend in a way because I suppose it's not really a healthy way of dealing with things and it makes you quite ill physically. It probably makes you mentally worse. It's sort of like it wants to help you but at the same time it'll kill you whilst it's doing it. So it is help but it's sort of like wrong help, in a way."

Shanice, inpatient

To Shanice, the relinquishing of agency that was key to the production of friendship in Part One provides anorexia with an opportunity to, as she put it, "take over." A constituent part of anorexia's desirability also therefore renders it undesirable. In many informants' narratives a sense of being "trapped in something," as Jumela put it above, ties to their subjectivities of friendship with anorexia and also to their experiences of their anorexia worsening; many described finding themselves caught between these, as though being pulled in opposite directions at once. In an email that she sent to me after discharge, Tara wrote of her daily struggle with anorexia. She described how she could feel herself slipping further into anorexia against her will and how she wanted to get better:

"I just hope I can find the power to pick meself back up b4 things really get outta hand."

Tara, inpatient, in an email after discharge from the EDU

Worsening of illness, experienced as 'things getting out of hand' as anorexia takes over, was a common topic of interviews in both field sites.

Describing a point at which agency is no longer shared with, or even relinquished to, anorexia, but is located fully in it, Leila said:

"Anorexia's like a ball of pure evil inside that completely takes over somebody and completely destroys their identity, everything that makes them them, and turns them into…like a walking zombie really. Because when it really hits and it eventually takes over you, you become nothing more than just a walking victim of anorexia, you are under the anorexic

spell. It's so hard, once you get in that cycle to get out of it… it's just like something that engulfs you completely."

Leila, inpatient

Likewise, Libby said:

"You become like a recluse and retreat into yourself. You lose everything because it's only you and the anorexia."

Libby, inpatient

I asked Libby, whether that meant that anorexia becomes a focus. She replied:

"Oh God yeah, completely. Completely…*The* Central Focus!"

Libby

In these accounts the world around informants recedes from view and touch. Anorexia, as Libby said, is the *only* relationship left. It goes from "holding your hand," to simply holding onto you, and this enforced belonging is accompanied by a narrowing of possibility which cuts the friendship back down to a struggle with food, as Milla said:

"It just narrows your whole life down to tiny pinpoint and all you can see is: does a strawberry yoghurt have more calories than a peach?'"

Milla

Thus, here anorexia is no longer producing informants' everyday lives; it is, rather, constraining or, even, destroying them. To return to Derrida, he discusses the pharmakon as a "supplement" (Derrida 1997 & 2004), something that "can only *displace* or *aggravate*" (Derrida 2004: 102 – *italics in the original*). Derrida states that the supplement, "adds only to replace. It intervenes or insinuates itself in-the-place-of; if it fills, it is as if one fills a void. If it represents and makes an image, it is by the anterior default of a presence" (Derrida 1997: 145). Here anorexia as supplement no longer coexists with informants but has, rather, supplemented them, rendering them abject. It is clear, intersecting with discussions in the previous chapter, why "the psychiatric perspective" on anorexia views "the patient as constrained and trapped by forces" (Palmer 2005: 2). Moreover, this echoes my discussion of spirit possession, also in the last chapter; there, there was multiplicity and partiality, but

also precariousness. Agency, and indeed personhood, balanced at the interface of being shared or being taken by an 'other.' This precariousness has now come to fruition. We might assume that this is the temporal point at which we lose sight of desire - that it is no longer coterminous with, but has instead been replaced by, ambivalence or even hatred in informants' accounts. Yet, Derrida also writes that the supplement "adds itself, it is a surplus, a plenitude enriching another plenitude, the fullest measure of presence" (Derrida 1997: 144). In these words there is an ambiguity that hints at possibility; even this isolated entrapment and narrowness can be inflected by desire.

In her interview Josie said:

"When I'm very ill then I feel like a living shadow and being emaciated is like being a living shadow and that is sometimes what I aspire to be."

Josie, pro-anorexia website participant,
interviewed online

Also using the word "shadow," Nora said:

"When you are noticeably anorexic you feel hollow and are treated differently by your friends and other people, you don't feel things and although you might be talking to someone you are aware that you're not really listening and it's hard to concentrate and eventually people stop trying and although you might be with others it is as though you're not really there but just a shadow, being emaciated means that you don't have to deal with "real" life."

Nora, Facebook Pro-Anorexia Research Group
participant, interviewed online

Nora and Josie suggest there to be a value in becoming more ill and disappearing into anorexia, which was also noted by other informants across the field sites. Furthermore, not only are values found in anorexia's worsening, in some accounts they are also *made* to emerge from it. Libby said:

"It's so all-encompassing, it takes up….. it fucks up my life and it, it… it's messing up my family's life as well and it impacts on my friends. I mean it

just affects everybody. But it makes me feel better about myself, for the most part. I've felt more confident, I've looked better. Erm… yeah, it has a sort of safety. That's a good thing. There are good things."

Libby, inpatient

Libby does not just *find* the value to having been taken over here, she also attaches a *new* value to it. Over time, Libby moves to keep up with her anorexia, adapting herself to its alteration of her conditions of life and possibility. As such, she not only engages with anorexia's effects, but also re-enacts these compromised conditions of possibility as valuable; she thereby makes desire simultaneously both the tool and goal of her actions. Libby's interview suggests that, as well as anorexia progressing as time passes, there is perhaps circularity within each day that passes. It alerts us to the fact that cause and effect may be, on the one level, utterly clear and acknowledged by informants' accounts of illness progression but that, on another level, these may be blurred and mutually-productive. This latter vision both cuts through and reconfigures anorexia's worsening, whilst also illustrating how it is informants' experiences of the "hell" of this worsening that necessitates such reconfiguration. To explore these mirrored processes, I turn to Hadia.

On the EDU every morning at 10.45 all the patients have to spend fifteen minutes in the Dining Room for morning Snacks. These comprise hot milk with *Nesquik* and two biscuits. Those patients allowed weekend leave are expected to rigorously replicate the EDU's food timetable, including all snacks, whilst away. Most informants admitted in interviews that even if they managed meals, Snacks were omitted. Hadia, however, said that on leave she always ate Snacks, if nothing else at all. On weekend leave Hadia always walked to the same *Starbuck's* and ordered the same latte and biscuits. She described this as making her anorexia stronger. Or rather, it was intended to do so. Hadia described how her fear of the biscuits made her feel "particularly anorexic" – it triggered her anorexia. Both in response to, and by co-opting, this fear, Hadia used Snacks not, as the EDU intended, to aid recovery but rather to still it. In her adherence to the exact same latte and biscuits, Hadia said, she delineated the boundaries of anorexia's strengthening, placing herself inside its static calm. The ritualised aspect of this, which contrasted to the enforced Snacks on the ward, incited anorexia, she said, "safely." Hadia described it as re-establishing her friendship with anorexia. At this

intersection of relationality and illness progression thus, Hadia mobilised anorexia to hold on to it. In so doing, she reinvented and subverted its hold on her into her hold on it, reconfiguring this as an act of friendship.

Hadia's self-created anorexic space both reiterates and yet reverses informants' descriptions of the enforced withdrawal of anorexia's worsening above. Hadia herself often described the illness in such starkly poignant terms. And yet, seemingly paradoxically, every weekend Hadia used Snacks to produce an anorexia she could willingly enter into. This is not a contradiction. Rather, I suggest, it is precisely her experience of how anorexia takes over and narrows possibilities that led her to re-invent it as "[her] space." Describing these mornings as times when she could "be alone with the anorexia," Hadia engaged with the constraints anorexia placed on her whilst also reconfiguring anorexia's effects upon her as desirable. This illustrates both Hadia's unwillingness to absent herself, in wider terms, from anorexia and also how such reconfiguring can be a mode of coping with the painful exigencies of psychiatric illness. As such, anorexia would seem to be dual - both a modality of creating space *and* the space itself; it is once, again, both condition and effect, simultaneously desired and undesired.

Hadia's narrative is reminiscent of Ellen Corin's discussions of "positive withdrawal" (Corin 2007 & 2010). Charting modes of withdrawal amongst her schizophrenic informants, Corin contends that these signify "a way to tame, contain, and articulate a sense of otherness in psychosis" (Corin 2007: 277) and "defend an inner space" (ibid. 283) through the construction of a kind of "psychic skin that parallels the social skin" (ibid. 283). Thinking about positive withdrawal in the context of anorexia allows us to contain in one moment both a recognition of suffering that anorexia causes and also how this can be(come) desirable in itself. Echoing the tactics of compromise employed by informants to maintain themselves as good anorexics in Chapter Two, Hadia illustrates that "people make-do with what they have" (de Certeau 1984: 18). Thus, both within, and ensuing from, the very real effects of illness, Hadia improvises. Her actions signify a sharing of agency with anorexia, but against a background of the knowledge that it has already taken it anyway. As Mary Catherine Bateson argues, "improvisation can be either a last resort or an established way of evoking creativity" (Bateson 1989: 4) and, "complexity is woven in both space and time" (ibid. 4). These entangled threads of

foreclosure and possibility in Hadia's narrative are also apparent if we turn to another informant, Milla. In her interview Milla described not only re-inhabiting anorexia's enforced boundaries, but also fusing those of herself and anorexia together, allowing it to simultaneously contain her and yet force her out into the world around her. The next section will explore these processes and, taken together with Hadia's narrative, will discuss how informants' practices of desire again invite attention to temporalities.

2: A. 2   Being Supplemented 'Out of Oneself:' Milla's Perimeters & (More) Temporalities of Pro-Anorexia

In Chapter Two I noted that Milla described anorexia as desirable because it permitted:

"Knowing where the perimeters of my body are."

Milla, inpatient

There I narrated how she patrolled these perimeters by pinching and encircling her fingers around her arms, checking that no flesh had crept between skin and bones. To add another layer to that discussion, I return to Milla's interview. She described anorexia's delineation of her perimeters as so valuable because:

"That's the only way that I can manage to deal with life… not just at the moment, I think forever. Erm, it's about keeping a really tight check on yourself and it started like that before it started with food. I never had… it never started as a losing weight thing. It was a sort of general crackdown."

Milla

Expanding on what she meant by "keeping a really tight check on yourself," Milla, echoing my discussion of how words 'hang around' in Chapter One, continued:

"You just want to draw everything back into yourself and that's a way of making yourself compact and at the same time it's a way of stopping yourself having an effect on anybody else because it's so easy to just say 'bluh, bluh, bluh' and really hurt somebody's feelings' you don't know when

you're going to actually hit on something that's going to damage someone for life. So that is sort of a way I have … I keep telling myself, you know, 'stop talking, stop talking' but in the absence of that, then I find it very difficult to shut up but I feel like if there's less of me physically, then I kind of feel like there is less of a ripple effect on the rest of the world."

Milla

Returning to Corin's metaphor of "psychic skin" (Corin 2007: 283), I note that Haraway asks, "why should our bodies end at the skin?" (Haraway 1991: 178). Michel Serres also writes of skin, "in it, through it, with it, the world and my body touch each other, the feeling and the felt, it defines their common edge" (Serres 2008: 80). Thus, skin not only closes off, it also "intervenes between several things in the world and makes them mingle" (ibid. 80). Skin connects us to the outside as much as keeps us in. Or, in Milla's narrative, it connects *by* keeping her in. Milla recognises that anorexia has already cut her off from the world and enclosed her. To this she attaches a new value that does not, unlike Hadia, reproduce withdrawal but rather reconfigures it as a paradoxical modality of connection, one that disallows "ripples" but also forces her 'out of herself.' She said:

"I don't want to nourish myself because I think… I think I just don't need it… I don't need all that cushioning and softening, I just need to get out there and deal with things because you know, everyone deals with things."

Milla

Gregory Bateson suggested that the self "network" is "not bounded by the skin but includes all external pathways along which information can travel" (Bateson 1972: 319). We could envisage anorexia, to Milla, as this pathway and as such, it is once again as much self as other. There is thus, perhaps "not a relation of mastery but one of co-emergence" (Massumi 1992: 14) of self and other into the world, as Milla maps her own perimeters onto those offered by anorexia. It is through her relationship with anorexia that all other relationships are both mediated and made. Thus, although both Hadia and Milla reconfigure that which has already happened, for Milla in particular, this is not just reactive. Rather, it alters how she convenes with the world around her not only in the present – as in Hadia's case – but also in the future.

Psychiatric and psychological literatures tend to tell a particular story about how anorexics are 'taken over' by anorexia. Recovery is frequently recognised as episodic, imbued with ebbs and flows; it is conceptualised as "a revolving door with some individuals going around several times before achieving their long-term goals" (Treasure and Ward 1997: 105) which sees "relapse as an integral part of the cycle" (ibid. 107[105]). Descent, in contrast, is more frequently viewed as a linear pathway that leads ever further into anorexia and its stark dangers – thus correlating narrowing of possibilities with time passing. This correlation is, to a certain extent, apparent in informants' narratives and needs recognising. Tennessee Williams famously said about plays that they diverge from what they represent by constructing a "world without time" (Williams 2000: 647), an artificial "repose" (ibid. 648). Williams argued that this timelessness imbues mimetic events with depths of poignancy that they do not have in 'real' life. I am aware here that in the equally "timeless world" of ethnographic texts, we risk the opposite. On the page, events, episodes and actions that do indeed follow each other in a possibly unwanted and sometimes chaotic but nevertheless temporally linear fashion in informants' lives are too easily flattened into a timelessness that not only robs them of teleology but also of significance. To avoid this, this second half of the chapter placed upfront the progression of illness and its entrapment and pain.

However, the ways of being that Hadia and Milla carve into their anorexia speak of horror *and desire*; circularity is borne of necessity in response to the undesired effects that anorexia has on informants, but it also re-makes such effects desirable. Descent into anorexia not only is not a straight line, it also does not preclude desire. As such, here descent also appears episodic, with episodes being "occasions that make experiences while not changing much of anything" (Berlant 2007: 760). This echoes with a sense of 'becoming same,' which rippled through Part One. As such, there are "divergent, convergent and parallel times" (Borges 2000: 53) to these narratives; improvised circularities are mapped over illness progression. In this mapping, "time takes forms of folds, or loops, or spirals" (Mol & Berg 1998: 5) *and* it is linear. This simultaneity resonates with Deleuze and Guattari's discussions of rhizomes. An "antigeneology" (Deleuze & Guattari 2004: 23), a rhizome is like a "map that is always detachable, connectable, reversible,

---

[105] Also, Blake, Turnbull & Treasure 1997; Prochaska & Di Clementi 1992.

modifiable, and has multiple entryways and exits and its own lines of flight" (ibid. 23); "any point in a rhizome can be connected to anything other, and must be" (ibid. 7). Moreover, it is "by rhizome that desire moves and produces" (ibid. 15). Thinking about the narratives of entrapment and improvisation that have emerged, I suggest that anorexia is *both* "rhizomatic" and also "arborescent" (ibid. eg. 18); it has many alternative pathways but these are also contained and constrained within a linear teleology. These narratives have therefore revealed "*what could be*, as a crucial dimension of what is or what was" (Biehl & Locke 2010: 323 – *italics in original*) whilst simultaneously highlighting what could *not* be. It is this tension that underscores informants' practices of reconfiguring anorexia in relation to anorexia's agency in the space of the present, which are the focus of the remainder of this chapter. The practices discussed from now on are, I argue, concomitantly reactive responses to anorexia's having already become too entrapping, too controlling and too uninhabitable and yet they are also generative. Thus, moving beyond informants' "making do" (de Certeau 1984) with(in) anorexia's boundaries, the chapter will now briefly explore how they redraw those boundaries, producing alternative desirable anorexia(s).

2: B   Making Alternative Anorexia(s)

2: B. 1   Using Food's Agency to Balance Anorexia & Personhood

We have already seen that anorexia is agential and is, therefore, an untrustworthy friend; "anorexia is sneaky" (Lipinski 2007: 63). Like anorexia, food was also often conceptualised by informants as agential and untrustworthy:

> "Food wants you to eat it! Don't do it!!!"

> "Food is mean and sneaky. It tricks you into eating it and it works on you
> from the inside out, making you fat, bloated, ugly, and unhappy."
>
> > *Quotations from a 'Letter from Ana' on a pro-anorexia website*

> "Food is sneaky, it's trying to temp you to eat it and get fat. Try this when you are all alone: Look at the food and laugh at it. Tell it that it can't tempt you and that you don't need it. This really helps!"

Tip from a pro-anorexia website

Here, and in many informants' narratives, food is framed as both 'making' you want it by 'tempting' you, as well as attempting to "sneak into" the body through smells or skin contact. This attribution of agency to food, particularly in the latter case, conceptualises eating, ingesting and digesting in ways that map corporeal vectors of eating beyond the digestive system, again reconfiguring boundaries of inside and outside in anorexia. But it also suggests that there is a simultaneous dual loss of agency on the part of informants – to both anorexia and food.

I touched on food's agency briefly in Chapter Two where it ran as a shadowy undercurrent to *Tips* that were intended to help informants avoid food. There too the desire to eat was shared between informants' bodies and food. It is because of their experience of food's agency that informants in the EDU often tried to have no contact with it at all, even putting on rubber gloves in Cooking Group. This avoidance was apparent in Raja's leave planning. Patients in the EDU were often advised to carefully plan their leave periods, putting in all meals and snacks. This exercise was intended to make feeding oneself easier by relieving patients of some of the agency, and thus guilt, of eating. Because of my involvement in OT activities one inpatient, Raja asked me to help her plan. Over a number of Fridays Raja and I sat on a bench in the hospital grounds with a blank piece of paper and a pen. Raja's leave planning oscillated between tears, black humour, evasion and frank honesty and I am grateful that she allowed me to record these here. Raja would often tell me, laughing, that there was no point writing meals into her days because she would not eat them. She said with humour:

> "I'll 'forget' to go to the supermarket and then find the fridge is empty again - oops there's nothing to eat!"

Raja, inpatient

When planning the activities of her weekend hour-by-hour Raja also 'forgot' to leave any space for meals, literally writing food out of her life. When I would point this out, Raja would say with a smile:

"So you noticed that again, huh? Damn!"

Raja

That Raja not only did not eat but even conceptually and practically effaced food from her life was arguably engendered by the intersection of her pro-anorexic desire with food's agency; she was adamant that she did not want to eat but was frightened that if she was in the presence of food, it would "make [her] eat it." But, there is a second aspect of food's agency that emerges in informants' accounts, that is seemingly paradoxical to this, but actually entangled; food also mediates (and incites) anorexia. It is this mediation that informants describe harnessing and utilising through reversal. Pushed, pulled and pained by a pervasive sense of helplessness in regard to both anorexia and food, particularly over time, some informants describe using food's agency to counter anorexia's agency. Pitting these agencies against one another not only regains some control over anorexia, but it also actively produces new, more desirable, anorexia(s).

In her interview Tara said:

"Sometimes I could sit and talk to someone perfectly rationally about food… but put me in front of it ….phewf that's bad! I don't hate food. I am terrified of it, absolutely terrified of it."

Tara, inpatient

Tara then said that what was "bad" about food was that it gave rise to anorexia – to "too much" anorexia, unwanted anorexia. We have seen food's production of anorexia before with Hadia's biscuits. But, there it was agential - or agential in the sense of relinquishing agency willingly. That it is often not became clear during an afternoon in the OT office with Leila. Although Cooking group, which I discussed in Chapter Two, took place every Wednesday night on the EDU, its preparations began in the afternoon when all participants walked to *Sainsbury's* together to buy ingredients. If a participant could not decide what to cook, the OT or I would look at recipe books or on the Internet with them before going shopping. One Wednesday afternoon Leila and I had scheduled an interview but instead Leila requested that I help her decide what to cook that evening. So, in the OT office, we browsed the internet for chicken recipes. Our conversation was chatty and light-

hearted until Leila had to decide, as per Cooking Group stipulations, what oil to add. At this point Leila became distressed. She said that her mind had filled with "a great pool of oil." Pausing for a moment as she visibly took stock of her heightened emotions, Leila said:

"See, somehow everything just seems to get ruined. Anorexia always gets in the way."

Leila, inpatient

Echoing how Cally's meeting with her husband on the EDU caused anorexia to rise up and take over as a friend, Leila described how the oil had "made [her] anorexia come back." As such, it was not only the oil itself that upset Leila, but rather the sudden unagential arising of anorexia that it triggered in her. Leila felt this to take over and push out not only herself, but also her desired relational anorexia, replacing one she felt she could cope with, with one she could not. And yet, the ebb and flow of desired and undesired anorexias in relation to food is also not the end of the story.

Some informants described using this 'triggering' agency of food to keep their anorexia in check, thereby maintaining it in a desirable relationship with personhood. To illustrate this I return to Raja and her weekend leave. Despite adamantly writing no food at all into her plan, almost every Sunday night Raja cooked and ate the same food. This comprised a dish of sausages and lentils from Nigel Slater's *Kitchen Diaries* (Slater 2005). Given that sausages are not 'safe' foods[106], this could hardly be described as an 'anorexic' choice in any classic sense. But, Raja said, this was precisely why she cooked it. In her interview, Raja described how at the weekends when on her own she would become scared that her anorexia was getting too strong. Sometimes something would trigger an unwanted rising up of anorexia in her and she found it difficult to "get back," as she put it, to her wanted anorexia without the EDU's help. Raja therefore meticulously cooked this particularly unsafe meal to "prove" to anorexia that she was "in charge of it." Then, fearing that all the food could itself be too triggering of anorexia, as we saw above with Leila, Raja would take two mouthfuls and throw the rest away. Raja's actions echo the notions of lack that were tackled in Part One. By cooking sausages

---

[106] See this thesis Chapter Two for a discussion of 'safe' foods.

Raja arguably temporarily removes her anorexia, expunging herself of danger. She then reproduces anorexia through the action of resisting her food, thereby performing a desired anorexia and anorexia as desired. As such, Raja pits wanted and unwanted anorexias against one another by engaging with the dangerous power of food and reclaims not only a particular desire, as we saw in Part One, but also a *particular anorexia,* as belonging to her.

These interactions of food, desire and anorexia have brought into question not only what anorexia does, but also what it *is.* In rejecting one anorexia as unwanted, Raja links a *particular* anorexia to desire, also performing it through that desire; desire here again "touches off and sets in motion different possibilities" (Probyn 1996: 13) and it is also the substance of those possibilities. And, each "local performance" (Mol 1998: 137) of anorexia reminds us that "everything – people, subjectivities, actions, scientific facts, technological artefacts, texts and symbols – achieve their form as a result of the network of relations in which they are located" (Moser & Law 2003: 2). As such, this section has both echoed, but crucially also diverged from, Part One's discussion of the multiplicity of desire. There, informants' desires were more or less wanted or inflected with ambivalence but, in relation, anorexia itself remained ostensibly singular and fixed within its boundaries; it was, we could say, shaded with different colours, but within the same lines. In this section, anorexia too has fractured into multiplicity, its boundaries shifting as they intersect with both foods and personhoods on a number of tangled levels at once. Alongside this multiplicity it is also clear here, again, that to be desirable, anorexia must exist in a very fine and continually processual balance (of agency) with personhood. The last section of the chapter will explore how discursive re-delineations of anorexia maintain that desired balance.

2: B. 2   Discursive (Re-)Formations: Assembling Anorexia(s)

During her interview Mickey said that looking back on the previous few years all she could remember was:

"The image of my feet on the pavement bathed in streetlight."

Mickey, inpatient

This is because Mickey had "spent years so consumed by anorexia," she said, that all day she had starved and all night she had walked. She recounted getting up in the middle of every night compelled to walk; Mickey had walked for miles and miles in the darkness with "no thought of [her] safety at all." Moreover, Mickey's walking was not limited to nights. She said that at the time this aspect of anorexia had "really got going," she had a part-time job. Mickey walked three hours across the city to work, arriving exhausted. At the end of the day she walked three hours home again. After some herbal tea and some carefully weighed-out food, Mickey would then go to sleep only to wake in the early hours of the morning and walk again. During her interview, describing this past behaviour, Mickey joked that she could tell me how long it would take to walk to any part of the city, saying, "I'm just like a cabby!" But, looking back on her walking, she now felt it to be "ridiculous" and "mad." She said:

> "I was nuts! I didn't seem it probably, I could have convinced you black was white. But I was nuts!"
>
> *Mickey*

Illustrating once again in this thesis the irony that pervades the doubled (or perhaps, multiple) awareness of informants, Mickey designates anorexia as "mad." During that interview she also said that being admitted to the EDU was "the best thing that ever happened to [her]." But, these statements are not as straightforward as they might appear. Mickey also said:

> "Of course, that was nuts, all that walking, totally nuts! But, starving's ok. As long as you keep it at that, anorexia's fine. I'm sticking to that one now!"
>
> *Mickey*

In Mickey's account there emerges more than one anorexia – the starving one and the walking one. These, moreover, exist in a hierarchy of desirability. Mickey said that being admitted to the EDU was such a good thing because it had cured her of walking, thus taking away a particularly unpleasant anorexia and leaving her with that which she wanted. It did not, she said, cure her of self-starving and about that she was pleased. Referring to the EDU, Mickey proclaimed with pride, "they could not beat it!" That there was also pain in this sentence was illustrated by her

continual pulling on her sleeves, scrunching them into her tightly closed fists as she spoke.

Mickey was not alone in looking back at a 'previous anorexia' and seeing it as wrong in relation to a more desirable present anorexia. Words that arose in this "reseeing" (Strauss 1997: 69) "narrative re-construction" (Williams 1984) were "delusional," "mad," "nuts" and "bonkers." Describing the time just before she started treatment Gillian said:

"I was in la la land!"

Gillian, inpatient

In every case such language was used about a past anorexia which was deemed valueless in relation to that which informants still had. It was therefore not uttered by recovered anorexics, but by informants who were still - or, importantly, *felt* themselves to be still - anorexic in the present; these informants were still living with(in) anorexia, but a *different* anorexia. The key difference was that which I have sought to reveal through the various discussions of this chapter, of agency. The less valued anorexias were always those in which anorexia had taken too much control and become too coercive, which had "made" informants "mad" and "go too far," or lose sight of their central concern of starving. These discussions mirror those regarding friendship in Part One. There, a past anorexia was reclaimed to make the present. Here that of the past is rejected for the same reason. This making of the present, thus, involves the siting of a boundary, its purpose to denote a *particular* anorexia as desirable. Amongst inpatient informants, this temporal division, importantly, was often erected between a time before treatment when anorexia was out of control and the present anorexia in treatment, which the EDU was not infrequently felt to have tamed, thereby, paradoxically, helping bring it back into a 'friendly' relationship with personhood.

These processes of discursive differentiation between what we might term 'good' and 'bad' anorexias are not only temporal, but also spatial and social. Informants often performed their own anorexia as better than that of others. Such performances were not only manifestations of competition like we saw in Chapter Two; in the "mad" or "bad" anorexias of others, informants also saw those which they too had previously had. As such, anorexias were located spatially and

temporally, in self and other, simultaneously. One of Chloe's interviews took place after a particularly fraught lunchtime on the EDU during which Holly had vomited in her plate. During her own interview Chloe referred to this incident saying:

> "I can't believe she thinks she's going to get away with that. She must be mad! I really do look at her now and think that, that she's mad, even though I used to be exactly the same."

Chloe, inpatient

I noted previously that psychiatric and psychological literatures often view recovery as a series of stages, each one further away from anorexia (see particularly Prochaska & Di Clementi 1992). From this we might assume that Chloe's comment signifies her to be at a different stage of recovery from Holly. And yet, this claim is problematized by an attention to ambivalence. Such literatures suggest that at each stage ambivalence towards anorexia increases and, in correlation, desire towards it decreases.[107] We have seen throughout this chapter that ambivalence and desire do not necessarily correlate in this way. As an adjunct to this recognition, here Chloe is ambivalent to the particular anorexia that she regards Holly as exhibiting but not ambivalent towards that which she feels she herself has. Describing the former as "mad," she called her own "quiet starving" and said she was happy with it. As such, Chloe relationally delineates the desirability of anorexia across the space from self to other, multiplying anorexia with each delineation. So far in this section the delineation of boundaries between desired and undesired anorexias, in both self and other, has related to the discussions of anorexia's agency over informants' actions and desires. Yet, there is also one further way in which anorexia is seen to get 'out of control;' this is through the bodily degradation that the illness causes.

In an interview I carried out with Lois some months after discharge she said that although now at a normal BMI she was not just as anorexic but, she stressed, "more anorexic" than she had been when emaciated. This statement evinces a dis-location of anorexia from the body so common in informants' accounts. This was prevalent in both the seemingly dis-embodied space of the Internet and the seemingly embodied space of the EDU; in each, anorexia was linked far more or less to the body than might be assumed at first glance. The relationship of

---

[107] cf. Blake, Turnbull & Treasure 1997; Cockell et al. 2002; Federici & Kaplan 2008.

the/an/many 'anorexic body/ies' to pro-anorexia on the Internet will be further explored in the next chapter. However, as a precursor to that discussion I will briefly unpack how anorexias, bodies and desires relate to one another here.

In her interview Lola said that she had put on weight because of the EDU's peer pressure system but, "nothing ha[d] changed inside." In fact, not only had she kept hold of her desirable anorexia despite moving beyond the biomedical categorisation of the illness, she also felt her anorexia had been made stronger by treatment. As such, after nearly a year in the EDU Lola felt both her desire *and* her anorexia to be stronger than on arrival. She said:

> "Whilst I wasn't at an anorexic weight a year ago… I was thinking anorexic thoughts but hadn't been at the anorexic weight … I feel like I haven't got a right to be called anorexic because I'm not emaciated. When I go back to school people will say, 'look at the size of her, how can she be anorexic?' and that freaks me out."
>
> *Lola, inpatient*

Lola's fear that she can no longer be *called* an anorexic illustrates her awareness of the relationship between the level of her visible bodily emaciation and anorexia in the eyes of others. She is frightened of being unmade by their gaze. But the de-linking of emaciation and anorexia which she, on the other hand, *feels,* was echoed by Kate:

> "It's the pigeonholing I can't stand…people automatically… one of the diagnostic criteria of anorexia is you have to have a BMI of below 17.5 so technically speaking I'm no longer anorexic. But then mentally I would say that I was very anorexic, the behaviours and things like that. And that bugs me, that it's just…physical. You know you can be absolutely…there are people in recovery who are still very anorexic, but who are not…emaciated."
>
> *Kate, inpatient*

I suggested in Chapter Two's discussions of being a good anorexic that the body and its relative emaciation functioned as an index of aspects of the 'good,' such as willpower and struggle, but that it was not the central concern of (pro-)anorexia;

this is supported here. Yet, however much informants frame, contextualise, privilege or discount emaciation in relation to their anorexia, the body also has its own agency; embodied subjectivities of starvation's effects emerge with their own force and pain in informants' lives and narratives. In contrast to Lola and Kate's accounts, of still being anorexic in the absence of emaciation, above, other informants described the extreme pain of starvation and then dislocated this from anorexia. Although seemingly opposite, these accounts employ the same mechanisms of delinking the body from anorexia. In relation to their pro-anorexic desires thus, I suggest that to informants, the body is at once an obstacle – or, an impasse, and yet also, paradoxically, a tool. For anorexia to remain desirable in the midst of sometimes immense corporeal suffering, some informants remove anorexia from the body, discounting the undesirable bodily symptoms simply as not part of the illness. This renders the body dual and liminal; it simultaneously *is* a particularly uninhabitable anorexia - its entrapping boundaries fused with those of anorexia - and yet also *has* nothing to do with anorexia. Such processes, therefore, intriguingly both absent the body, and yet also re-establish it as central to pro-anorexic desire. The absenting of the body becomes a technology through which anorexia is re-assembled and/or articulated as desirable.

In her interview Nancy described how bodily symptoms had made her realise that, even though she did not want to, she had to get help for her anorexia. She said:

"The physical side kind of got a bit too bad and I couldn't walk up stairs any more [laughs] that was a bit of a pointer! Erm, no, that scared me. Yeah, when it got scary and when even fruit and vegetables were starting to freak me out, that's when I knew things were getting to be too much of a problem and when I couldn't cope at home…. Because I couldn't do it myself. Erm, I don't know. As much as you hate to admit it, you have to acknowledge that you are really struggling."

Nancy, inpatient

Nancy said that until she was unable to climb stairs:

> "I could have just gone on and being anorexic, you know? Happily gone on and on."
>
> *Nancy*

It is perhaps to this second statement that we can link Miriam's; she said:

> "You just disengage from what might happen to you. You know, people would say. 'your sodium levels are low, your potassium levels are low, you're anaemic, look at your ECG – you've got depressed thingies.' I don't know…they'd say, 'look at this, this is bad. If you keep doing this, this will happen, if you keep losing weight, if you get down to a really low weight your organs will be damaged, you'll get this, you'll get that."
>
> *Miriam, inpatient*

Miriam's statement, in particular, might seem to support suggestions that regarding mind and body "as two ontologically separate entities" (Giordano 2005 B: 153) is the "metaphysics [which] may be regarded as one of the essential foundations of eating disorders" (ibid. 153). Likewise, Bordo suggests that although anorexics are perhaps not self-consciously Cartesian, Cartesian categories of mind and body are played out in their lives (Bordo 1988). For her part, Ellmann suggests, "self-inflicted hunger is a struggle to release the body from all contexts, even from the context of embodiment" (Ellmann 1993: 14). Negotiating between these previous discussions, I suggest that whilst a pervasive dualism does arise in informants' narratives, against the background of this chapter's discussions of relationality and the mobilisations and mobility of desire, such dualism tells a very different story. In informants' accounts, the body emerges neither as central to anorexia, nor, importantly, as discounted. It is, rather produced *and* "productive" (Grosz 1994: 12), at once both dislocated from, and yet enmeshed with, informants' personhood. The above accounts suggest that informants' bodies are caught up in anorexia, entangled in a fluid relationship with personhood and the illness, which is both produced and shifted by desire; between anorexia and the body there is thus both a relationship and a rupture. Rather than seeing anorexia as *about* wanting to not be bodily, such accounts suggest we need to think from the opposite angle, that informants

renounce their bodies *after,* or, *within* anorexia in order to maintain a relationship with anorexia.

Eva also graphically described the effects extreme starvation had had on her body; these had been at their worst just before admission. Eva remembered exhaustion so engulfing that she could not walk across her flat. She recounted bones so sharp that when she turned over in bed she felt them scratching against her skin from within; her spine had even broken through at her coccyx. She described how her hair had fallen out and her skin dried to flakes. She had been scared that she was about to go blind because her vision was so blurred. But of all this, Eva said:

> "Anorexia's got nothing to do with my body. The physical bit's just a symptom of my mind."

> *Eva, inpatient*

In order to inhabit anorexia, Eva dis-inhabits her body, thereby conceptualising anorexia and bodies as not fitting together. She frames a desirable, inhabitable anorexia as not only not corporeal, but as *anti*-corporeal; it is not absent, as such, but rather actively absent. A particular body is constructed in relation to anorexia, as much as a particular anorexia is enacted in relation to the body. This boundary-process gives bodily suffering an uncertain paradoxical centrality in Eva's account. Through her body, Eva alters anorexia's boundaries, leaving out what is threatening or unpleasant, reaffirming the desirability of anorexia. It also allows Eva to engage with treatment in order to feel physically better without renouncing her anorexia, which echoes Mickey's happiness at being cured of walking, above. If bodily suffering is only an undesired symptom of anorexia, by taking it away the clinic restores Eva's desired anorexia, re-diagnosing her. Eva thus engages with the clinic but discursively delineates anorexia in a way that does not tally with its models. If the clinic treats Eva's body but anorexia is not to be found there, anorexia is safe and treatment cannot take it away. Moving anorexia around protects it and echoes other modalities of protecting one's friend discussed in Part One. Like those, Eva's narrative speaks of both stasis and mobility; it evinces Eva's sense of anorexia's permanence and innateness but also how it is rendered mobile by threat. As such, in a dual temporality, anorexia has, at once, never been located in the body and yet

is also de-located from the body in the present. Both this rupturing and linking are propelled by desire and they arguably fuse locations that might have appeared separate and separates what we might have assumed to be fused.

In this brief glimpse at informants' conceptualisations of relationships between anorexia(s) and body/ies, boundaries have been permeable and malleable, as well as being re-sited as much by anorexia's undesirability as by its desirability. It is in relation to the, also 'unfinished,' body that the fluidity of anorexia has become most apparent. Ways in which informants both lay their bodily boundaries over those of anorexia, as well as dislocate these perimeters from each other has illustrated that not only do anorexia's boundaries change but also, that anorexia is processually reconstituted. Anorexia is enacted as many whilst also being made to "hang together" (Mol 2002 A); this is performed by informants' perpetual (re-)nominations of particular desired parts to stand for the whole in specific contexts or temporalities. As such, throughout this chapter, but particularly in conversation with the body, anorexia has emerged as an "assemblage;" it comprises "contingent and shifting interrelations among 'segments'—institutions, powers, practices, desires—that constantly, simultaneously construct, entrench, and disaggregate their own constraints and oppressions" (Biehl and Locke 2010: 323[108]). Anorexia is "the product of multiple determinations that are not reducible to a single logic" (Collier & Ong 2005: 12). Moreover, "the temporality of an assemblage is emergent. It does not always involve new forms, but forms that are shifting, in formation, or at stake" (ibid. 12). Conceptualising anorexia as an assemblage takes account of the ways in which, throughout this chapter, flows between anorexia and desire have been multi-directional, with each of these forming part of the other across shifting contexts and temporalities. We have seen that desires, bodies, foods and selves all form part of the assemblage of anorexia and are also constituted by the illness; whether anorexia contains or propels desire or vice versa is in perpetual motion. It is with these assemblages of fluid but fixed, contextual but permanent, and both desired and undesired anorexia(s), that informants arrive in the EDU. The next chapter will therefore explore the meeting, both in the EDU and the Internet of pro-anorexia and the clinic.

---

[108] Also, Brown & Tucker 2010; Deleuze & Guattari 2004.

Conclusion

This chapter's explorations of pro-anorexic desire have opened our vision to not one but many desires and, even, many desirers, both human and not. I have argued informants' desires for anorexia to be wanted, held onto, and actively worked upon, but also unwanted and, even, painful. The chapter has revealed that informants do things *with* their desire but also that they do things *to* it. In both of these, we saw that desire mirrors anorexia; in informants' accounts there is a pervasive blurring between anorexia and pro-anorexic desire. Each propels the other at different times and it is difficult to "posit a primacy of expression over content, or content over expression" (Deleuze & Guattari 2004: 97) when thinking about their relationships. I began by tracing what informants' discussions of anorexia's friendship told us about pro-anorexia. I argued that to understand their desire for anorexia, it is imperative to address how informants experience the many, sometimes binding, ties between anorexia and self, and to recognise these very much as social inter- and intra- relationships. That anorexia and self are sometimes separate, sometimes fused, and that anorexia is externalised as a modality of connection, illustrates that desire for anorexia is as much about holding on as it is about becoming more anorexic. As such, this chapter's examinations of desire and ambivalence intersected with, but also deepened, Chapter Two's explorations of being a 'good anorexic.' Here we saw that friendship centrally relies on informants' relinquishing of agency. It is through this relinquishing that anorexia is, as Chloe put it at the beginning of the chapter, "the way I do things;" it mediates informants everyday lives 'for them.' As such, this sharing of agency with anorexia paradoxically maintains agency over anorexia. Informants also do this by separating pro-anorexic desires into wanted and unwanted and attributing the latter to anorexia itself. In this chapter we have also seen that ambivalence and desire towards anorexia on the part of informants are simultaneous. However, in its 'demanding' enactments of reciprocity on the part of informants and productions of its own lack, we also glimpsed in Part One how anorexia can take over informants and it was to a closer examination of this loss of agency that Part Two turned. There, informants' reconfigurations of anorexia's effects upon them illustrated how experiences of anorexia can be contingent but not necessarily inevitable, inflected with both foreclosure and possibility. I explored how in the face of the stark

realities of becoming lost inside anorexia informants reclaim this withdrawal as desirable. Recognising these improvised ways of being permits a vision of both the very real and arguably horrid progression of anorexia and also how despite, or even because of, this many informants live with and want anorexia. Exploring alternative anorexias in informants' narratives, illustrated how some are agentially 'triggered' whilst others arise within a complex matrix of personhood, bodies and foods. I suggested that informants experience a dual loss of agency, feeling themselves torn between, and acted on by, anorexia and food. I then suggested that informants use these two agents, pitting them against one another to quell each other's agency. This process actively produces new desirable anorexia(s) by re-siting the boundaries of the illness. It is this re-drawing of anorexia on which the chapter ended. I explored how informants delineate certain anorexias as desirable in relation to others that pertain to past selves, other people, or activities other than starving. This re-assembling of anorexias continually maintains the illness in a desired – and desirable – relationship to personhood despite how it can sometimes be deeply undesired - and undesirable. At each moment throughout the chapter, thus, where informants' desire for anorexia potentially abated, it re-emerged. Hence, the ambivalence on which we saw the clinic attempt to "capitalize" (Cockell et al. 2002) in Chapter Three could not be easily grasped here; it ebbed and flowed and existed alongside desire. It has therefore become clear how containment of anorexia, from a clinical perspective, might start with the body, focusing on bodily degradation and centrally (re-)locating that in anorexia. But, the discussions at the very end of this chapter problematized any seemingly axiomatic relationships between anorexia(s) and bodies. Thus, continuing this discussion of the body, the next chapter, *Dialectical Engagements: Complexity, "Bad Examples" & Thinness as Pro-Anorexia Meets the Clinic,* will explore how the clinic performs a particular bodily anorexia. Against a wider background of the appropriations and subversions of biomedical discourses and practices on the part of informants, I suggest that this "bad example" (Ngai 2001) of anorexia is appropriated and inhabited by informants, becoming a paradoxical, but problematic, object of desire.

**Chapter Five   Dialectical Engagements: Complexity,
"Bad Examples"[109] &   Thinness as Pro-
Anorexia   Meets the Clinic**

> "For I have known them all already, known them all —
> Have known the evenings, mornings, afternoons,
> I have measured out my life with coffee spoons;
> I know the voices dying with a dying fall
> Beneath the music from a farther room.
>   So how should I presume?"
>
> *Extract from 'The Love Song of J. Alfred Prufrock'*
> *by T. S. Eliot (1963: 13 – 17)*

During her admission to the EDU, Tina spent every day sitting on a sofa in the central corridor from where she could hear, watch and smell all the Ward's daily happenings. Never talking, Tina watched the meds trolley being wheeled up and down, a group of patients flying paper airplanes along the corridor with me, and patients being escorted to the back steps for cigarettes; she watched the putting up of tinsel at Christmas and the cutting of ghosts from sugar paper at Halloween. Tina heard tense negotiations for leave passes, meds and OT activities by the door of the Nursing Office. Sometimes she sat completely still listening to the strains of whale song escaping under the doors of the Small Lounge from Relapse Prevention Group. On more dramatic days Tina sank into the sofa as staff rushed past carrying a screaming patient to the Dining Room for Assisted Feeding. And all of this Tina recorded on hospital paper of the sort found in clinic notes, which has a pre-ordained space for name and hospital number. Staff offered Tina other sorts of paper but she always refused and requested more clinic-note paper. On every single sheet Tina neatly wrote her patient number and her primary and secondary diagnoses and every day she tied that day's writings to those of the day before, thereby compiling an alternative set of clinic notes. Tina often merged these notes with her official set by sending extracts, as letters or with a stapled commentary,

---

[109] Ngai 2001.

into Management Meetings. There, Tina's notes were read aloud and discussed by staff before being filed into her hospital notes. As such, Tina hybridised her clinic notes, challenging biomedical frameworks, both conceptual and concrete, and the possibilities of experience they offer, whilst simultaneously applying those frameworks to her personhood. As clinic notes are "part of the knowledge basis of the professional discourse" and its "power relations" are "implicit in [their] distinctive structure" (Smith 1990: 89[110]), through her (re-)writing of these, Tina both maintained herself apart from the clinic whilst also appropriating, inhabiting and, perhaps, silently subverting it. In Tina's actions we glimpse the multitude of complex and intimate engagements with the clinic amongst informants; it is to these that this chapter turns.

It became clear early in fieldwork on the pro-anorexia websites that participants frequently and actively engaged with the discourses and practices of biomedicine[111] in nuanced and intriguing ways; not only did these engagements not preclude pro-anorexic desire, but they were produced by it, woven through it and, even, constitutive of it. This finding challenged the then-common - particularly in the press - perception of the sites as vehemently opposed to biomedicine which ensued from an assumption that their "anti-recovery stance" (Fox et al. 2005) led participants also to entirely eschew treatment. During fieldwork in the EDU I sought to understand whether similar engagements were also found amongst anorexics in treatment, alongside their much-documented treatment resistance.

I have already argued in this thesis that there is frequent dialogue and exchange between pro-anorexia websites and clinical settings. Some informants described moving between the websites and treatment, often participating in both simultaneously. Between these spaces there is also a flow of knowledges and nosologies, texts and discourses. This chapter now suggests that not only are nuanced and subversive engagements with biomedicine found amongst informants in both sites, but that these contribute to how anorexia is performed, articulated and, importantly, desired, by informants in both; relationships between informants and their anorexia and between pro-anorexia and the clinic cannot be easily disentangled. We saw in the last chapter's discussions of anorexia's entrapment as potentially desirable how "spaces of all kinds become inhabited" (Stewart 2010 A:

---

[110] Also Goffman 1961.
[111] Also Bell 2009.

2). This chapter extends this by investigating how the "kinds of spaces that people occupy and exist in" (Tucker 2010: 528) are simultaneously clinical and (pro-)anorexic; informants' "worlds of identity and desire" (Stewart 2007: 12) and ways of being anorexic are often carved from seemingly antithetical clinical frameworks, which they appropriate, critique and subvert in accordance with their subjectivities of personhood, anorexia and the relationships between these. By, once again, avoiding binaries, this chapter does not offer a "romance of resistance" (Abu Lughod 1990); this would not take account of the complexities of agency so far unpacked and, moreover, it would be too linear. Instead, I trace how "different aspects of knowing, feeling, listening, and acting circle[..] back on other aspects, with no pure spaces, no straight lines, no clear inside or outside, and no true entry or exit points in sight" (Desjarlais 1997: 204).

This thesis has argued that the relationship between corporeal thinness and anorexia is not axiomatic, as might be supposed from a common cultural "spectaculariz[ation of] the anorexic subject position" (Allen 2008: 588). This chapter now suggests that informants' wider appropriations and subversions of clinical categories and tropes, knowledges and practices, invite a revisiting of this relationship; here thinness re-emerges as a part of pro-anorexic desire, but not in ways one might imagine or that have been tackled in previous literature. Suggesting that a "hyperreal" (Baudrillard 1983) anorexia is "performed" (see Mol 1998 & 2002) by treatment's mimesis of informants' anorexic practices, I trace how this performed anorexia becomes desirable to informants in both spaces as it juxtaposes with, and is absorbed into, what it means to be a "good anorexic." Through the clinic's reinvention of informants' desire, being good at anorexia which, depending on context, was done *through* the body in Chapter Two or even *without* the body in Chapter Four, would seem to become centrally *about* the body at the interstices of pro-anorexia and the clinic. Yet, once again, there is revealed to be ambiguity and ambivalence to this new centrality.

Although the thesis as a whole comprises a multi-sited design and practice, it is perhaps in this chapter that the importance of this is most elucidated. Recognising "the dialogic features of social reality" (Markham 2005: 794) in which "online and offline practices are co-articulated" (Leander & McKim 2003: 212), illustrates that not only does each field site illuminate the other, but also that they impact upon

one another; the Internet is "embedded in a specific place, which it also transforms" (Miller & Slater 2000: 21) and "experiences in virtual reality affect real life" (Turkle 1997: 324). Placing the clinic and pro-anorexia side-by-side in analysis, in a mirror of their drawing together by informants *both* in the EDU *and* on pro-anorexia websites, allows us to trace the ruptures and emergences at their tangible intersections - as well as at the more conceptual meeting points of pro-anorexia and the clinic. In the echolalia and echopraxia between the clinic and pro-anorexia, dialectical tensions give rise to contingent yet tangible forms of anorexia. Haraway argues that dialectics "is a dream language, longing to resolve contradiction" (Haraway 1999: 291). But, this is not a chapter about resolving contradictions. Instead I seek to give "ambiguity, perspective, plurality, contradiction, and uncertainty their due" (Lambek 2004 A: 3), exploring "partial connections" (Strathern 2004) and mimesis, doubles and reflections, antiphrasis and ambivalence; doing this necessitates a particular narrative structure.

It has been suggested that "to make sense of multiplicity we need to think and write in topological ways, discovering methods for laying out a space, for laying out spaces, and for defining paths to walk through these" (Mol & Law 2002: 8); topology "doesn't localize objects in terms of a given set of coordinates" (Mol & Law 1994: 643) and it is also "tactile" (Serres 2008: 81). This chapter seeks to capture exchanges and flows between the EDU and the websites – and thus between biomedicine and pro-anorexia - by continually moving between, and within, field sites on the page. To echo ways in which each site is present in the other, there is also a deliberate mirroring to each chapter half; the same tropes and motifs occur in both, emerging in different ways and diverging contexts. This structure is also intended to continue the reflections on temporality that the previous two chapter's discussions of personhood and anorexia began. It calls into question the idea that anorexia 'derives' in one space and moves straightforwardly to another. This would, not least, suggest that we know what anorexia is - that we can see its outlines, its beginnings and ends. Rather, informants' engagements with the clinic constitutes one of the aspects of pro-anorexia that particularly draws attention to the flux and shape-shifting of anorexia in their narratives; seeming antitheses come together as the clinic itself is absorbed into the "assemblage" (see Collier & Ong 2005) of anorexia.

Part One begins by exploring informants' relationships with their diagnosis of anorexia, illustrating that "people do not simply become the diagnostic categories applied to them —they inhabit them to greater or lesser degrees, refuse them, redefine and redeploy them, or ignore them entirely" (Biehl & Locke 2010: 330). My data does support discussions of how people may relate to themselves through biomedicine (eg. Rose 2007) but, with the previous chapter's explorations of relationality in mind, I also suggest that diagnosis does not instigate this vision of oneself; rather, it affirms what is felt to be already there, legitimating informants' personhood as much as their illness. Moving from this affirmation to informants' accounts of striving to fit themselves (in)to their diagnosis introduces a sense of the doubledness and simultaneity of appropriations and subversions of the clinic. These are seen in informants' relationships with clinical categorisations of health and harm, where health both maintains its clinical parameters whist also being opened up to include anorexia within its perimeters. This half of the chapter then explores how the knowledge and practices of biomedicine are appropriated and subverted by informants, not only to individually maintain themselves as anorexics, but also to use the clinic's own gaze against it. However, that this gaze can be subverted in such a way tells a story not only about pro-anorexia but also about the clinic itself and how it conceptualises and, perhaps, thereby performs anorexia.

Part Two therefore travels along this gaze into the clinic to explore informants' appropriation and subversions of one very particular aspect of the clinic. Whilst recognising that "medicine is not a coherent whole. It is not a unity. It is rather an amalgam of thoughts, a mixture of habits, an assemblage of techniques" (Mol & Berg 1998: 3), I suggest that anorexia treatment performs anorexia in a particular way. Food practices and the intangibilities of day-to-day life in treatment assume, produce and solidify correlations between anorexia and corporeal thinness, which we have seen are widely contested by informants. From this correlation of 'more anorexic' with 'more thin' emerges a "hyperreal" (Baudrillard 1983) anorexia, at once mimetic and yet nascent. The chapter traces how this anorexia enters informants' subjectivities of desire as many recount 'learning anorexia' in the clinic. As 'good anorexics' are now produced in relation to the clinic's gaze, being good at anorexia becomes not only something done *through* bodies, but also *about* the body. However, I explore how to informants, whilst this 'hyperreal' anorexia is

desirable, it is also 'other' to their 'own anorexia;' this engenders negotiations through which informants assemble the clinic into anorexia whilst also largely rejecting and subverting its paradigms of pathology, recovery and, even, of thinness.

In terms of the thesis's central themes, this chapter explores the **overlaps and disjunctures between pro-anorexia and treatment resistance**. In so doing, it continues the thesis's discussions of **relationships between personhood, agency and illness** and argues that only against the background of these can we revisit the visuality of thinness.

Part One   Tracings: Informants' Appropriations & Reconfigurations of the Clinic

1: A   Categories & Inhabited Spaces

1: A. 1   Relationships with Diagnosis

During the grey muggy summer of fieldwork a new patient, Rohina, was admitted to the EDU. Rohina was in her thirties and had been diagnosed with anorexia, along with co-morbid conditions, for ten years. Rohina and I met when I introduced myself, explained what I was doing on the Ward and gave her an information sheet and consent form to consider. A few days later Rohina approached me with her signed consent form. To it she has stapled a handwritten but photocopied list of her medical diagnoses, each with some accompanying information. Rohina explained that it was "impossible to know [her]" without knowing her diagnoses – without, she said, "meeting them first." Rohina then verbally described each of her illnesses, their primary and secondary symptoms, and how they intersected with each other. This, like the paper list, was articulated in the technical language of textbooks, ICD classifications and the DSM. That Rohina felt I should meet her diagnoses not only with her but "*first,*" initially shocked and saddened me. Echoing Chapter Three's discussions of clinical usage of "that's the anorexia talking," I found myself not wishing to, as I felt, 'reduce' Rohina to her diagnoses. My feeling correlates with critiques of medicalization that have not only shown how clinical categories can obscure or ignore social contexts,[112] but have also drawn attention to the potential harm of psychiatric labelling.[113] That "those deemed 'mentally ill' are denied the status of the fully human" (Martin 2007: xvii), as these debates have shown, was echoed by some informants' accounts of the EDU. In their interviews Chloe and Libby said:

> "It's difficult to be in a place where you're treated as mentally… well, you're not actually…. You're treated not as somebody who's mentally ill, but as

---

[112] cf. Illich 2001; Zola 1972. Also, Kleinman 1986 & 1988; Kleinman, Das & Lock 1997; Lock 1993; Scheper-Hughes 1992.

[113] cf. Laing 1976; Scheff 1975; Szasz 2010. See also Foucault 2001; Kutchins & Kirk 1997.

somebody who's actually mentally retarded, I think. You all get lumped together as these crazy people."

Chloe, inpatient

"They're making everyone the same and they're just… you do lose your individuality. In a way here it's almost kind of….. you have to… kind of go along with that loss of individuality because everybody is treated the same."

Libby, inpatient

However, to assume that informants experience diagnostic labelling *only* as part of this 'lumping people together' would belie the complexity of informants' pro-anorexia and its relationships with the clinic. Whilst recognising that, as Judith Butler puts it in conversation with Adorno, "when the 'I' seeks to give account of itself, it can start with itself, but it will find that this self is already implicated in a social temporality that exceeds its own capacities for narration" (Butler 2005: 7 – 8), this is also not the end of the story. Rohina's 'account of herself' might seem to be one of, to call on a classic anthropological discussion, 'disease' rather than 'illness' (see Kleinman 1986). Yet, as I suggested in Chapter One's discussion of my use of the term 'the illness' throughout this thesis, with pro-anorexia we cannot be so categorical. Rohina's diagnostic categories are concomitantly clinical *and* experiential; their very perimeters have, to borrow from Massumi, "a felt quality" (Massumi 2010: 61) that does, perhaps, relate to the narrowing of possibilities for experience (see Desjarlais 2010) in the EDU *and* by anorexia, but which cannot be reduced to these. Tracing how the "logic of diagnosis" (see Corin 2007) is absorbed into what Milla in Chapter Two called the "logic of anorexia," I suggest that both diagnostic categories and the act of diagnosis are invested with pro-anorexic desire.

Many pro-anorexia websites have pages of *Diagnosed Anorexics* or sometimes, *Admitted Anorexics.* These comprise lists of celebrities who have 'come out' as anorexic, usually by publicly going into treatment. Such pages often include biographies, vital statistics and photographs. The photographs are sometimes divided into before and after in which the in-between is treatment. Unlike the before and after pictures common to advertisements for plastic surgery or diet products, those on pages of *Diagnosed Anorexics* are lauded for looking the same before and after. Their corporeal consistency is a marker of being unaltered -

'unbeaten' – by treatment and the undercurrent of a simultaneous engagement with, and subversion of, the clinic that this evinces will be an enduring trope in this chapter. However, for now, the other way that diagnosis frequently features on pro-anorexia websites is in pages of diagnostic information. These comprise listings, usually derived from the DSM IV (APA 1994),[114] of primary diagnostic criteria for anorexia, bulimia and EDNOS - with anorexia split into subtypes - and of possible co-morbid conditions. Diagnostic criteria are accompanied by "what to expect" paragraphs, which discuss the physical and mental symptoms that 'fulfil' these criteria, thereby mingling, or perhaps filling, biomedical categories with experiential detail, and vice versa. On many of the sites there is a short bio page on the *Webmistress/master.* Alongside information like age or occupation such pages often include a diary of what the *Webmistress/master* eats and/or their weight. They also sometimes provide information that 'proves' them to be clinically diagnosed anorexics, such as listing the date of diagnosis or their hospital stays. It was this information that Kyra was discussing in her interview when she said:

"I would also often look for sites where the 'creator' was a genuine anorexic?!"

Kyra, Facebook Pro-Anorexia Research Group participant,
interviewed online

Kyra's use of the word 'genuine' echoes another informant, Robert's, discussion of why he valued his diagnosis; he said:

"I don't even, in myself, I don't really see it as an illness. But with a diagnosis people might take you more seriously…legitimate, that's the word."

Robert, inpatient

Kyra and Robert suggest that to informants diagnoses are desirable because of the legitimacy that they bestow. This intersects with previous discussions that have suggested that medicalization "is embraced by people for a variety of reasons" (Nichter 1998: 327). Hence, submitting to medical categories and practices is not necessarily antithetical to personhood but, rather, may be an "expression of

---

[114] See Allen 2008; Warin 2006 different perspectives on anorexics' relationships with the DSM.

agency" (ibid. 327[115]); as Lock and Kaufert put it, "at the site of the individual body […] biopower may be experienced as enabling" (Lock & Kaufert 1998: 7).

However, legitimacy is also an ambivalent term; this was illustrated by the shame which accompanied Robert's pride, as well as by many informants' discussions of the relationship between legitimacy and care. In her interview Kate said:

"I suppose diagnosis makes you worth caring for. Otherwise I think I'm wasting a bed that a sick person needs."

Kate, inpatient

Kate's words were echoed by Bella who said:

"I'm not worthy of this diagnosis, I'm fine. I look at everyone else and think how ill they are but I'm fine."

Bella, inpatient

'Proving' (see Desjarlais 1997: 233) one's anorexia thus mingles pride with a subjectivity of suffering. But, Bella's words that she is "not worthy of [her] diagnosis" also evince, once again, an ambivalent intertwining of personhood and diagnosis. This was clear in Josie's interview. Josie discussed the legitimacy of diagnosis in relation to the social stigma of anorexia. She recounted how when she went into hospital her mother told friends and family that Josie was "'run down' or 'taking a holiday'" because, Josie explained, "she feels ashamed to have an anorexic daughter." But in her interview, Josie herself drew a distinction between behaviour and diagnosis. About the former Josie said:

"We all seem to be ashamed of our behaviour because it is not seen to be "normal" and people cannot understand why we want to starve ourselves yet obsess about food all the time. I had one friend who used to sleep with a packet of biscuits as this gave her comfort and yet it is not the type of

---

[115] Also Charland 2005; Cussins 1998.

behaviour that you would discuss with people because it is strange and shameful to admit that you do something like that."

Josie, pro-anorexia website participant,

interviewed online

In contrast, Josie experienced the legitimacy of diagnosis as comforting. This is because, she said, although her anorexic behaviour was "not normal," diagnosis made it normal – as she put it, "normal for anorexia." This legitimate 'new normality' assuaged Josie's sense of shame. Her narrative suggests that inhabiting one's diagnosis can be an attempt "to live with what would otherwise be unendurable" (Fischer 2007), where what is unendurable here is not so much the anorexia itself, but rather, its social stigma. There is a gap between Josie's mother's feelings about anorexia and Josie's own sense of her illness. Diagnosis offers a way to align these, thereby closing the gap. As such, Josie's interview resonates with a sense of "becoming," which Deleuze describes as efforts to carve out possibilities from things "too big," "too strong" and "suffocating" (Deleuze 1998: 3); becoming signifies "individual and collective struggles to come to terms with events and intolerable conditions" (Biehl & Locke 2010: 317). This 'coming to terms,' Josie makes clear, is important precisely because social stigma is so misaligned with her sense of personhood. In the context of the last chapter's discussions of relationality and the "intersubjective fusion" (Jackson 2002: 340) of anorexia and informants, these accounts suggest that what is legitimised through the bestowal of diagnosis is informants' sense of themselves as well as of their illness, where relationships between these are frayed and mobile but consistently present.

Nikolas Rose suggests that "we experience, articulate, judge, and act upon ourselves in part in the language of biomedicine" (Rose 2007: 25-26). In her research Saukko found that her anorexic informants "used these definitions to make sense of themselves" (Saukko 2000: 299[116]). These discussions highlight how "classifications", as Hacking puts it, "*change* the ways in which individuals experience themselves" (Hacking 1999: 104 – *italics mine*). However, I suggest that the temporality within these discussions varies from that in many of my informants' narratives. Their engagements with diagnosis did not so much resonate with notions of being '*changed*' by diagnosis, but rather with *affirmation.* For many,

---

[116] Also Martin 2007.

diagnosis affirmed an existing sense of themselves as anorexic. This was clear in Libby's interview; she described visiting an emergency GP just after diagnosis because she could not stop crying. During that visit the GP listed anorexia's diagnostic criteria and told her many things that, as he put it, "you'd expect an anorexic to feel." Libby said:

> "When he told me that I felt a sense of relief – happiness – because I'm being how an anorexic should be. It's like, if you want to be an ano… if you're going to be an anorexic… like, I feel really happy and relieved – relieved is a good word for it – when people tell me…when I started realising things in myself that were stereotypically anorexic."
>
> *Libby, inpatient*

Libby described how the GP had told her that she "might be obsessed with food *now*" that she had anorexia. Libby happily recounted how she had "*always* watched cookery programmes" and so the GP's words affirmed to her that she, as she put it, "had always been anorexic." Although "labelling" anorexia as an illness is clinically the first stage of isolating the illness to remove it – a process discussed in Chapter Three - here being diagnosed instead opens up a space in which Libby can be "stereotypically anorexic," where personhood and anorexia (re-)merge. Informants in both field sites echoed Libby's words, discussing how diagnosis affirmed them not only as *having* anorexia, but as *being* anorexic both in the present and, importantly, also in the past; this re-evokes the dual temporality of anorexia's permanence explored in the last chapter and shows that to informants diagnosis, rather than the label of a temporary aberrant state, is a marker of permanence.

However, if diagnosis legitimises one's personhood by affirming that one is 'good enough' to be clinically diagnosed, it necessarily carries with it a visceral anxiety about *not* being good enough. Juxtaposed with its comforting stasis, diagnosis also engenders attempts to live up to it; or perhaps, "to make an end is to make a beginning" (Eliot 1963: 221). In her interview Milla said:

> "I'm not sure that I am actually anorexic…. I have a problem with food. But, I think that's because of my own shortcomings. It's not to do with an illness

and it's not because of something that's invaded my mind. It's something that's come organically out of my wiring."

Milla, inpatient

At first glance, we might compare Milla's words to Chloe and Libby's discussions of the 'lumping together' done by the clinic, above. It might appear that Milla is rejecting the label 'anorexia,' or at least, the labelling. However, Milla explained that she inhabited her diagnosis "anxiously," feeling "not good enough" for it. Here this is not only about being unworthy of care, but about being 'essentially' unworthy. Milla questioned whether her "problem with food" was "enough" to warrant the appellation (or, perhaps, accolade) 'anorexic.' Echoing the thesis's previous explorations of 'being' and/*as* 'becoming,'[117] Milla demonstrates that inhabiting one's diagnosis is active as well as static; diagnostic criteria become tools against which she measures herself. Diagnosis is therefore not just something that is 'done' to informants. It is something that they reach towards, feeling their way around its perimeters and, importantly, attempting to fit themselves to, and within, these. In her interview Eva said:

> "Telling me I was anorexic allowed me to be anorexic and so therefore it allows… even with my mum I think, she just kind of thought 'ok so she doesn't eat but it doesn't really matter because'… not that it doesn't matter but, 'it's because she's anorexic.' Therefore she wouldn't try and force me to eat because she knew there was a reason for it. But not only that, but… it makes me…if I have a thought, a positive thought, I tell myself off for it because it's not anorexic and *I'm* anorexic"

Eva, inpatient

Eva suggests that the very moment of receiving her diagnosis set a process in motion. In her interview, Jumela described how she had visited her first pro-anorexia website on the same day she was diagnosed. Demonstrating both the potential danger of these websites as well as their value to informants, Jumela said:

---

[117] See Mead 1967 and Chapters Two & Four this thesis.

"I decided to go onto it to be sure I was anorexic, because I was very new to the situation. I found it so amazingly helpful that I actually started to use it for hours every day."

Jumela, Facebook Pro-Anorexia Research Group participant,

interviewed online

These accounts of living up to one's diagnosis[118] echo those of informants in the last chapter who described following and pressing themselves into their anorexia as it moved away from them of its own accord or through the actions of the clinic. Now clinical agency and anorexia's agency paradoxically pull in the same direction. Informants press further into anorexia *through* the clinic. This simultaneity and the sense of, once again, "making do" (de Certeau 1984) that this section's discussions of ambivalence, personhood and 'becoming' have evoked, are extended by the next sections' discussion of pro-anorexic delineations of health and harm. From these emerges a sense that "the line between compliance and subversion is always a fine one, difficult to draw with any certainty" (Grosz 1994: 144).

1: A. 2　　　"Healthy Anorexia"

Many pro-anorexia websites have pages of health information, which ranges from advice on vitamins and the care of 'anorexia-dried' skin to warnings about endocrine changes in the starved body, ketones, electrolytes and heart failure. Woven through participants' anecdotal exchanges, this information derives from medical journals and textbooks, with sources sometimes identified. On one site the *Webmistress* uploaded extracts from *The Biology of Human Starvation* (Keys et al. 1950). This was employed to illustrate the staged effects of starvation on the body as this, in her words, "breaks down." I suggested in Chapter One that widespread press assumptions that participants to pro-anorexia websites 'do not know what they are doing' are not supported by my fieldwork data. Instead, I concur with Williams and Reid in their study of the websites; they state, "many of the pro-anorexics have such a strong want for their anorexia that they are willing to sacrifice their health in order to continue with their anorexic behaviours: They know of the dangerous consequences associated with their behaviours but this

---

[118] Living up to one's diagnosis in the context of anorexia has also been noted by other social scientists, namely Allen 2008; O'Conner & Van Esterik 2008; Warin 2010.

does not deter them from continuing" (Williams & Reid 2007: 150). This is supported by this quotation:

"Pro anorexia is the desire to remain eating disorder thin without the side effects of ill health or the consequences of an eating disorder. And in some cases, accepting the side effects but attempting to simply stay alive."

Quotation from a "What is Pro-Ana?" page

Looking closely at parameters of health and harm on the websites reveals there to be other complex engagements with biomedical knowledge and categories.

A pro-anorexia website suggests:

"If you're gonna be Anorexic, be as healthy as possible."

Tip on a pro-anorexia website

Likewise, in their interviews, Paula and Jumela said:

"I've never been unhealthy with the anorexia. I always made sure I ate something and it was always really healthy food when I did eat."

Paula, inpatient

"I use the sites to keep myself healthy."

Jumela, Facebook Pro-Anorexia Research Group participant,
interviewed online

Echoing how "normal for anorexia," as Josie put it, was carved into the inhabited space of diagnosis, emerging here is a specific sense of "anorexic health." Health is framed as something that is produced *in spite of* anorexia but also, particularly in Paula's interview, as also possible *through* it. Pro-anorexia websites often have a plethora of *Tips* on how to "stay healthy," meaning to produce this 'anorexic health:'

"Water is important. You must drink water to survive, and it has zero calories, so there's no excuse to not drink it. As we typically get much of our water content through foods, when we reduce food intake we begin to

dehydrate ourselves, which is dangerous. Also, cold water chills the body which may raise metabolism to get warm again."

"Try taking some supplements to keep yourself healthy."

"Vitamins and Minerals are essential for optimal weight loss and well-being. You must take these in order to survive and so you need to take a basic daily multivitamin."

Tips on pro-anorexia websites

These *Tips* were echoed during fieldwork in the EDU where informants also told each other to take vitamins or, simply, to "look after yourself."

This type of health advice in both field sites performs 'health' as not in tension with maintaining and enhancing anorexia. Just as we saw how diagnosis is no longer "prefigured by the therapy that will 'follow' from it" (Mol & Law 1994: 661), once it is appropriated by informants, health information that would normatively preclude anorexia is no longer correlated with recovery from the illness. As such, informants "bricolent innumerable and infintesimal transformations of and within the dominant cultural economy in order to adapt it to their own interests and their own rules" (de Certeau 1984: xiv), actively *making* anorexia *through* health advice that derives from the clinic. In his discussions of AIDS activism, Steven Epstein describes how in relation to medical knowledge people often "neither simply enlist experts nor attack them but, rather, undergo a process of 'expertification'" (Epstein 1996: 13). This exchange and use of health advice can be seen as an "expertification;" informants learn and leave intact ways of reading health through vitamin levels and electrolyte balances, whilst employing them to maintain illness. As such, health is here an "immutable mobile" (Latour 1987). It is mobilised and restaged but, importantly, not re-signified; becoming deictic, health maintains its boundaries but is made to relate to anorexia in seemingly antithetical ways. There is a sense of 'hybridity' (see Haraway 1999) and antiphrasis here, but also of a tension between fluidity and fixity.

Echoing how diagnosis offered a way of "making do'" (de Certeau 1984: xv), here a clinically-rooted category of health is opened up in order that anorexia can be inserted into it. This reassembling of health may seem fluid but it signifies, rather,

a paradoxical quantification (see Canguilhem 1991) and solidification of a category that is, to the clinic, arguably more mutable and multiply constructed than informants allow it to be now. Placing anorexia inside health stretches but also tightens health's boundaries by giving it a mirror opposite to define itself against. Evincing how health and harm are made into differences in "kind," not "degree" (Mol 2002: 122), health's opposite becomes, quite simply, death. This was demonstrated by one of the *Tips* above which advised participants to take vitamins "to survive." A 'healthy anorexia' is one that successfully negotiates dying on a day-to-day basis and "information on how to survive and how to avoid becoming seriously ill" (Ferreday 2003: 284) is information on how not to die. Given Chapter Two's discussion of death, 'good anorexics' are, thus, 'healthy anorexics.' Informants' 'expert' engagements with BMI charts in both field sites also illustrate how the maintaining of health, in opposition to death, makes one a good anorexic.

BMI charts are one of most common technologies of the eating disorders clinic. In the EDU patients' BMIs were continually calculated, particularly if they were about to go on leave, had just returned, or if they wanted join a Group such as Cooking Group; this latter, as we saw in Chapter Two, had a stipulated minimum BMI, which hints forward to Part Two's suggestion that through its practices the clinic elides anorexia and thinness, judging a patient with a higher BMI to be 'less anorexic.' To these calculations there was also, particularly before a leave period, a narrative of danger as working out a patient's BMI signified a calculation of risk. It is this balancing of risk that pervades informants' engagements with BMI charts. Informants in both field sites recounted how they constantly calculated their BMIs not only to give themselves target weights but also to see if they were creeping too close to death.

If death is the only marker of unhealthy, anything that avoids it becomes healthy; one can be healthy and starve or, indeed, be healthy and take diet pills:

"Diet pills are amazing, but you have to be careful. Try to eat something small and safe when you take one, like an apple or a small piece of grilled chicken. If you don't then you will get awful side effects."

Tip

Yet, this mention of "side effects" is interesting; it demonstrates how in relation to these pro-anorexic categorisations of health and harm, experiential subjectivities of suffering in which informants might *feel* unhealthy or unwell are dually positioned. Symptoms that might indicate a lack of health are only 'unhealthy' if they are deemed to be the surface markers of a deeper threat of death – if they indicate fatal electrolyte imbalances for example. If they just "feel bad" but are not fatal, such affective sufferings are not relevant to this schema; they are denied any figurative significance, rendered instead merely diacritic as surfaces and subjectivities "relate but don't add up" (Mol & Law 2002: 1). Bodies only become central here if about to die. Keeping them healthy arguably keeps - and intends to keep – bodies absent from relationships between personhood and anorexia; this way they are not threatening. This rejection of a necessary correlation between bodily surfaces, depths and subjectivities echoes previous discussions both of relationships between bodies and anorexia and also between binaries of inner and outer, the latter which we saw to be problematized particularly by informants' usage of "that's the anorexia talking." But, if diacritic, bodily suffering can also, if sufficiently linked to the "quiet starving" of a good anorexia as Chloe put it in the last chapter, be paradoxically healthy; it signifies that informants are 'doing anorexia right' even if it *feels awful,* as these quotations illustrate:

> "Find something that makes you feel ill and look at it while you eat. After a while you will begin to associate food will feeling ill"

> "When you start to get dizzy and weak, you're almost there".
>
> *Tips*

However, if suffering begins to hamper informants' practices of starving – and thus, relationships between anorexia and personhood - by making these feel less desirable, once again the clinic is borrowed from. During fieldwork, informants in both field sites advised each other how to soothe joint pain, heal sores and 'feel better' with medications and techniques learnt from medical textbooks and on websites such as *Netdoctor*. One *Tip* that illustrates the simultaneous desires of easing suffering and continuing starving is:

> "Epson Salt baths are soothing to sore-achy, weak muscles and also help eliminate toxins through the skin. Warm Epson Salt baths are great during fasts."

Engagements with painkillers and Epsom salts are reminiscent of discussions in the last chapter in which informants, such as Eva, discussed allowing their bodies to be cared for by moving the illness out of the body beyond the clinic's reach. This implicates not only the knowledge and categories of the clinic in producing an anorexic health, but also perhaps more deeply intertwines the clinic with the day-to-day production of anorexia itself. Throughout this section the clinic has been co-opted in various ways to both make anorexia 'good' and to be 'good at anorexia.' But, when the suffering body is woven through, and even made to support, these processes, there emerges a glimmering hinterland of ambivalence. Because suffering can indicate the proximity of death, and thus that anorexia has 'gone too far,' appropriating health advice not only supports, but also "interferes" (Haraway 2008) with, anorexia by limiting its agency. Echoing the discussions of care and stigma where diagnosis offered a negotiated modality of "becoming" (Deleuze 1998), here there is a "double resistance" (Abu Lughod 1990: 52) to the clinic *and* anorexia; the agency of both are "ambiguated" (Battaglia 1997) as each countervails the other. This sense of doubledness and ambivalence also pervades the next section's discussion of informants' appropriations and subversions of clinical texts.

1: B   Appropriations & Subversions of the Clinic

1: B. 1   Texts: Ambivalences & Oppositions

Throughout this thesis I have paid attention to texts, particularly memoirs, and their social life in the field; I have argued these to conjoin the field sites, embodying tangible as well as conceptual meeting points. In previous chapters I have also mentioned the *Letters from Ana* found on pro-anorexia websites. In the current context of appropriations and subversions, it is interesting to trace the relationship between these letters and the clinic. *Letters from Ana,* only found on the Internet, are subversive accompaniments to, and extensions of, *Letters to Ana* that derive from treatment and which are also present on the websites.

Writing a letter to one's anorexia is set as a therapeutic writing task in a range of eating disorders treatments and was a technique utilised on the EDU.[119] It is intended to incite a patient's ambivalence, thereby instigating desire to recover in a similar way to the clinic's use of "that's the anorexia talking" in Chapter Three. Most commonly structured as a letter in two parts that set out the pros and cons of the illness, these letters address *Ana* as *either* friend *or* enemy. They thereby frame as binary the many nuances of informants' relationships with anorexia. Many pro-anorexia websites feature pages of *Letters to Ana* and these are not infrequently prefaced by statements that the participant "wrote this for my clinician/therapist…" But, replication of the same letter across multiple sites also illustrates how these texts are dislocated from their therapeutic rationale to become communal tropes of pro-anorexia, passed around as symbolic 'templates' of ambivalent relationality. Two lines from a *Letter to Ana* are:

"Please Ana, don't give up on me. I'm so weak."

"Please Ana, remove me from this hell."

In their transfer to the Internet, many of the letters lose their binary structure, thereby allowing *Ana* to be *both* friend *and* enemy and the texts to be simultaneously ambivalent and desiring. As such, although *Letters to Ana* might seem to bring the clinic and pro-anorexia into dialogue with each other, this is a dialogue of silences and reversals. Transferred to the sites, particularly in tandem with *Letters from Ana,* these epistolary forms signify an assertion of subjectivities of anorexia that do not fit with biomedical ontologies. Particularly as "writing is inseparable from becoming" (Deleuze 1998: 1), informants' transfer of their letters from treatment to the Internet signifies an ambivalent assertion of voice that signifies, at once, both a "struggling along" (Desjarlais 2010) and an enactment of desire. But, I also suggest that the constant exchange and reading by other website participants of these letters adds a further layer to them; it, perhaps, gives them a multiple anorexic

---

[119] See Schmidt et al. 2002; Serpell et al. 1999.

voice, formed through the "relational character of textual identity" (Chambers 1991: 5).

If informants' discussions of an 'anorexic health' signified the simultaneous appropriation and yet redeployment of clinical categories, the ways in which *Letters to* and *from Ana* become a part of pro-anorexia instead illustrate how words themselves can be re-performed by reading as well as by re-writing. Reading has been described as "a 'space' where there is room for maneuver" (ibid. xvi) and as "an oppositional practice productive of change" (ibid. xvii). In the reading of these letters, we see how "if the text acts once, it can act again, and possibly against its prior act" (Butler 1997: 69). Reading performs these letters as pro-anorexic in ways that both undermine the suffering and ambivalence that resonate through their contents, whilst also absorbing these into the landscape of pro-anorexia. Reading's performances of oppositionality and dislocation can also be traced through informants' engagements with the writings of the clinic itself.

On one of the websites on which I was conducting participant observation the *Webmistress* posted a link to an article on Web MD entitled *Weight-loss tip: Add extra calcium to a low fat diet* (Davis 2000). The article discusses how dietary calcium may help reduce body fat as part of a low-fat diet, and explains what foods this is found in. Next to a link to the paper, the research was distilled into*:*

"Take calcium tablets to burn fat, doctors say it works!"

Tip on a pro-anorexia website

Although by following the link this *Tip* could be contextualized if a participant desired, the narrowing of the research into this advice to take calcium tablets whilst starving evinces a dislocation; this now pro-anorexic 'fact' is broken from its clinical roots and fitted into an entirely different ontological positioning. As such, although, like the health information discussed above, this research is often taken from medical journals and textbooks, here it loses its connections with these, whilst also maintaining their legitimacy. On another site was posted:

"Studies show that the longer you stay in a darkened room, the hungrier you'll get."

Quotation from a pro-anorexia website

Here "facts function differently" (Dumit 2006: 587), becoming mutable as they are transformed into "evidence" (Latour 1987[120]) for, and support, ways to maintain, anorexia. As such, these appropriations of clinical research demonstrate "the production through reading of a meaning that is not said, a (mis-)reading" (Chambers 1991: xvi). This sense of ironic 'mis-reading' is also apparent in informants' engagements with clinical texts about anorexia itself.

We have previously seen how many informants use recovery texts and memoirs lent by staff to 'skim them for tips,' as Chloe put it in Chapter Two. Although subversive in the sense of using books about recovery to enhance illness, such 'mis-readings' can also be contextualised as part of the widely-documented ways in which anorexics in treatment learn how to be 'better at anorexia' from each other[121] – and now, of course, from pro-anorexia websites. But, informants in both field sites also frequently recounted reading clinical texts about anorexia, from carers' literature to textbooks. About her readings, Gillian said:

"See, all of us in here, there's really nothing we don't know about anorexia."

Gillian, inpatient

A book that was freely available on the EDU, and which I often found lying around in the Patients' Lounge, was *Skills-based Learning for Caring for a Loved One with an Eating Disorder* (Treasure et al. 2007). It was sometimes lent by staff to patients, and almost always to their carers, so that the latter might understand anorexia better. In her interview, Miriam described how both of her parents were reading this book; she painted a humorous verbal portrait of them sitting side-by-side on the sofa at home each with a copy in their hand, "comparing notes about me," as she put it. Explaining why she had set about reading this text the instant it was lent to her parents, Miriam said:

"It's just to see how much they know, really, so I can keep one step ahead of them."

Miriam, inpatient

---

[120] Also, Latour & Woolgar 1986.
[121] See Gremillion 2003; Shelley 1997; Warin 2010.

In Miriam's discussion of her use of this book to position herself in relation to her parents and to treatment, we have slipped from one modality of appropriation and subversion of clinical 'facts' to another. By engaging with and borrowing research like the calcium paper above, informants subvert clinical knowledge itself, fracturing 'facts' to fit with their desires, thereby absorbing these into anorexia to maintain and enhance the illness. Here, Miriam keeps the knowledge intact, using it, rather, as a tool of subversion against her parents and the clinic. She "keep[s her] anorexia safe," as she put it, by building a protective wall of knowledge around it. Miriam's reading thereby transforms this text from 'ways to help your loved ones fight anorexia' into 'ways to fight for anorexia against your loved ones' and, indeed, treatment professionals. Miriam's 'keeping ahead' *through* - or perhaps, *with* - the clinic illustrates how, as Grosz writes in conversation with Foucault, power "is transformed, realigned, shifted with transformations in the order and functioning of knowledges" (Grosz 1994: 148[122]). But, it also shows how this "practice of oppositionality" (de Certeau 1984) is performed within, and, importantly, *from* the clinic's own power. Miriam's pro-anorexia here draws on and perhaps even "depends on the power it opposes" (Chambers 1991: xiv). It is to such "mutual entailments of power and opposition" (ibid. 2) in pro-anorexia that the next section turns. It explores practices to avoid treatment that co-opt the clinic's gaze, using it against itself; we see how "power is a thing of the senses. It lives in a capacity, or a yearning, or a festering resentment. […] It can be harvested for future reference" (Stewart 2007: 84) from, and within, the biological intimacies of corporeal practices.

1: B. 2   Using the Clinic Against Itself

Gaviscon is an indigestion remedy and one that is ever-present on the EDU. It is not a prescription only drug and so it can be requested by patients as well as prescribed by doctors; or, to put it another way, it can be activated by patients' subjectivities of suffering as well as by the clinical gaze. At times during fieldwork, in multi-disciplinary meetings patients' drug charts were examined and it was suddenly realised that some patients had successfully but legitimately consumed vast quantities of *Gaviscon* by requesting it after every single meal from different

---

[122] Also, Foucault 1977 & 1980

members of staff. This process was also discussed, unprompted, by some informants; many talked about *Gaviscon* with desire, and this was clearly doubled. On the one hand, the large amount of food that was consumed as part of treatment meant that many informants, after months of self-starving, found eating extremely physically uncomfortable, even painful. *Gaviscon* signified a way to agentially assuage their own suffering. Echoing informants' soothing of suffering caused by anorexia, above, here the tools of the clinic are used to make treatment less "unendurable" (Fischer 2007). As only a digestion remedy, thus, we might regard *Gaviscon* as indicative of the claim that "oppositional practices do not really work against prevailing systems but, to the contrary, strengthen them by making them liveable" (Chambers 1991: 7). But, we know also that "the social lives of medicines" (Reynolds Whyte, Van der Geest & Hardon 2002[123]) are not so linear or singular. *Gaviscon* is - or at least it is according to informants - a laxative; actually, *Gaviscon* is only a laxative in very large quantities. Many informants recounted going to the Meds Hatch to ask for *Gaviscon* to *both* assuage their uncomfortable feeling of fullness and to use it as a laxative. These desires are not in conflict; getting rid of the food does also rid one of indigestion. But, "getting rid of food" was also a phrase used by many informants who discussed their pro-anorexic desire to "get rid of lunch," for example. Informants' use of *Gaviscon* as a laxative therefore constituted an appropriation of a clinical tool in order to subvert the clinic. Although *Gaviscon's* oppositionality was enacted within the material spaces of the body, much more common to this process of appropriating to subvert was a deflection of the clinical gaze.

Whilst waiting for a place to become available in an EDU, Paula had once been admitted on section to a general medical ward. Paula described the staff on the general medical ward as "not knowing what to do with [her]." She said:

> "They're not clued up. And by and large, particularly if you've had a problem for many years, we are. You know, if they... well, for example, if they do their horrific naso-gastric tube feeding or whatever, if they do it to other patients on the ward who are usually elderly and post-op and all the rest of it, then they do it and that's it. But, if you do it with us... well, you know,

---

[123] Also, Sanabria 2009.

we'll make a little hole in the bottom of it or … take it out and lie it next to you… and all sorts of things… and they wouldn't be aware. Whereas here they're ultra-vigilant, as you see, with everything. There they give you a meal and walk away. So they don't know if you share it with the person in the bed next to you."

Paula, Inpatient

I asked, "and did you share it?" Paula replied:

"Oh God yeah, of course! I had a diabetic patient next to me… and we had two things going on. First she would eat all my food and end up in a diabetic… I mean, now I'm older and I wouldn't, I know the medical implications for her. She got a lot sicker than me because she had her diabetic highs and lows, she was in a terrible state. And in the end because she was in such a terrible state they put her on nil by mouth… and so I removed her nil by mouth sign every time the dinner trolley came round and put it by my bed. Because it's auxiliaries that go around with the meals as well, not the nurses, and if they see a nil by mouth sign over your bed they just pass you by… so I would just get passed on by."

Paula

Here Paula visually reframes her body with the borrowed words of the 'nil by mouth' sign. This kind of oppositional practice substantiated by concealment and deflection resonated through many informants' interviews, as we have seen in previous chapters. In hers, Laura wrote:

"I think a good anorexic is someone who continues to stay out of treatment and to eat and exercise as they wish. A good anorexic is constantly trying to avoid being "found out" even if many people that they know are well aware that they have an eating issue. For me, all my family are experts on my eating habits and it doesn't matter how much i try to hide it from them they know when i am not eating, however, even though inside me i am well aware that they know i will do everything in my power to try and conceal it from people. I am currently having hospital treatment and while i try to make the

scales go down every day of my life, when i go to be weighed i drink loads of water, i put weights in my clothes just to try to stop people from knowing."

Laura, Facebook Research Group participant,

interviewed online

Ways to both stay out of treatment and to circumvent it when inside are exchanged through the movement of informants between pro-anorexia websites and clinical settings. Within each, the falsifying practices Laura describes are shared and honed before being passed back to the other. Particularly pertinent to this discussion is how such practices focus on obscuring the visuality of the anorexic body, seeking to rupture the "dissecting" and "vertical" (Foucault 2003) readings of anorexia by the "medical gaze" (ibid.); informants do this by appropriating biomedical knowledge through which drugs and bodies, visuality and weights, are all connected and reconnected, ruptured and mimed. Extending informants' discussions of how the body "betrays" anorexia by revealing it and rendering it vulnerable in the previous chapter, many informants discussed how anorexia's visibility not only stemmed from emaciation, but was also enacted by the "access of the medical gaze into the sick body" (Foucault 2003: 168). Hence, many pro-anorexia websites advise participants how to temporarily alter the insides of the body, thereby obscuring anorexia from the inside out.

One of the ways most commonly discussed by informants in both field spaces is waterloading, which is the drinking of vast amounts of water to make the body heavier before being weighed by a clinician.[124] On pro-anorexia websites there is much debate over how much water is 'safe' and how much 'dangerous' – the latter again meaning, simply, fatal. On the EDU during fieldwork waterloading was also a very frequent occurrence, with some inpatients drinking as much as four litres of water in the hour before a weigh-in. This was such a large quantity that it would not all pass through the body and many would vomit it up again straight after the weigh-in. It was once joked in Management Round that nobody ever needed to water the plant in the Admin corridor "because the patients do." A *Trick* on a pro-anorexia website states:

---

[124] See Patel, Pratt & Greydanus 2003; Robinson 2009 for clinical perspectives on waterloading.

"Waterloading is really good. A pint of water is about a pound of weight. But remember, this won't work for you if they do a urinalysis (when you pee in a cup), your doctor will totally know you've been waterloading."

Trick

Waterloading's inadequacy against the technological perspicacity of the clinic's gaze, however, leads us to consider another practice that employs the cellular intricacies of biomedical knowledge to temporarily alter the cellular intimacies of the starved body, thereby literally making it appear different.

Some *Tricks* on pro-anorexia websites suggest:

"Practice meditation to control your heart rate."

"Dress warmly to increase body temperature temporarily"

"Always eat a few spoonfuls of salt before you go to a check-up. This will raise blood pressure. But NO more than a teaspoonful in each cup of water or you'll shock your system."

Tricks

Salt eating, as this final *Trick* discusses, is a common oppositional "tactic" (de Certeau 1984) on the Internet and it was also practiced by some informants on the EDU during fieldwork. There, informants had their blood pressure taken at least once every two days, sometimes, if deemed medically necessary, more than twice a day. In the Ward there was no salt available because staff knew that salt would not only alter blood pressure readings but might also instigate water retention and dangerously alter electrolyte balances that had already been sent awry by starvation. Knowing this clinical link between starvation and low blood pressure and, therefore, that having this taken would reveal their continuing resistant hidden self-starvation, some informants went to the hospital canteen for packets of salt, eating many at a time. Often the empty packets lurked, discarded, on the floor of the Patients' Lounge.

Through waterloading and salt eating informants dissimulate anorexia and simulate a healthy body, the former Baudrillard tells us implying "a presence, the other an absence" (Baudrillard 1983: 5). Yet, he also suggests that "simulation

threatens the difference between 'true' and 'false,' 'real' and 'imaginary'" (ibid. 5); offering the example of someone who 'simulates' illness, Baudrillard asks, "since the simulator produces 'true' symptoms is he ill or not?" (ibid. 5). Given that through salt eating informants agentially reverse one of the corporeal manifestations of their anorexia, we could suggest that they do not only conceal the illness, but actually (partially) remove it. This removal, moreover, is a paradoxical enactment of being a good anorexic; it reasserts anorexia's presence through its (partial) bodily absence; as Sianne Ngai suggests, emulation "often works to produce the exact opposite of identification: to make manifest an incongruity or disjunction, to forcefully assert one's difference from that which one emulates" (Ngai 2001: 194). Yet, we already know that the relationship between both subjective symptoms and, indeed, the body more widely, is problematized by informants; perhaps anorexia cannot be altered through the body as it is, according to many informants, not located there. Hence, we need to ask not so much how these practices are related to anorexia, but rather, how they are linked to the clinic itself. They gain their significance and power from the clinic's gaze; perhaps they are also produced by it. Foucault discusses how, in the construction of objectivity, visibility is privileged; exploring how this "alliance" between what is said and what is seen historically emerged (Foucault 2003) he charts how the "medical gaze" became one imbued with "vertically […] plunging from the manifest to the hidden" (ibid. 166). I suggest that to fully comprehend engagements between pro-anorexia and the clinic – and, moreover, to see how these are *dialectical* not one-way – we need to explore how a clinical emphasis on the visuality of the anorexic body actually performs links between 'the manifest and the hidden,' thereby locating anorexia firmly in the body. It is to this that Part Two now turns.

Part One has explored the multiple, nuanced and often fractured ways in which informants in both field sites appropriate and inhabit, exchange and subvert, categories and knowledges of the clinic. I first traced how the bestowal of diagnoses offers informants a space in which to *be* anorexic, thus affirming their sense of their own personhood in both the present and the past. The chapter then explored how informants construct a 'healthy anorexia;' by leaving clinical knowledge seemingly intact, this anorexia is threaded from, and to, normative paradigms of health. Yet, anorexia is also inserted into a tightly drawn category of health and contrasted only with death. Through engagements with texts and substances we saw how pro-anorexic oppositionality is enacted within the power structures of the clinic as biomedical knowledge is not only appropriated by informants to maintain themselves as good at anorexia, but also to subvert the clinic's gaze. I suggest that only against the background offered by these discussions can we fully comprehend how informants relate to a very particular but central clinical performance of anorexia and see how "patterns of sensation, forms of agency, or a sense of personhood come about in specific social interactions" (Desjarlais1997: 28) between pro-anorexia and the clinic. Thus, **Part Two** begins by exploring how, through a seeming mimesis of anorexics' own practices around food and eating, the clinic produces a correlation between more anorexic and more thin, employing its gaze not only to locate anorexia within the body but also to frame anorexia as *about* the body. Although this constitutes a way of being (a good) anorexic that is contested by informants, holding together the clinic and pro-anorexia in one analytic space reveals how informants learn and inhabit this anorexia, rendering it simultaneously visual and haptic.

Part Two   Mappings: Mimed & Emergent Anorexias

2: A   The Clinic's Performances of Anorexia

2: A. 1   Food: Mimesis & Production

One afternoon in June Poppy, an inpatient, and I passed the time between Lunch and Snacks by messing about on the Internet in the OT office, randomly following links, reading the news, and looking up 'stuff' that came to mind. Poppy mentioned that she had overheard another informant and me chatting about poetry. Listening to that conversation, she said, had re-ignited a curiosity about poetry, which she had not read since being at school. So, Poppy wondered if I could point her towards some poetry to read and we began to *Google* famous poets, reading anything that the search engine offered. Fifty lines into *The Love Song of J. Alfred Prufrock*, Poppy gasped and said:

> "Oh wow, that's so much like here!"
>
> *Poppy, inpatient*

The line to which she was referring was:

> "I have measured out my life with coffee spoons."
>
> *Eliot 1963: 14*

Poppy explained that on being admitted to the EDU, and realising that inpatients were allowed to keep their own coffee in the Dining Room, she had asked her mother to pop out for a jar of coffee. Clearly anticipating a long stay, her mother bought a "massive," as Poppy put it, 300g jar of coffee. At the time, Poppy said, she had been surprised and told her mum that she'd "never get through all that." But, Poppy said:

> "Now look at me, 300 jars later! I could measure this admission in endless jars of coffee. When I look back over the last few months I think of all those jars of coffee… and of all those meals… having to eat over and over for so many months."
>
> *Poppy*

Poppy's measuring of her admission in coffee and meals denotes the centrality of eating to life on the EDU. For Poppy, each cup of coffee has designated a meal and each jar, the months of admission enforcing those meals.

Given the risks of severe emaciation and the "intensive care" (Treasure & Schmidt 2005: 95) required by the starved body, it is clear how from a clinical point of view, "there is no doubt that the appropriate treatment is food" (ibid. 95). Moreover, as we have seen throughout this thesis, this suffering body is arguably one of the few ways that anorexia can be clinically 'grasped,' given the illness's mobility and elusiveness in informants' accounts. Thus, although the NICE guidelines state that "weight gain is only one outcome of interest" (NICE 2004: paragraph 6.4.9), arguably "the common goal is 'to re-feed the patient,'" (Griffiths & Russell 1998: 128) across eating disorders inpatient treatment. On the EDU this takes place, as I noted in Chapter One, within an expansive programme of psychological intervention and support. However, the necessity of planning the eating of 3,500 calories into the day means that all time is arranged around meals. In their interviews Kate and Lola said:

> "Every day is just, sort of, eating, to be honest. All I've been doing here is…. my whole life is planned around meals."

> *Kate, inpatient*

> "Ten minutes before a meal the panic's rising, more stress….and just that… every day you wake up and think, 'it cannot be another day! I cannot do this! I can't… can't do all that eating again.' It's awful here."

> *Lola, inpatient*

The "constant eating," as another informant, Elle, put it, was a continuous topic of conversation with many informants. If I bumped into someone I had not seen for a few hours and asked them what they 'had been up to,' many would reply with humour, "eating!" It frequently infuriated informants when staff would not admit that 3,500 calories was, as Chloe put it, "a shed load of food." A temporary psychiatric nurse once said to the patients during lunch:

"Gosh you really do have to eat a lot, don't you!"

Peter, Temporary Psychiatric Nurse

He was chastised for this in a subsequent staff meeting but some informants greeted his words with delight, saying that they 'appreciated his honesty,' which was contrasted to the discursive norms of the unit. Abigail said in her interview:

"They [staff] always tell us 'you have to eat, it's normal.'…Oh yeah, cos, everyone has a sandwich an hour after they've had lunch! It's just getting that sense of what is normal back again and …at the moment I just don't have a clue… It's just making me hate food, it really is. I mean, yeah…I may have an eating disorder but I am still a normal person as well. My anorexia is just as bad as it was a year ago. I'm fatter, that's the only difference. All they do in inpatient treatment is feed you, food, food, food, more food….I wish they'd admit that all they do is feed you and then let you go… I just wish they'd admit that… or warn you that's what's going to happen when you go in. They say they're going to change you and… and help and stuff. But they don't, they just make you fatter. It's shit."

Abigail, inpatient

In the EDU eating was also enforced by the Peer Pressure System and by Assisted Feeding. Although "feeding against the will of the patient should be an intervention of last resort in the care and management of anorexia nervosa" (NICE 2004: Paragraph 4.4.4.9) and it "is extremely rare in specialist units" (Tiller et al. 1993: 680) Assisted Feeding did take place during my fieldwork, but only of two patients.[125] It involves holding down a patient on a beanbag in the Dining Room and pipetting *Fresubin* or cream into their mouth. On their way into this room for meals informants would sometimes glance or gesture at the beanbag, which lay slumped and stained just inside the door, and shudder. Whilst it does demonstrate the care of the physician for the patient (see Yager 1995) by saving lives, Assisted Feeding was an event of horror during fieldwork, replete with screaming that cut through the EDU. At the end of an Assisted Feed, staff would be wet with *Fresubin* and vomit and the patient would be grey and limp, cradled in a nurse's arms. Perhaps because of the horror inspired by Assisted Feeds, they are surrounded by whispers

---

[125] See Chapter Three this thesis for relationships of Assisted Feeding with treatment enforcements and refusals, particularly in Holly's life.

and myths; for the entirety of fieldwork, there was a *Mars Bar* in the Dining Room freezer. Many informants whispered that it was for an Assisted Feed, to be blended with cream. According to staff there was no truth in this at all; no one seemed to know what the *Mars Bar* was doing there. Eventually, on a long night shift, a nurse ate it.

In their interviews many informants noted the contradiction of the fact that food, in the form of *Fresubin* or Assisted Feeds, was a punishment for not eating. This is the first sense of how, just as informants' borrowed from the clinic to rupture its power, the clinic also appropriates anorexia to subvert it - to "break the self-starver's will" (Eckermann 1997: 157); if oppositionality is, as we saw above, dependent on the power it opposes,[126] here the clinic is dependant – even, modelled – on the anorexia it opposes. This mimesis was pointed out to me by many informants. In the EDU everybody looks at everyone else's plate, assessing whether their food portion is bigger. However, although being over-served was a pervasive anxiety amongst informants, when carefully taught to serve food in the Dining Room I learnt how to calculate and weigh portions with an exactitude and rigidity that clearly mirrored the kind of behaviour described by informants in their interviews; as Mandy Allison puts it in her memoir, treatment "mimics facets of the illness" (Allison 2009: 141). It was about this that Lia said:

"It's a surreal setting, here."

Lia, inpatient

In her interview Elle attributed to this mimesis the "torturous" nature of treatment; she said:

"It [treatment] acts out the torture that's inside your head. You're already trapped in food and weight. The Ward is a physical representation of this and so that's why you're so desperate to get out."

Elle, inpatient

Elle's words do suggest, perhaps, why an "overemphasis on weight and weight restoration have been identified as unhelpful or harmful aspects of treatment by

---

[126] Foucault 1977 & 1980.

adults receiving inpatient treatment (Button & Warren, 2001 [127]). But, there is also something more complex to this mimesis. As regimented portioning of food, or eating within a certain time, for example, are subsumed into clinical praxis and invested with teleologies of recovery, this echopraxia, which (force) feeds rather than (self) starves, performs itself as a reversal, making tangible diverging "praxeontologies" (Hirschauer 1998: 15). Taussig argues that "mimesis registers both sameness and difference, of being like and being other" (Taussig 1993: 129) and in the enactment of ontological otherness, through this mimesis the clinic dislocates these practices from their wider contexts for informants. In Chapter Two I argued that, as part of making oneself a good anorexic, food practices are relationships of absence. Since then I have also linked these to the relationality of maintaining anorexia, as well as shown how even where food is concerned anorexia, 'does not always talk;' all these nuances could be described as replete with, to borrow from Derrida, "that fragile fluctuating center which forms never reach" (Derrida 2001: 225). In the clinic's mimesis of informants' food practices these links are broken precisely because, particularly where food is concerned, the clinic assumes that 'anorexia *always* talks.'

Michelle discussed how deliberate tactics to avoid eating, such as crumbling her toast into her pyjamas or putting butter in her pockets in the EDU were not the same as "forgetting to eat a bit of lettuce or a crumb on [her] plate," as she put it. Echoing many other informants, Michelle said that the former "is anorexic," the latter, "just normal." Although in Part One we saw how informants carved from the clinic ways of asserting a "normal in anorexia," here Michelle maintains these terms as distinct to set herself apart from the clinic and to explain how, despite their multiple overlaps and points of contact, anorexia and personhood are *also* distinct; there is distance as well as proximity between these, which the clinic effaces when it makes patients "dab every last crumb from our plate with our wet fingers," as Michelle put it. This effacement was also illustrated during one of the EDU's interdisciplinary meetings. It was noted by staff that some patients had been adding a little water to the mandatory fruit juice with meals, claiming it to be "too sweet." Although this was a permitted practice in the EDU, the dietician commented:

---

[127] See NICE 2004: 6.5.4 on drop-out from treatment.

"Well that's just not normal is it, who adds water to fruit juice? That's just anorexic."

Sheila, Dietician

Yet I too had been adding water to my fruit juice.

Thus, as well as miming what it sees, perhaps the clinic mimes what it *assumes* it sees. Derrida suggests that mimesis is "always commanded by the process of truth" (Derrida 2004: 206), that it "signifies the presentation of the thing itself" (ibid. 206). Whilst the *visual* resemblance between informants' practices and the clinic's mimesis seems to support this, Abigail was not alone in saying:

"The Ward's more anorexic than we are."

Abigail, inpatient

Mol argues that "medical practices perform their objects" (Mol 2000: 82), suggesting that "enacting disease takes the form of counteracting it" (Mol 2002 A: 93); by "acting on it, transforming it, they *do* [it]" (Mol 1998: 144 – *italics in original*). I suggest that in replicating the practices that it *assumes* are central to anorexia, the clinic *makes* them central. In her interview Galina said of treatment:

"They also didnt give me info on how to eat normally or tips to help to begin to get over it so in that way they helped my ed to keep going if that makes sense."

Galina, pro-anorexia website participant,
interviewed online

The clinic not only, perhaps, performs a new "virtual object" (Mol 1998: 154) of anorexia, but also, Galina suggests, places this within Galina herself; this latter paradoxically roots Galina to, or perhaps within, her anorexia. There is thus not only a doubledness here but also an emergent multiplicity; anorexia is at once present and enforcedly absent in the Dining Room - both 'real' and simulacrous, virtual and tangible, conceptual and corporeal, on *both* sides of the serving hatch. By effacing informants' relationships of absence, the clinic makes alternative linkages. Dislocating informants' eating practices from anything but bodies and anorexia serves to tie these two together. As such, bodies are not only made in the literal sense of nourishment, but also in a more conceptual way; the clinic maps a new

anorexia through the body's digestive geographies (see Foucault 1989; Willems 1998). By making the body present *to* treat it – and also *by* treating it - the clinic locates anorexia *in* the body, thereby 'making' bodies (that are) *essentially anorexic*, and anorexia (that is) *essentially bodily*.

It is perhaps important here to remind ourselves that "there is multiplicity even inside medicine's biomedical 'core'" (Mol & Berg 1998: 3) and "where in textbooks the various versions of a disease tend to be neatly aligned to form a coherent overall picture, in practice there are gaps, fissures and frictions between different performances of any 'one' disease" (Mol 2000: 96). One might suggest that although a particular bodily anorexia emerges from the clinic's feeding practices, this is perhaps only 'an anorexia among many' performed by the clinic, and thus one not warranting such discursive prominence. However, not only was this enforced elision of anorexia and bodies frequently discussed by informants, but it was also apparent in the more intangible day-to-day happenings of the EDU. To illustrate this, thereby giving a sense of the potential power of this correlation of bodies and anorexia to "interfere" (Haraway 2008) with the other anorexia(s) of informants, the next section charts how bodies and anorexia become metonymic as the clinic discursively 'affirms' anorexia as centrally *about* the body.

2: A. 2   Clinical Performances of Anorexia as *About* the Body

In her interview Shereen, an inpatient, expressed her annoyance at being chastised by nursing staff for carrying the hoover to her bedroom, recounting how she was frequently told, "it has wheels for a reason." Shereen protested that she carried the hoover not because she wished to burn calories but, rather, simply because this was a more efficient way of navigating around her possessions in the tiny institutional room that was her temporary home. Echoing informants above, about this Shereen said:

"They [staff] make everything normal abnormal."

Shereen, inpatient

Shereen's words are reminiscent of Mandy Allison's account of eating disorders treatment; in her memoir she writes:

"One nurse would not let me open the windows in my room insisting that I was not hot, but that I wanted to let cool air in order to burn calories [sic]."

Allison 2009: 145

This cumulative daily solidification of a linear and unproblematic linkage between anorexia and the body was also shown by the EDU's attitude to one informant, Stella's, slippers.

"What can one say, I ask, about a slipper?" (Serres 2008: 64) says Michel Serres. In the EDU many things were asked and uttered about Stella's slippers. These were old, worn and not a little battered. Her toe could be glimpsed through the end of one and the other was fraying at the seams. But the soles remained and they were, to all intents and purposes, which comprised walking up and down the Ward, intact. Stella felt that they "would do" and were "good enough" as to replace them when they still "worked as slippers," as she put it, would be "wasteful." To Stella, her slippers were precisely "a place of seams, mixture and marriage" (Serres 2008: 66), part of her wider anti-consumerist ethics. In her interview Stella justified keeping her slippers by saying:

"The way society is now it just seems so complex and in terms of consumerism…. if you were to go and pick a television or a camera or a mobile phone, the list is endless, the choices and the decisions. There's this constant effort to produce a new variety or just something different. Or just, 'new extra this' – even cornflakes, you know, 'extra crunchy' with 'extra added this'…. added whatever, something that people think might be good for their health or improve their teeth of whatever…. Or types of teabags! It's just ridiculous the amount of choice. And there is just such a lot of waste and it creates… whether it's about food or anything, it creates an attitude that it's ok. But the amount of waste we produce is just ridiculous and it's actually shameful I think. Some people elsewhere would do anything for the minutest thing we throw away."

Stella, inpatient

However, the EDU staff often discussed Stella's slippers, trying to convince her to buy a new pair. Staff drew Stella's attention to the visual appearance of her old

slippers, which they clearly linked to her body, pointing out that both *looked* "uncared for." To staff, keeping these slippers was proof that Stella's 'anorexia was talking.' That there were sometimes such resonances between starving and other behaviours was illustrated by Bella and Abigail's laughter-filled but poignant discussion one day in the Patients' Lounge about how they found it difficult to fill their cars with petrol. Given that, as de Certeau suggests, "each individual is a locus in which an incoherent (and often contradictory) plurality of […] relational determinations interact" (de Certeau 1984: xi), such a linkage in Stella's case cannot be ruled out unthinkingly; but as it was vehemently denied by Stella, it also cannot be assumed. By conceptualising Stella's footwear *through* anorexia in this way, staff not only assumed that her eating was *about* the body, but also 'fleshed out' and extrapolated from this assumption. By delinking Stella's slippers from anything but her body and her anorexia, the clinic, again, binds these tautologically together. Through Stella's slippers we can therefore trace how correlations between visuality and substance, surface and depth, are performed by the clinic; it enacts these as coterminous, using the appearance of anorexia *on* the body to make an assumption of the illness as both *in* the body and *in control*. This construction of anorexia through the gaze was most demonstrated during fieldwork by the metonymy of bodies and keys in the EDU.

Lia argued that central to her experience of the EDU was:

"How people perceive you from the weight you are visually."

Lia, inpatient

She expanded on this by discussing how body size was correlated with trust; Lia said that because she had been admitted at a particularly low weight and therefore continued to be emaciated well into treatment, staff assumed that she was 'more anorexic' than other patients who weighed more. And yet, Lia argued, many of these "other patients [were] *much more* anorexic," where that meant:

"More sneaky. You know, they try to hide food or try to not have… not have Snacks or whatever. They're much more anorexic cos they can't be

> trusted. But they look bigger so staff think they're alright….and they trust
> them."

<div align="right">Lia</div>

Although she regarded such patients as untrustworthy because they were more under anorexia's control, Lia suggested that in formulating systems of trust it was only patients' bodies that the clinic noticed. To them, she said, thinner meant more anorexic and thus less in control; larger meant less anorexic and more in control. Given that leave periods or OT activities were decided through this schema, the visuality of the body functioned in the Ward as a key that quite literally opened or closed possibility in a pragmatic sense, as well as illustrated the conceptual defining of anorexia.[128]

Foucault argued that the medical gaze is not only diagnostic, but also disciplinary (Foucault 1989). He suggested that "the disciplines are techniques for assuring the ordering of human multiplicities" (Foucault 1977: 218) and "one of the primary objects of disciplines is to fix" (ibid. 218). We have seen that food is fixed inside the body through regimented feeding practices; anorexia is fixed into the clinic through the visuality of the thin body; and bodies are fixed inside the clinic through this elision of bodies and keys. What is fixed in all of these is the correlation of visible thinness and anorexia. To the clinic, thus, thinness is an index of loss and change, of the disappearance of the "authentic self" into anorexia, as we saw in Chapter Three. Van Loon, in conversation with Derrida, suggests, "an index is like a trace of something else, indicating that this 'other entity' was once, but is no longer, 'present'" (Van Loon 2002: 110). In reading the body as indexical, the clinic makes it the ground upon which the illness and personhood are separated; if anorexia is in the body, feeding the body produces recovery.

Yet, it has also become clear that in pragmatically effacing the bodily traces of anorexia, the clinic also performs a "hyperreal" (Baudrillard 1983) anorexia that is centrally *about* the body. This is a de-relational anorexia of surface, invested with, and reflective of, only pathology, and related to nothing but itself and the body; it is, to borrow from Deleuze, "a hecceity [...] as opposed to a subjectivity" (Deleuze 2007: 130) and one, moreover that would seem to clash with informants' own subjectivities. As such, this performed anorexia could be described as "a body-

---

[128] See also Allison 2009: 153; Bowman 2007: Esp. 163, 198.

without-organs, which is only defined by zones of intensity, thresholds, degrees and fluxes" (Deleuze 2007: 130[129]), by dislocated moments of foods and slippers, images and illness. Yet, although 'body-without-organs' (Deleuze 2007) is a term that resonates with virtuality, it also flickers with potentiality. As the link between more anorexic and more thin solidifies in the clinic, it also becomes "transportable" (Mol 1998: 161) or even, perhaps, "liveable" (Chambers 1991: 7) - an accolade that we saw in Part One's discussion of *Gaviscon* to be ambiguously oppositional and yet self-defeating. Suggesting that "it is the map that engenders the territory" (Baudrillard 1983: 2) the second half of Part Two will now explore informants' relationships with this clinically performed bodily anorexia. Borrowing Sianne Ngai's term "bad examples" (Ngai 2001: 216), which she describes as "examples that actually produce what they should only reflect" (ibid. 218), I explore how this 'hyperreal body-without-organs' is appropriated, subverted and inhabited by informants who body forth "a sensuous sense of the real" (Taussig 1993: 16).

2: B   Informants & the 'Hyperreal' Anorexia
2: B. 1   Loopings & Emergences: Learning the Clinic's Anorexia

Like informants in the previous chapter, Claudine said in her interview:

> "I think there's…there's symptoms and effects of the anorexia, which manifests itself in a physical form, or whatever and therefore is seen like an illness and maybe, yes, the weight… the low weight is an illness in itself … yes, that's what it's like; the low weight's the illness but the mental thoughts are me."

> *Claudine, inpatient*

As well as echoing Part One's discussions of how a 'healthy anorexia' does or does not intersect with subjectivities of suffering, Claudine illustrates, once again, that to many informants anorexia is a relationship through which they mediate their lives, not their bodies. In contrast to the clinic's performances of an anorexia that is bodily but not embodied, for many informants, anorexia is embodied but not bodily. It is with this in mind that we need to approach informants' accounts of vomiting.

---

[129] Also Deleuze & Guattari 2004.

An expectation that anorexics vomit is built into the locks and keys in the clinic - into the limitations placed on patients' movements during Rest Periods and Toilet Supervisions. In her interview Lia described this expectation as:

"…..really really hurtful. It's the most horrible feeling in the world"

Lia, inpatient.

She said that although staff:

"….assume that's just what anorexics do, we don't![130]"

Lia

Vomiting is, as we saw in Chapter Two, liminal; it purifies bodies but it is also "abject" (Kristeva 1982) and is thus not a wholly laudatory part of being a good anorexic. Yet, whilst discussing vomiting with visceral horror, Lia also admitted that she had begun vomiting since entering treatment; she said:

> "I've never vomited, vomiting's not me. I hate it, it's disgusting. But, I'd say that a lot of my behaviour's got a lot worse since I came into hospital. I did not have the faintest idea, you know… I struggled outside with eating…. obviously I didn't eat ice-cream, I know that was a problem. But I never knew that if you had more, had more on your plate that was a bad thing, I never thought of it that sort of way. And then all of a sudden calories became important. With me it was never about calories, it was more about fat content and healthy eating."

Lia

It might be suggested that Lia's vomiting demonstrates, following Hacking, a "looping effect of kinds" (Hacking 1995: 21) in which "people classified in a certain way tend to conform to or grow into the ways they are described" (ibid. 21). That the clinic "may even lead people to evolve their feelings and behaviour in part because they are so classified" (Hacking 1999: 104) is demonstrated by Tara's discussion of how she too had begun to vomit in treatment:

---

[130] Whilst I recognise that the particular relationship that vomit has with each sub-type of anorexia is different, there is not space to reflect on these here. Rather, this discussion's focus is on how informants who did not vomit outside the clinic began to do so in treatment.

"It [the expectation] can make someone angry and then when someone's angry it can bring on emotions that people use this eating disorder for and that can strengthen and can make you like: 'well, I'm going to do it anyway!'… You'll be like, you know, 'it's hard enough. I'm trying not to but you asked so there you go!'"

Tara, inpatient

In her interview, likewise, Elle said:

"The transition [to inpatient treatment] and that change means that the way that someone struggles inside of here is going to be different to how they struggle outside because…. erm,…control is taken away and you have no control over any aspect of your life, including your eating disorder…. erm, means that then it's going to come out in some ways for you to grab some control back."

. *Elle, inpatient*

Elle's and Tara's words clearly suggest that "treatment that focuses heavily on acquiring a correct, healthy body weight may inadvertently help perpetuate sufferers' control issues" (Reid et al. 2008: 960[131]), thereby instigating this "looping" (Hacking 1995 & 1999) as an oppositional practice. However, against the background of the clinic's performance of the 'hyperreal' anorexia, this is not the end of the story.

Vomiting is arguably not only a conforming to expectation, or an enactment of resistance, but is also a new "line of flight" (Deleuze 1998; 2007[132]), where these are "movements of transgression, excess and exit" (Van Loon 2002: 115). Thinking about vomiting in this way maintains its connection to the clinic's expectations, as "far from being outside the social field, or coming from it, flight lines constitute its rhizome or cartography" (Deleuze 1998: 127), whilst also acknowledging the sense of the new in informants' accounts; this latter, I suggest, reflects their encounter with the clinic's performed anorexia of bodily emaciation. Lia's words that "I never thought of it that sort of way" and "then all of a sudden" resonate with a feeling of mobility and, even, of surprise. Lia has found herself faced with a 'template' of anorexia that is not only enacted differently but is also *about* different things; it *is*

---

[131] Also, Eivors et al. 2003; Sesan 1994.
[132] Also, Deleuze & Guattari 2004

different. This was illustrated by many informants, not only by those in the EDU, but also by those who were simultaneously on pro-anorexia websites and in other EDUs; in his interview Robert said:

"I've had twice the experience here that my stomach's kicked out… erm, the doctor's said 'fair enough it's re-feeding syndrome, it happens with a lot of people' and the dietician confirmed… but it's the aspect of 'right, have you been taking laxatives?' And it's like, 'no! I have never actually done that in my whole life, you don't have to keep asking me, you really do fuss don't you!' They just… if you're an anorexic, you tick all the boxes: you tick vomiting you tick exercising, you tick laxatives, diuretics… I didn't even *know* anything about laxative or diuretics before I came here!"

Robert, inpatient

And Kate said:

"You come in here and it's all portion sizes… that sort of thing that never occurred to me 'til I came into hospital, and BMIs and, you know…. all these things had never…yeah, I'd just never thought of them."

Kate, inpatient

In her interview Claudine said that if she saw staff weighing food,

"Then I'd feel I should do that too."

Claudine, inpatient

Laurie described how since entering the EDU and learning that "such a thing existed," he had "constantly calculated [his] BMI." He said that before admission his anorexia had mainly been done by reducing fats and he explained that the illness was "about controlling stuff, not about how I look." By the time of his interview, however, Laurie felt that he "should calculate his BMI" to, as he put it,

"….Check that I'm doing it right."

Laurie

Although Laurie's words might evoke Chapter Two's discussions of how informants make themselves good at anorexia day-by-day through bodily practices, his anxiety instead suggests that, miming the same prepositional shift that we saw take place in the clinic's performances above, the anorexia which he is now attempting is no longer only *through* or *with* the body; it is *about* the body. Unlike the calculations of risk that I argued earlier to be central to informants' BMI calculations, from the clinic Laurie has learnt that BMI charts also measure thinness and, as such, thinness has entered his conceptualisation of "doing it right."

We saw above that although the clinic's practices *looked* mimetic of those of informants, they were, perhaps, "more anorexic." The "hyperreal" (Baudrillard 1983) anorexia which emerged from that "mimetic excess" (Taussig 1993: 254) now, I suggest, incites a similar 'excess of mimesis,' encouraging informants to 'do anorexia right' by "engag[ing] the image with the reality thus imagized" (ibid. 255). Demonstrating "the potential for examples to give rise to the very idea or principle they should merely illustrate" (Ngai 2001: 217 – 218), Claudine's and Laurie's words, in particular, suggest that as "body meets image" (Massumi 2002: 46), their pro-anorexic desire is passed through their bodies *and* through the clinic, coalescing in the clinic's performance of 'how anorexia *should* be done.' Although we saw in the last chapter that pro-anorexic desire is seldom formed by lack, the echolalia of this verb 'should' in informants' accounts perhaps re-invigorates a sense of lack. Although the clinic's anorexia is omnipresent in treatment practices, in informants' interviews it also seems painfully elsewhere; it is *the* anorexia, but not *their* anorexia. Informants express a desire, or perhaps a need, to draw this anorexia into their personhood and establish a relationship of belonging with it; here, "belonging is a matter less of identity than of identification" (Grossberg 2000: 154). As the clinic locates anorexia within the body (whilst also feeding it out of the body) it also opens up informants' bodies to their own "dissecting" gaze (Foucault 2003). Informants thus look to their bodies to discover whether or not they are 'good anorexics.' Finding a lack, many evinced the need to put anorexia there and thereby approximate themselves to this 'new' anorexia. Given that the *only* linkage that this particular anorexia has, in the clinic's terms, is with the body it is also only through the body that this anorexia *can* be approximated to personhood. It is this attempt

to establish a relationship with an experientially 'other' anorexia that echoes through some informants' relationships with Assisted Feeding.

Whilst also acknowledging her horror at the constant threat, as she perceived it, of being assisted fed on the EDU, Jenny was not alone in describing her extreme jealousy of those who did undergo this intervention. She said:

> "It [treatment] gives you a guideline, in a way, of how to think and when you feel so confused you can follow that path and things make sense again and to be an anorexic makes sense again. So, it's the same with the tube feeding thing, it's kind of like, 'she's being a better anorexic than me,' whereas I… if I could say that I'd been tube fed there'd be a sense of relief and happiness that I really was anorexic."

Jenny, inpatient

Likewise Hadia said:

> "I know, I know…. erm, I know it's so wrong, but I just really wish I had been Assisted Fed…. It's so anorexic."

Hadia, inpatient

Butler suggests that "identifications belong to the imaginary" (Butler 1993: 105); this sense of the imaginary has been evoked by my discussion of the clinic's re-invention of lack. But the imaginary is also effaced by informants' "phantasmatic efforts of alignment" (ibid. 105) where they attempt to (re-)join anorexia and personhood through the body. In relation to this *Thin Commandment* that is now the clinic itself, informants not only learn the new anorexia, but also body this forth by investing practices such as Assisted Feeding with desire as well as horror. This encounter means that the clinic's anorexia becomes, within informants' bodies, "a creature of social reality as well as a creature of fiction" (Haraway 1999: 272), as Haraway described the Cyborg. We thereby see how, through its appropriation, "the imaginary and the real must be, rather, like two juxtaposable or superimposable parts of a single trajectory, two faces that ceaselessly interchange with one another, a mobile mirror" (Deleuze 1998: 63).

However, although informants' accounts of 'learning anorexia from the clinic' resonate with the complex relationality explored in the last chapter, if calculating one's BMI and needing to be Assisted Fed now are, not simply a part of,

but *entirely* how relationships with anorexia are forged, then here we witness not only a re-connection of anorexia and bodies, but of, particularly, being a good anorexic and thinness. As such, as *the* 'good' way to be anorexic is delineated in relation to the clinic here, this has seemingly become *about* the body. It is thus to thinness that the next section (re-)turns. Tracing the relationship of *Thinspiration* on pro-anorexia websites with the clinic's 'hyperreal' anorexia reveals that even where thinness might have been assumed to be at its most unproblematic, it is ambiguous. Paying attention to the "'yet-ness' of a body's affectual doings and undoings" (Seigworth & Gregg 2010: 3) in relation imagized emaciation re-evokes an idea of process that places the clinic itself, rather than thinness, at the heart of pro-anorexic desire.

2: B. 2   Hardcore Bones: The Clinic's Performance as *Thinspiration*?

I have referred to the pages of *Thinspiration* on pro-anorexia websites in previous chapters. In Chapter Two I noted that the frequency with which texts such as memoirs become *thinspirational* undermines ideas of anorexia as the striving towards a visual goal. But much *Thinspiration* does, on the other hand, take the form of photographs depicting emaciated bodies. Although, as noted in Chapter One, press coverage has widely suggested that "pro-anorexic sites have often held up certain celebrities as examples of 'thinspiration'" (Howard 2007: 15), almost all of my informants who discussed their engagements with *Thinspiration* recounted looking not for pictures of celebrities or models but for 'anorexic bodies,' whether these be those of celebrities or not. In her interview Kyra said:

> "I looked for not just slim models, but bony ones, ones that look ill! Like the size zero and even more for more double zero actresses. Like when Nicole Ritchie and Lindsay Lohan were really skinny and Portia de Rossi was pictured on some red carpet and from behind you could see her ribs."
>
> *Kyra, Facebook Pro-Anorexia Research Group participant,*
> *interviewed online*

Likewise, Josie said:

"I know from personal experience I liked to look at really bony girls. At the time it didn't disgust me like it might a 'normal person.'"

Josie, pro-anorexia website participant,

interviewed online

Kyra's and Josie's words echo the pro-anorexia website in Part One which stated:

"Pro-anorexia is the desire to remain eating disorder thin"

In her interview Laura said:

"I think it's important to have pictures of emaciated people and not just thin people because its a reminder of what i am aspiring to be. Some people are naturally thin and so might not even have to work hard at achieving being thin whereas if the pictures are of emaciated people then It shows you that thin is achievable if you just work harder at it, and if others can become that thin then so can you. There is something horrifying about looking at these very anorexic people but there is a part of me that just aspires to being like them. i dont want to be thin i want to be emaciated and often the only place to find anorexic looking pictures is on these pro ana sites."

Laura, Facebook Pro-Anorexia Research Group participant,

interviewed online

And, echoing discussions of diagnosis, earlier, Nora wrote in her interview:

"I think that thinspirational pictures of actual anorexics plays a big role in these sites. I think that the fact that many thinspiration pictures are of diagnosed anorexics makes the whole pro-anorexic culture more competitive. I do not like looking at pictures of emaciated people who are say, from the third world and think that it is disturbing that some people actually use these helpless people as "thinspiration" – to me that is disgusting. But strangely if I know that the person that I'm looking at is

anorexic then it appeals to my competitive side and encourages me to starve myself."

<div align="right">

Nora, Facebook Pro-Anorexia Research Group participant,

interviewed online

</div>

Following on from the last section's discussions of how informants approximate themselves to *the* good anorexia of the clinic in ways that render thinness an apparent goal, here we can trace that goal as it weaves through informants' narratives. In this context of belonging and its anxieties, although thinness has returned as central, it has clearly done so in a very specific way. The above quotations describe thinness not in visual terms but as an index of relative illness. By paying attention to temporality we see how thinness as the marker of illness is not so much a future goal or even a visual bodily state; it is, rather, an affirmation of one's existing relationship with anorexia. The importance of this is illustrated not least by the fact that although most *thinspirational* photographs are of women, it became clear during fieldwork that those who were inspired by them crossed the gender divide. As a delineator, thus, of a kind of ambiguously desirable pathology-identity (which echoes Part One's discussion of diagnosis) this "eating disorder thin" also cannot be disentangled from the clinic; its desirability derives not only, perhaps, from being temporally later than diagnosis, but also from being temporally later than - although, crucially, unaltered by - treatment. This is a simultaneous embodiment of the clinic's 'hyperreal' anorexia and rejection of treatment; at once appropriation and subversion, thus, this particular thinness gains its desirability from the lived nexus of illness and the clinic. It is perhaps not only through the body that anorexia and personhood are (re-)fused, but through the clinic itself; treatment offers a paradoxical alternative pathway of belonging to one's anorexia. We saw in the last chapter how desire produces "ever-new alignments, linkages, and connections" (Grosz 1994: 168) and also that there is an "unfinished (and uninstigated) character to desire" (Brown & Tucker 2010: 232). Here, we cannot dislocate *Thinspiration* from the clinic, although, we also cannot reduce it to this either; *Thinspiration* is a "deterritorialization and reterritorialization" (Deleuze & Guattari 2004: 72) of the clinic, as well as of its particular performances of anorexia. Casting an alternative light on engagements with Assisted Feeding, this suggestion can be particularly traced through one common aspect of *Thinspiration.*

Many pro-anorexia websites have sections of *thinspirational* photographs entitled *Bone Pictures* or, sometimes, *Hardcore Bones.* As well as photographs that extremely emaciated website participants have uploaded of themselves in various situations and contexts, *Bone Pictures* often comprise photographs of anorexics taken within medical contexts. "Forensic in its detail" (McGrath 2002: 5), such imagery, like that in medical textbooks frequently shows only bodies with no heads; or the back view of an emaciated naked body standing in front of a height chart; or bony arms attached to drips; or feeding tubes going into concave stomachs. The photographs that do include heads sometimes depict a person just staring into the camera from a hospital bed or the close-up of a nasogatric tube. That *Hardcore Bones* pictures are, on the one hand, "photographs of agony" (Berger 2003: 289) was clear from Leanne's discussions of this type of *Thinspiration:*

> "Unfortunately it is a very sad culture to be a part of and when I am in "recovery" I can take a step back and see what we are all doing to ourselves and it is those times that I stop using pro ana sites because I actually find it extremely distressing to think that I am using a dying person to feed (excuse the pun) my own illness. Although I use these pro-ana sites I do find them deeply disturbing and get extremely disgusted at myself for using them because when I look at these very anorexic people and I'm using them to encourage my own eating disorder I forget that I am looking at some seriously ill people who often are at deaths door and I am well aware that many might die because of their illness and yet I still aspire to being like them."
>
> *Leanne, pro-anorexia website participant,*
> *interviewed online*

However, that these photographs are also not only spaces of desire, but of intense desire, is evidenced by the fact that it is particularly on entry to these pages that pro-anorexia websites flash up disclaimers stating that these photographs may be "very triggering." Although we might regard such disclaimers, alongside the depictions of extreme emaciation, as evidence of thinness as the haecceity of anorexia, their clinical framing suggests that this is not the only story about desire that *Hardcore Bones* tell. By rupturing any expectation of portraiture through the

paucity of faces depicted, these *Bone Pictures* do not necessarily linearly transfer our attention to bodies. Rather, in these photographs feeding tubes and wrist bands, hospital beds and drips are arguably given as much visual prominence as the bodies they frame – even more, sometimes. Not only through these does "the patient become[…] a symptom of his/her disease"(McGrath 1984:15), but also of the clinic itself. Yet, there is an ambivalent doubledness to this. It has been suggested in relation to photography that "what is real is not just the material item but also the discursive system of which the image it bears is part" (Tagg 1988: 4). Here the person and body at once disappear into this landscape of clinical objects but they also 'become real' through this positioning. Or, to put it another way, not only does the clinic absorb the anorexic, but the anorexic also absorbs (thereby appropriating *and* subverting) the clinic. As these photographs are re-performed as spaces, objects and relations of pro-anorexic desire, feeding tubes and hospital beds draw the clinic into the processual "assemblage" (Collier & Ong 2005) of anorexia, coalescing desire - as well as ambivalence and pain - around the clinic itself rather than around the emaciated body.

In Part One I noted how "oppositional practices" (de Certeau 1984) are enacted *within* systems. It has been suggested that because of this, such ways of turning the "world inside out" (Bakhtin 1984: 11) are necessarily self-defeating as they are "needed by the system" (Chambers 1991: 7) to reinforce itself. Whilst this could be argued about informants' oppositional practices against the clinic in Part One, I also suggest that here we see this in reverse; anorexia is not only ruptured by the clinic but, rather, it has emerged in informants' accounts and *thinspirational* photographs in these last two sections as *needing* the clinic to *make* it desirable. Thus, echoing the appropriations and subversions we saw in Part One, here the clinic's anorexia is not so much 'learnt' as it was in the last section where informants moved towards it, but, rather, used to inspire their *own* desire within informants. As such, the 'hyperreal' anorexia is appropriated into the *process* of being, and becoming, a good anorexic that is defined at once *through* and *against* the clinic. In the return to these ideas of 'assemblage' and 'process,' thinness has emerged, once again, as entangled with, but ambivalently positioned in relation to, pro-anorexic desire; at times it appears central, at others peripheral as it moves in and out of informants' narratives, practices and images across the two field sites. In

Bones photographs we see, in graphic intensity, what the thesis has suggested since Chapter One; intrinsic to pro-anorexia is how informants' subjectivities, experiences and productions of anorexia are enmeshed with anorexia's psychiatric boundaries, categories and performances. These - like desires and ambivalences, relationality and rupture, comfort and hatred – are constituent parts of informants' "heterogeneous, contingent, unstable, partial and situated" (Collier & Ong 2005: 12) anorexia that at once produces, but is also much more than, corporeal thinness.

Conclusion

By tracing the circulations and flows of knowledges and bodies, anorexias and practices, between informants in both field sites, this chapter has illustrated how ways in which anorexia and personhood are experienced, articulated and desired in each field site impact on the other. Paying attention to how "possibilities and threats that pop up in the process remain lodged in the actual look of things and are preserved as such" (Stewart 2007: 36) between the two field sites has also revealed the dialectical engagements between pro-anorexia and biomedicine itself; the latter, this chapter has shown, performs anorexia in ways that are absorbed into, and bodied forth by, the former. I have therefore argued that the clinic and anorexia are not just simultaneous agencies in informants' subjectivities of anorexia, but are, rather, implicated and imbricated. Part One began this exploration of relationships and circularities, borrowings and ruptures by tracing the appropriations and subversions of the clinic on the part of informants in both field sites. We first saw how diagnosis is inhabited by informants; it emerges in accounts as a space in which personhood and anorexia 'fuse' and each is legitimised through the other. Then, in the borrowing of categories of health and the resignifications of clinical 'facts,' we saw that "various 'orderings' of similar objects, topics, fields, do not always reinforce the same simplicities or impose the same silences" (Mol & Law 2002: 7) as they move within and between field sites. After exploring how informants appropriate and subvert fragments of the clinic to individually maintain themselves as (good) anorexics, the chapter then demonstrated that some also employ "tactics" (de Certeau 1984) to subvert the clinic's gaze. Through all these negotiations and ruptures, Part One was replete with "leaky distinction[s]" (Haraway 1999: 274), "floating signifiers" (ibid. 275) and "potent fusions" (ibid. 275). I suggest that it is only against the background of these complex, and often contradictory, engagements with the clinic that we can forge an understanding of informants' engagements with one very specific central performance of the clinic and, thereby, understand how the clinic frames informants' paradigms of what is meant by being good at anorexia. Part Two therefore turned to explore how, through practices and the intangible moments around these, eating disorders treatment performs anorexia as both *in* and *about* the body. Arising from the clinic's mimesis of what it *saw* informants' practices to be, I argued that this centrally-bodily

anorexia was a product of "mimetic excess" (Taussig 1993: 254) and ruptured linkages. Yet, by turning back to informants, the chapter traced how, at the moment at which "body meets image" (Massumi 2002: 46), this 'hyperreal' anorexia is invested with desire, or perhaps need, by informants. Finding a lack within themselves deriving from the discrepancy between *the* anorexia and *their* anorexia, many informants learn how to 'do' and 'be' the clinic's anorexia. In this alignment, it seemed that thinness had returned to reveal itself as synecdochical for, and the ultimate goal of, (a good) anorexic. However, the chapter ended by journeying across field sites to look at *thinspirational* photographs on the Internet. I suggested that although these might seem to affirm the centrality of thinness, this is, once again, only part of the story. Particularly in *Hardcore Bones* where wrist bands and feeding tubes abound, the visual imagery of treatment is as powerful and as invested with desire as are the bodies to which such accoutrements attach; through both its legitimisation of, and intervention into, 'anorexia-as-illness,' the clinic itself is, I suggest, as central to pro-anorexic desire as corporeal emaciation. As such, intimate subjectivities of relationships between personhood and anorexia are not easily disentangled from those between people and biomedicine. By returning to the idea of anorexia as an assemblage that the last chapter introduced we saw that thinness clearly is a *part of* anorexia, but one that is fluidly positioned and, perhaps, mobile; it is sometimes central, sometimes peripheral, juxtaposed with the many other desires and ambivalences, objects and words, that constitute informants' experiences and subjectivities of their anorexia, which have been explored throughout the thesis. Thus, by examining "the circulation of cultural meanings, objects and identities in diffuse time space" (Marcus 1995: 96), this chapter has once again shown anorexia to be a "shape-shifting reality" (Law 2007: 598); the illness has emerged as inchoate and multiple, yet also fixedly central, to the lives of informants who often simultaneously hate and desire it. It is to these many ambivalences and complexities that the *Conclusion* will now return.

Chapter Six   A Conclusion

> "If anorexia is, for the patient, a means to an authentic and worthwhile life, then, giving up the anorexia—gaining weight—can mean giving up the reason for living."
>
> *(Gans & Gunn Jr. 2003: 680)*

> "Never say you know the last word about any human heart."
>
> *Line from 'Louisa Pallant' by Henry James*
> *(1990: 192)*

Wishing to do something to pass the "awful time," as she put it, of Rest Periods, and to "keep my brain going in here," Joanie created a Book Club on the EDU. When she handed me the photocopied short story to read in preparation for the first week's club, I looked down to see that I was holding Alice Munro's *Labor Day Dinner* (Munro 1997). Noticing my glance, Joanie said ruefully:

> "I picked it because Alice Munro is such an amazing writer… Well, maybe also because there's lot of food in it too!"
>
> *Joanie, inpatient*

This thesis has explored pro-anorexia, a desire to maintain and enhance their illness found amongst anorexics. I have argued that informants' articulations of wanting to hold onto anorexia, and thus to resist treatment, cannot be explored without listening to their subjectivities of the nuanced and intimate relationships between anorexia and personhood. Joanie's words about her choice of text for Book Club highlight the sense of complexity and multiplicity that have pervaded this thesis; through them we glance at the threads that weave together Joanie's sense of herself – of her boredom and intellectual curiosity – with that of anorexia's presence in her life. She illustrates the necessity of recognising anorexia's agency but her doubled awareness also incites us to look beyond notions of the anorexia as 'always talking.' Without taking pro-anorexic desire as either fully agential or just a product of the illness, this thesis has therefore explored informants' ways of

desiring and holding onto anorexia, and the selves, bodies and anorexias these ways enact. Through these I have explored the "multiple refracted realities" (Denzin & Lincoln 2003: 10) in informants' accounts of anorexia, and have investigated how informants forge possibilities of experience within, in spite of, and even through, their illness. In these discussions many anorexia(s) have moved through the thesis's pages.

This conclusion will now re-trace the contours and multiplicities of anorexia(s) that have emerged. Gathering together the multivocal threads of the thesis, I will reflect on how exploring pro-anorexia engenders an image of anorexia that is at once partial and yet replete with intimate nuance; it offers access to largely hidden subjectivities of an illness that is often desired, but that is also just as frequently acknowledged by informants to cause immense suffering. But, Joanie's Book Club also draws our attention to a tension embedded in the act of concluding. After Book Club, Joanie lent me her copy of Munro's short stories and on the train home from the field I read another one, *Differently*. This opens with the protagonist, Georgia, being admonished for something she has just written by a creative writing instructor; he says:

> "Too many things. Too many things going on at the same time; also too many people. Think, he told her. What is the important thing? What do you want us to pay attention to? Think."

> *Munro 1997: 335*

I argued in Chapter One for a coherent ethics from field to text, one based on a continual open listening which allows seeming antinomies to be held together in one analytical space and which does not impose hierarchies or assumptions. Only through this, I suggested there, can we take account of pro-anorexia. As such, the hyper-reflexivity that this thesis has practiced is an intrinsic part of an ethical ethnographic approach to anorexia. In writing this Conclusion, I remembered this story read long ago on the train; its memory alerts us to the friction between an open listening and the writing of closing words. With this in mind, this Conclusion will not only return to what has been said, but will also explore silences and contradictions that may have lurked at the 'margins of the page.' Attempting to "hold what is said and what is unsaid in some uneasy but lively tension with one

another" (Lambek 2004 A: 8), allows the thesis to maintain a continuing openness to other narratives, both in the field and the academy. Thus, although we might have had *the* Introduction, this will only ever be *a* conclusion; its "point is neither to throw away the book, nor imagine it ever complete" (Tagg 1988: 33).

This research began with fieldwork in an English eating disorders unit and on pro-anorexia websites. These websites are spaces in which both desires for, and ambivalences towards, anorexia are voiced, shaped and exchanged by participants. It was the complexities and nuances found in such articulations that prompted the research's first question, which was whether similar subjectivities of anorexia, personhood, and the relationships between these, are also experienced and expressed by anorexics within treatment. As such, at first the websites illuminated - although, crucially, did not engender assumptions about - the EDU. As the research unfurled, I saw what I have argued throughout the thesis, that there is also frequent dialogue between pro-anorexia websites and clinical settings. Informants often described moving between the websites and treatment, sometimes participating in both at once. Between the two spaces there are also exchanges of knowledges and categories, texts and discourses, bodies and even, anorexias. Such connections between field sites may weave through both but be 'present' in neither; their edges touch in frayed but tangibly haptic ways. It became clear that not only do my field sites illuminate the intricate nuances of informants' relationships with anorexia in one another, but they also impact on each other in very pragmatic ways; I have argued in this thesis, particularly in Chapter Five, that each contributes to how anorexia is performed, articulated and, importantly, desired, by informants in the other. It is, perhaps, at their intersections that paradigms of desirable anorexias and, what we could term, the accepted 'boundaries of a good anorexic,' emerge. This common cultural currency suggests that the EDU and pro-anorexia websites encounter one another in more dialogic and philosophical ways; although both "look sideways" (Hannerz 2003: 207) to other spaces in which anorexia, and indeed, pro-anorexia, are present, interwoven through the resonances and reflections between them are the conceptual meeting points of pro-anorexia and the clinic both across and within the sites.

In all the ebbs and flow, exchanges and (re-)performances traced by the multi-sited design and practice of this research, anorexia has emerged as "a tangle of trajectories, connections and disjunctures" (Stewart 2007: 5). It might, perhaps, seem easier to the reader to say what anorexia is not than what it is. Yet, whilst acknowledging that this illness might have appeared throughout the thesis as "a slippery phenomenon one that changed its shape, and was fuzzy around the edges" (Law 2007: 598), I also suggest that this 'slipperiness' is an integral part of informants' experiences of anorexia; it is, moreover, one that is particularly revealed by exploring pro-anorexia.

The turn away from a sole focus on emaciation to address subjectivities and materialities in this research meant that I entered the field with no expectations about what – or, indeed, where – anorexia is. This analytic stance engendered an emphasis on voice; I sought to listen to informants' narratives, rather than to 'see' anorexia as intrinsically *about* bodies or *always* tied to eating. I asked what the illness was to informants whose daily lives were entangled with it on many levels. This emphasis engendered multiple perspectives on anorexia, not only from one informant to the next but with the same informant at different temporal moments. In these, as we have seen throughout the thesis, anorexia changes shape; its centres and peripheries change places and more or less seemingly axiomatic tropes of the illness are placed within or left outside its perimeters in a continual process of (re-)assemblage. It is therefore clear that in their discussions informants offered particular portraits of anorexia, performing it in ways that often diverge from its depictions in wider literatures or treatment regimes. In this divergence we can perhaps glimpse a tension in my research; it might be suggested that the thesis has *only* seen anorexia as it appears through pro-anorexia and, thus, that it can only offer a narrative of limited partiality to sit alongside existing discussions of the illness.

However, not only does the range of experiences and emotions in my data problematize this, but I also suggest that we cannot dislocate anorexia from pro-anorexia, or indeed from *anti*-anorexia, on the parts of informants. Anorexia is many things in informants' accounts *because* their desires, ambivalences and subjectivities – their pro-anorexia - make it many things. As such, although it might seem that this research has approached anorexia in a temporally back-to-front

fashion, there is a fundamental circularity to its object, which cannot neatly be divided into parts; pro-anorexic desire *produces* anorexia – with or without informants' agency – and their experiences of anorexia (re-)fuel that desire; it is changeable in informants' accounts which come first. This is, of course, not to suggest that anorexia does not 'exist' outside or before the nexus of desires and subjectivities of which it is a part. It is an illness with very real symptoms and consequences. But, these too occupy a variety of positions in relation to informants. Although in its diagnostic categorisation, the "virtual object" (Mol 1998: 154) of anorexia may be conceptually bounded, it is also experientially malleable; anorexia is therefore, at once, both virtual and actual across the two field sites; in this interplay we can both map desire as productive, as argued in Chapter Four,[133] whilst also taking account of the painful realities of psychiatric illness.

Therefore, although asking about pro-anorexia may seem only to offer partiality and moving glimpses of the illness itself, "the knowing self is partial in all its guises, never finished, whole, simply there and original; it is always constructed and stitched together imperfectly" (Haraway 1991: 193). As such, perhaps it is precisely this partiality and multiplicity that this thesis most offers; by approaching anorexia through informants' words, this research on pro-anorexia has not obfuscated, but rather widened, our view of anorexia. It has offered intimate and intricate visions of the illness that might remain hidden to other ways of looking, particularly perhaps to those with a focus on gender or emaciation. Seeking most definitely not to compete with these alternative visions, the discussions of personhood, agency and desire in this thesis perhaps offer insights into both the popularity of pro-anorexia websites as well as into the high rates of treatment failure amongst anorexics. It is therefore hoped that this research compliments existing studies of the illness across the medical and social sciences. What this potential tension of holding together in analysis both anorexia and pro-anorexia has highlighted, however, is the ways in which we cannot dislocate anorexia from the relations in which it is embedded; I therefore now turn to re-trace the relationships between personhood and anorexia described by informants in both field sites.

Anorexia and personhood have emerged throughout this thesis, to borrow from Augé, "like palimpsests on which the scrambled game of identity and

---

[133] See Deleuze and Guattari 2004; Deleuze 2007; Grosz 1994; Probyn 1996 on desire as productive.

relations is ceaselessly rewritten" (Augé 1995: 79). We have seen through narratives of "intersubjective fusion" (Jackson 2002: 340) that personhood and anorexia move within and through each other; not only is "personhood an unfolding process" (Curtin & Heldke 1992: xiv) but so too is anorexia and in many informants' accounts their unfolding – and indeed, enfolding - is simultaneous. Particularly in Chapter Three, it was clear that although many informants in both spaces experience anorexia as a 'part of' them this does not preclude a powerful sense of alterity also *within* the self; the image from fieldwork that perhaps most illustrates this dualism was Eva's statement that if a doctor attempted to remove her anorexia, "he'd just leave his shoelaces behind anyway." This sense of partial and fluid alterity offered an alternative perspective to how relationships between personhood and anorexia are conceptualised by the clinic.

Also in Chapter Three, we saw how eating disorders treatment seeks to separate informants from their anorexia, conceptualising these as both distinct and also positioned in relation to each other within a clear teleological temporality. The clinic, I argued, regards patients' 'authentic selves' as inherently prior to the temporary and aberrant state of anorexia and thus as necessitating disentangling from anorexia through a move towards future recovery. In between, this self is very much conceptualised, I have argued, as having disappeared into anorexia. One of the ensuing central praxes of treatment, which is enacted by clinicians' utterances of "that's the anorexia talking," is therefore an attempt to aid patients to externalise their anorexia in order to separate from it. In Chapter Four, however, we saw that some informants externalise the illness not as a modality of disconnection but, rather, of connection. Personhood and anorexia move fluidly around a fixed point of contact and this connection is described by many informants as a "friendship," in terms replete with a sense of belonging.

In Chapters Four and Five I argued that there are multiple temporalities to this imbrication of self and anorexia; we saw that practices that maintain the illness in the present also "resee" (Strauss 1997: 69) the past in ways that solidify rather than contradict the sense of permanence described by many informants. I have therefore sought to re-iterate here that it is these tangible and simultaneously intra- and inter-subjective relationships that are central to informants' pro-anorexia. Through them we see that pro-anorexia signifies a desire to maintain an existing

(relationship with) anorexia; such desire is, perhaps we could say, about attachment not lack. Yet, if we briefly re-trace our steps through the landscape of this attachment, we see that to this also there is a tension around temporality, which echoes the circularity of anorexia and pro-anorexia discussed above; there is a dialectical engagement between being attached to something that one already has and maintaining it by perpetually reproducing it.

It has emerged in this thesis that anorexia's value derives simultaneously from informants' sense of it as 'part of' or 'belonging to' them and also from how the illness mediates their relationships with the world around them; it is, as many clinical analyses have suggested, a modality of control. But, to extend this, it is one through which "the everyday is produced" (Tucker 2010: 526) as it 'helps' with emotions and lives. Throughout the thesis, from Cally's marriage counselling to Milla's mapping of her perimeters as part of a "general crackdown," and from the "quiet starving" mentioned by both Kate and Chloe to Lia's spilt milk, anorexia has been something *through* which informants' lives are lived (agentially or unagentially); anorexia signifies to many informants, to return to a quotation we have heard before, "the continuity of the subject's sense of what it means to keep on living on and to look forward to being in the world" (Berlant 2010: 94). Descriptions of anorexia's 'help' and how it is sometimes present when informants themselves do not wish to be, suggest that it is these mediations that continually reaffirm anorexia's value. As such, however, although Deleuze suggests that "illness is not a process but a stopping of the process" (Deleuze 2008: 3), the circularities evinced by this attachment reveal that holding onto anorexia is an active process, and one through which both selves and anorexia(s) must be continually reproduced alongside – or, rather, in order to maintain – the (re-)production and control of the everyday.

This idea of maintaining one's anorexia as an active process has therefore pervaded this thesis. In the context of this central relationality being a good anorexic has emerged as a subject positioning as much inter- as intra-subjective. It is made through the 'looking after' of one's anorexia, which includes protecting it from treatment. Poised at these intersections of self and illness, being a good anorexic is neither static nor does it happen at a given point. It does, however cast an alternative light on bodily practices of eating and starving amongst anorexics. In

this thesis I have suggested that rather than being solely means-to-an-end body managements, practices of self-weighing and self-starving are intricately tied to the maintenance of relationality. Their indexing of the willpower of being good at anorexia cannot be separated from this context. Being unmade by one's own actions or the gaze of others signifies, precisely, a rupture or a calling into question of the connection between one's personhood and anorexia.

I argued in Chapter One that a focus on emaciation may enact a particular temporality in its looking, subscribing meaning to anorexia retrospectively from the starved body; this, I suggested there, risks losing a sense of the embodied present in which self-starvation produces and protects one's anorexia. Within these processes the body is made *with* anorexia, where anorexia is enacted *through* the body but is not necessarily *about* it. In contrast to the clinic's performances, that we saw in Chapter Five, of an anorexia that is arguably bodily but not embodied, for many informants, anorexia is utterly embodied but not necessarily bodily. This thesis has argued there to be a sense of relentlessness as bodies and anorexias, personhood and everyday lives continually move in relation to, and mobilise each other; they must be maintained in balance. As such, my discussions have revealed the "complex assemblages that come to compose bodies and worlds simultaneously" (Seigworth & Gregg 2010: 6). Thus, although I have centrally moved away from, whilst also not discounting the value of, focuses on thinness and gender in this thesis, this has not signified a dualistic ignoring of the body. Rather, this thesis has sought to compliment these ways of looking by thinking about the body in alternative ways, taking account of its many positionings and manifestations in informants' accounts.

In the last chapter I evoked an image of topology to think about ways of writing that take account of multiplicity. Here I suggest that in order to address the complexities of bodies, and of thinness, where these may not necessarily be even linked in informants' accounts, we perhaps require this topological stance once again. To understand informants' subjectivities of how bodies and anorexia are at once so intertwined but not necessarily coterminous, we need to think in ways that allow us to move around the body, taking account of its many multiple temporal and spatial positionings. I explored in Chapter Four how some informants described dislocating their anorexia from their bodies, thereby allowing the clinic to assuage their palpable physical suffering whilst also preventing it from intervening in, or even

being able to grasp, their anorexia. This seeming lack of an axiomatic relationship between surfaces and depths, outsides and insides, subjectivities and sufferings, evinces how relationships between personhood and anorexia are maintained and reproduced in spite of extreme bodily suffering.

Mirroring this overall fluidity between bodies and anorexias, thinness has also emerged in informants' accounts sometimes as that through which anorexia is produced, as we saw in Chapter Two, at other times as *co-existent* with anorexia, and sometimes as a *symptom* of anorexia; as such, corporeal emaciation continually shifts from anorexia's centre to its peripheries and back again. In Chapter Five, our focus was returned to the body as I explored how the suffering body is not only often desperately and poignantly in need of treatment, but also the only part of anorexia that the clinic can grasp. That discussion illustrated the difference between resisting treatment and resisting recovery not only in relation to having one's body cared for whilst maintaining anorexia, but also by tracing how various aspects, practices and performances of the clinic are invested with pro-anorexic desire. Thinness returned as a vector through which informants could absorb the clinic itself into the 'assemblage' of anorexia. As such, relationships between personhood and anorexia and between pro-anorexia and the clinic cannot be disentangled simply. Thinness was also present in an intriguing way in Milla's account of "patrolling her perimeters." She discussed how by keeping her body thin she also holds herself 'inside anorexia.' To her, fat signifies an unwanted breach of the self out into the world. As such, we see how perhaps neither 'fat' nor 'thin' are purely visual *or* purely embodied states, but are rather socially malleable categories and, indeed, metaphors.

However, although on the one hand these mobilisations of bodies and anorexias resonate with informants' agency, there is also an undercurrent of ambiguity to them; we have seen on many occasions in this thesis that the need to balance anorexia and personhood ensues not only from the perceived betrayal of the body, but also from the unwanted exigencies and effects of anorexia's agency. I suggested in Chapter Four that informants' friendships with anorexia centrally rely on the sharing of agency with, or the relinquishing of it to, anorexia. The importance of reflecting on the complexity of agency is therefore apparent. We might suggest, following Michael Lambek, that "at the moment we think we are

acting most as ourselves or being most agentive, we are actually caught up by something else" (Lambek 2004 A: 3). Indeed, given the extreme physical and mental pain that has continually resurfaced in the thesis, it might be argued unethical to not take account of anorexia's agency over informants' thoughts and behaviours. It is certainly this sense of compassion that leads the clinic to categorise what I termed for simplicity's sake 'bad behaviour' as "the anorexia talking;" although, we saw in Chapter Three the adverse effects of this on informants.

Yet, I evoke here Joanie's Book Club choice; in the mingled motivations of her decision Joanie lived through these unagential connections of anorexia and self and yet was also aware of an agency and self outside of these. Thus, where anorexia's agency is concerned we, once again, need to maintain an openness to multiplicity and simultaneity. To do this I have, as I discussed in Chapter One, used the term desire rather than belief throughout this thesis; intersecting with my turn to the 'immanence' and intimacy of "microanalysis" (cf. Biehl & Locke 2010) this has signified an attempt to ethically position myself as able to think about agency in non-blaming ways – ways that think about choice *and* constraint, illness *and* desire. This thesis has, thus, not assumed pro-anorexic desire to be agential, but nor has it undermined this possibility. Informants' accounts evince pervasive blurrings of their own agency with that of anorexia, and indeed between the latter and a desire for the illness. We have also seen how informants enact "tactics" (de Certeau 1984) to limit anorexia's agency. In Chapter Five I discussed how the clinic and anorexia are sometimes used to "ambiguate" (Battaglia 1997) one another's power and in Chapter Four, how food and anorexia are employed to countervail each other. These struggles over agency intersected with informants' conceptualisations of 'good' and 'bad' anorexias; in the former some agency, at least, is maintained, whereas a bad anorexia is one where agency is lost. Both Chapters Two and Four explored this through, for example, the liminality of vomiting and the 'bad anorexia' that made Mickey walk all night. Both of these were contrasted to the self-starvation that reproduces both oneself and one's anorexia.

We see by turning our attention to agency, thus, how much of this thesis has been about reconciling these "realities that are performed" (Mol 1998:145) in relation to, and in spite of, anorexia's agency. Yet, although so far in this Conclusion I have spoken more about mobility and how anorexia is seen to "spin faster and

faster between opposed yet interconnected meanings" (Taussig 1993: 17), informants' narratives also resonate with stasis. As well as informants' discussions of anorexia as a space into which to retreat, an open ear to anorexia's agency also alerts us to how the illness is, as Laurie put it, "like that Julius Caesar plot, you know?…His friend that killed him but became his friend before killing him." Through informants' accounts of entrapment and constraint, this thesis has reflected on how anorexia signifies *both* an agential *and* unagential inhabiting of spaces that resonate with compromised conditions of possibility and curtailed opportunities of experience. Moreover, by mapping the intersections of illness progression and desire I showed these to be intertwined; from the "everyday creativity" (de Certeau 1984: xiv) of informants' accounts, it is clear that pro-anorexic desire can be about finding ways to live with, and through, the "unendurable" (Fischer 2007). It signifies a response to, and reconfiguration of, the sheer daily realities of the illness. As such, the thesis has illustrated the conjoinings of desire and ambivalence.

We saw in Chapter Three that the clinic reads into informants' ambivalence a binary solidity founded upon its visions of anorexia versus the authentic self. In informants' narratives, on the other hand, I have argued that ambiguities and pain, ambivalence and horror, not only exist alongside desire but can also propel it; ambivalence can strengthen as much as rupture informants' relationships with anorexia as they approximate themselves to an illness that, resembling Plato's pharmakon (Plato 2005; Derrida 2004), is only remedy for its own poison. As such, I have sought to show in this thesis how ambivalence towards anorexia is a *part* of pro-anorexia, rather than an antithesis. I suggest that given that spaces as ostensibly about desire as *pro*-anorexia websites are also replete with ambivalence, it is perhaps important to our understandings of anorexia as a whole to take account of this mutually-productive enmeshing of desire and ambivalence. In both field sites, moreover, desires themselves are fractured and multiplied as many informants describe *wanting to want* anorexia. We have also seen, particularly in Chapter Two, that informants' ambivalence towards anorexia changes shape depending on whether its object is self or other; in others the relationships between suffering and anorexia are, for many informants, much clearer, and anorexia less desirable. In such visual interactions, however, informants highlight a seeming tension between

how one listens to others' voices and desires alongside their bodies. This is also something on which this thesis has reflected.

In the clinic the sometimes urgent necessity of saving lives privileges the information offered by the visible and quantifiable starved body over the anorexic's voice, thereby placing these in a hierarchy. This particular way of looking, alongside clinical paradigms of anorexia's effects on personhood, as "the anorexia talking," can affect our ability to concomitantly address both informants' pro-anorexic articulations and anorexia's effects on selves and bodies. It is therefore clear that "struggles over what will count as rational accounts of the world are struggles over how to see" (Haraway 1991: 194). As such, this engenders consideration of how it is possible to position ethnographic analysis in relation to clinical discourses and the realities of illness. Although engaging with informants' vocal articulations of pro-anorexia, in this thesis I have not sought to simply reverse the body/voice dualism; this would leave it in place and unethically marginalize corporeal realities. Rather, throughout this research, I have continually reflected on its modes of seeing, listening and knowing. By maintaining, from field to text, "an ethnographic attention […] that is loosened from any certain prefabricated knowledge of its object" (Stewart 2005: 1027), I have sought to hold in one analytical space informants' voices and bodies, clinical discourses and anthropological ethics. I have invited these to dialogue, and even, "interfere" (Haraway 2008) with each other, whilst being careful not to permit them to enact silences.

In extension, I have also explored how it is ethnographically possible to address the many complexities of pro-anorexia itself. What may seem like incompatible binaries, such as pro-anorexia and biomedicine, desire and ambivalence, are not only related, but often mutually productive in informants' accounts. Overall thus, concomitantly listening to informants' pro-anorexic desires and recognising the dangers of anorexia as an illness intersects with critical debates at the heart of ethnography and its politics of engagement. Paying continual attention to these, by navigating "between and within competing and overlapping perspectives and paradigms" (Denzin & Lincoln 2003: 11), stories, voices and levels of analysis, I have deliberately avoided jumping easily to conclusions when thinking about anorexia. Always looking for "the outside story which is part of the inside story" (Back 2007: 9), I have paid attention to the half-glimpsed, the partial and the

contradictory. In so doing, I have desired to "displac[e] the rigid discipline of 'subject' and 'object' that sets Us apart and leaves Them inert and without agency" (Stewart 1996: 26). As such, however, I now return to my discussion at the beginning of this Conclusion about the inherent tension of concluding.

In this conclusion I have attempted to walk back through the thesis in ways that draw out, rather than write out, ambiguities, contradictions and multiplicities in informants' lives, experiences and subjectivities of anorexia. Continual reflection on these complexities arguably constitutes an ethical way to take account not only of pro-anorexia, but also of the many "resonances and dissonances that characterise subjectivity" (Grosz 1994: xii) more widely. Faced with dissonances and partiality – of narratives, perhaps, that seem not to 'fit' – I suggest that an ethical writing does not attempt to neaten but rather to listen. In any thesis there has already been a loss of other stories; in the move from the dwelling in of the field to the dwelling on in text "the enigmas and oblique events and background noises that might be barely sensed and yet are compelling" (Stewart 2010 A: 1) have been distilled and filtered; "what is said, what is allowed as an element in order, always depends on what is not said, on what is displaced and marginalized" (Mol & Law 2002: 13). This is inevitable. As such, however I seek now not to further "impose a form (of expression) on the matter of lived experience," but rather to move "in the direction of the ill formed or the incomplete" (Deleuze 1998:1). Rather than writing both other possible narratives *and* the complexities present in this one into a bounded 'answer' about pro-anorexia, I wish to end on a note of partiality. As I noted at the beginning of this Conclusion the unpacking of partiality and complexity is perhaps what a thesis about pro-anorexia most has to offer. I therefore now seek to leave space for other voices and alternative analyses, both in the field and in existing and future research. This has not been a definitive narrative of pro-anorexia or anorexia; instead it has sought to reflect on, and engage with, the subjectivities and experiences of individuals who desire their anorexia and hate it, struggle through it and agentially produce it, without attributing any stigma to, or enhancing the pain of, any of these.

"Every phrase and every sentence is an end and a beginning."

(Eliot 1963: 21, Little Gidding)

❖ References

ABU-LUGHOD, L. (1990) The Romance of Resistance: Tracing Transformations of Power through Bedouin Women. *American Ethnologist,* 17**,** 43 – 55.

ADAM, B. (2004) *Time,* Cambridge, Polity Press.

ADLER, P. A. & ADLER, P. (1987) *Membership Roles in Field Research*, London, Thousand Oaks & New Delhi, SAGE.

AGAMBEN, G. (1998) *Homo Sacer: Sovereign Power and Bare Life*, Stanford, CA, Stanford University Press.

ALLEN, J. T. (2008) The Spectacularization of the Anorexic Subject Position. *Current Sociology,* 56**,** 587 - 603.

ALLISON, M. (2009) *Dying to Live: A Journey Through and Beyond Anorexia,* Brentwood, Essex, Chipmunkapublishing.

AMETELLER, L., CASTRO, J., SERRANO, E., MARTINEZ, E. & TORO, J. (2004) Readiness to Recover in Adolescent Anorexia Nervosa: Prediction of Hospital Admission. *Journal of Child Psychology and Psychiatry,* 46**,** 394 - 400.

ANDERSEN, A. E. (1995) Eating Disorders in Males. IN BROWNELL, K. D. & FAIRBURN, C. G. (Eds.) *Eating Disorders and Obesity: A Comprehensive Handbook.* New York & London, The Guilford Press.

APA (1994) *Diagnostic and Statistical Manual of Mental Disorders IV,* Washington D.C, American Psychiatric Association.

APA (2000) Work Group on Eating Disorders. *Practice Guideline for the Treatment of Patients with Eating Disorders*, Washington DC, American Psychiatric Association.

APPIGNANESI, L. (2008) *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present,* London, Virago.

ASA (1999) *Ethical Guidelines for Good Research Practice.* Association of Social Anthropologists of the UK. Published at: http://www.theasa.org/ethics/Ethical_guidelines.pdf.

ASTHANA, A. (2007, January 7th) Danger of the Websites that Promote Anorexia. *The Observer.*

ATKINS, L. (2002, July 23rd) "It's Better to be Thin and Dead than Fat and Living." *The Guardian.*

AUGE, M. (1995) *Non-Places: Introduction to an Anthropology of Supermodernity,* London & New York, Verso.

BACK, L. (2007) *The Art of Listening,* Oxford & New York, Berg.

BAKHTIN, M. M. (1982) *Dialogic Imagination: Four Essays (New Edition),* Austin, University of Texas Press.

BAKHTIN, M. (1984) *Rabelais and His World,* Bloomington, Indiana University Press.

BARDONE-CONE, A. M. & CASS, K. M. (2006) Investigating the Impact of Pro-Anorexia Websites: A Pilot Study. *European Eating Disorders Review,* 14**,** 256 - 262.

BARR, L. (1989) An Interview with Gayatri Chakravorty Spivak. *Blast Unlimited,* 19**,** 84 - 97.

BATESON, G. (1972) The Cybernetics of "Self": A Theory of Alcoholism. IN *Steps to an Ecology of the Mind,* New York, Ballantine Books.

BATESON, M. C. (1989) *Composing a Life,* New York, Plume Books.

BATTAGLIA, D. (1997) Ambiguating Agency: The Case of Malinowski's Ghost. *American Anthropologist,* 99, 505 - 510.

BAUDRILLARD, J. (1983) *Simulations,* New York, Semiotext(e).

BBC News [Uncredited] (2005, February 8th) BBC Probe into Anorexia Websites. Published at: http://news.bbc.co.uk/l/hi/wales/425109.stm

BBC News [Uncredited] (2007, January 6th) Warning Over Pro-Anorexia Sites. Published at: http://news.bbc.co.uk/l/hi/uk/6236529.stm

BBC News [Uncredited] (2009, May 12th) Anorexic Says Men Need More Help. Published at: http://news.bbc.co.uk/1/hi/england/cornwall/8045237.stm

BECKETT, S. (1986) *The Complete Dramatic Works,* London, Faber & Faber.

BELL, L., CLARE, L. & THORN, E. (2001) *Service Guidelines for People with Eating Disorders.* DCP Occasional Paper No. 3, London, The British Psychological Society.

BELL, M. (2009) '@ the Doctor's Office': Pro-Anorexia and the Medical Gaze. *Surveillance & Society,* 6**,** 151 - 162.

BELL, R. M. (1985) *Holy Anorexia,* Chicago, University of Chicago Press.

BENJAMIN, W. (1972) A Short History of Photography. *Screen,* 13, 1, 5 – 26.

BERGER, J. (2003) Photographs of Agony. IN WELLS, L. (Ed.) *The Photography Reader.* London & New York, Routledge.

BERLANT, L. (2007) Slow Death (Sovereignty, Obesity, Lateral Agency). *Critical Inquiry,* 33**,** 754 - 780.

BERLANT, L. (2010) Cruel Optimism. IN GREGG, M. & SEIGWORTH, G. J. (Eds.) *The Affect Theory Reader.* Durham & London, Duke University Press.

BIEHL, J. O. (2010) Human Pharmakon: Symptoms, Technologies, Subjectivities. IN GOOD, B. J., FISCHER, M. M. J., WILLEN, S. S. & DEL VECCHIO GOOD, M.-J. (Eds.) *A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities.* Malden, MA & Oxford, Wiley-Blackwell.

BIEHL, J. O., GOOD, B. & KLEINMAN, A. (Eds.) (2007) *Subjectivity: Ethnographic Investigations,* Berkeley & London, University of California Press.

BIEHL, J. O., GOOD, B. & KLEINMAN, A. (2007 a) Introduction: Rethinking Subjectivity. IN BIEHL, J. O., GOOD, B. & KLEINMAN, A. (Eds.) *Subjectivity: Ethnographic Investigations,* Berkeley & London, University of California Press.

BIEHL, J. O. & LOCKE, P. (2010) Deleuze and the Anthropology of Becoming. *Current Anthropology,* 51**,** 317 - 351.

BIEHL, J. O. & MORAN-THOMAS, A. (2009) Symptom: Subjectivities, Social Ills, Technologies. *Annual Review of Anthropology,* 38**,** 267 - 288.

BINNS, P. (1995) Integrity, Boundary and the Ecology of Personal Processes. IN GRIFFITHS, A. P. (Ed.) *Philosophy, Psychology and Psychiatry* Cambridge, Cambridge University Press.

BIRMINGHAM, C. L., SU, J., HLYNSKY, J. A., GOLDNER, E. M. & GAO, M. (2005) The Mortality Rate from Anorexia Nervosa. *International Journal of Eating Disorders,* 38**,** 143 - 146.

BLACKMAN, L. (2008) Affect, Relationality and the 'Problem of Personality'. *Theory, Culture & Society,* 25**,** 23 - 47.

BLAKE, W., TURNBULL, S. & TREASURE, J. (1997) Stages and Processes of Change in Eating Disorders: Implications for Therapy. *Clinical Psychology and Psychotherapy,* 4**,** 186 - 191.

BLOOMFIELD, S. (2006) Pro Anna Websites. *Eating Disorders Association Press Release.*

BLUEBOND-LANGNER, M. (1978) *The Private Worlds of Dying Children,* Princeton, Princeton University Press.

BOGLE, I. (May 2000) *Eating Disorders, Body Image and The Media.* London, British Medical Association Board of Science and Education Pamphlet.

BOLT, B. (2007) Material Thinking and the Agency of Matter. *Studies in Material Thinking,* 1, 1 – 4.

BORNEMAN, J. & HAMMOUDI, A. (2009) The Fieldwork Encounter, Experience and the Making of Truth: An Introduction. IN BORNEMAN, J. & HAMMOUDI, A. (Eds.) *Being there: the Fieldwork Encounter and the Making of Truth.* Berkeley, University of California Press.

BORDO, S (1988) Anorexia Nervosa: Psychopathology as the Crystallisation of Culture. IN DIAMOND, I. & QUINBY, L. (Eds.) *Feminism and Foucault: Reflections on Resistance.* Boston, MA, Northeastern University Press.

BORDO, S. (1990) Reading the Slender Body. IN JACOBUS, M., FOX KELLER, E., & SHUTTLEWORTH, S. (Eds.) *Body/Politics: Women and the Discourses of Science.* London & New York, Routledge.

BORDO, S. (1993) *Unbearable Weight: Feminism, Western Culture, and the Body,* Berkeley; Los Angeles & London, University of California Press.

BORGES, J. L. (2000) The Garden of Forking Paths. IN YATES, D. A. & IRBY, J. E. (Eds.) *Labyrinths: Selected Stories and Other Writings by Jorge Luis Borges.* London, Penguin Classics.

BOURDIEU, P. (1977 [1972]) *Outline of a Theory of Practice,* Cambridge, Cambridge University Press.

BOWMAN, G. (2007 A) *Thin: A Memoir of Anorexia and Recovery,* London, Penguin Books.

BOWMAN, G. (2007 [B], April 9th) "I Had Anorexia like Allegra Versace." *New!,* 64 – 65/

BORZEKOWSKI, D., SCHENK, S., WILSON, J. & PEEBLES, R. (2010) E-Ana and E-Mia: A Content Analysis of Pro–Eating Disorder Web Sites. *American Journal of Public Health* 100, 1526–1534.

BRAZIER, M. & CAVE, E. (2007) *Medicine, Patients and the Law (Fourth Edition),* London, Penguin Books.

BREDEN, A. K. (1992) Occupational Therapy and the Treatment of Eating Disorders. *Occupational Therapy in Health Care,* 8**,** 49 - 68.

BROTSKY, S. R., & GILES, D. (2007). Inside the "Pro-Ana" Community: A Covert Online Participant Observation. *Eating Disorders*, 15, 93–109.

BROWN, S. D. & TUCKER, I. (2010) Eff the Ineffable: Affect, Somatic Management, and Mental Health Service Users. IN GREGG, M. & SEIGWORTH, G. J. (Eds.) *The Affect Theory Reader.* Durham & London, Duke University Press.

BRUCH, H. (1974) *Eating Disorders: Obesity, Anorexia and the Person Within,* London, Routledge and Kegan Paul.

BRUCH, H. (2001) *The Golden Cage: The Enigma of Anorexia Nervosa (New Edition),* Cambridge MA & London, Harvard University Press.

BULIK, C. M., SLOF-OP'T LANDT, M. C., FURTH, E. F. V. & SULLIVAN, P. F. (2007) The Genetics of Anorexia Nervosa. *Annual Review of Nutrition,* 27**,** 263 - 275.

BURKE, E. (2009) Pro-Anorexia and the Internet: A Tangled Web of Representation and (Dis)Embodiment. *Counselling, Psychotherapy, and Health,* 5, 1, The Use of Technology in Mental Health Special Issue, 60- 81.

BURKE, K. (1969) *A Grammar of Motives* Berkeley, University of California Press.

BURKITT, I. (2008) *Social Selves: Theories of Self and Society (Second Edition),* Los Angeles, London, New Delhi & Singapore, SAGE.

BURNEY, J. & IRWIN, H. J. (2000) Shame and Guilt in Women with Eating-Disorder Symptomatology. *Journal of Clinical Psychology,* 56**,** 51 - 61.

BUTLER, J. (1993) *Bodies that Matter: on the Discursive Limits of Sex,* New York & London, Routledge.

BUTLER, J. (1997) *Excitable Speech: A Politics of the Performative*, New York, Routledge.

BUTLER, J. (2000) Ethical Ambivalence. IN GARBER, M., HANSSEN, B. & WALKOWITZ, R. L. (Eds.) *The Turn to Ethics.* New York & London, Routledge.

BUTLER, J. (2005) *Giving an Account of Oneself,* New York, Fordham University Press.

CANGUILHEM, G. (1991) *The Normal and the Pathological (New Edition),* New York, Zone Books.

CANDEA, M. (2007) Arbitrary Locations: in Defence of the Bounded Field-Site. *Journal of the Royal Anthropological Institute (New Series),* 13**,** 167 - 184.

CANDEA, M. (2010) Anonymous Introductions: Identity and Belonging in Corsica. *Journal of the Royal Anthropological Institute (New Series),* 16, 119 – 137.

CARO, I. (2008) *La Petite Fille qui ne Voulait pas Grossir,* Paris, Flammarion.

CARRITHERS, M., COLLINS, S. & LUKES, S. (Eds.) (1985) *The Category of the Person: Anthropology, Philosophy, History.* Cambridge, Cambridge University Press.

CATAN, T. & BENNETT, R. (2007, January 8th) Spain Takes Lead in Closing Down the Websites that Tell Girls it's Good to be an Anorexic. *Times Online.* Published at: http://www.timesonline.co.uk/article/0,,8122-2536634.html

CHAMBERS, R. (1991) *Room for Maneuver: Reading (the) Oppositional (in) Narrative,* Chicago & London, University of Chicago Press.

CHARLAND, L. (1998) Is Mr Spock Mentally Competent? Competence to Consent & Emotion. *Philosophy, Psychiatry, & Psychology, 5,* 67 - 81.

CHARLAND, L. C. (2005) A Madness for Identity: Psychiatric Labels, Consumer Autonomy, and the Perils of the Internet. *Philosophy, Psychiatry, & Psychology,* 11, 335 – 348.

CHARLAND, L. C. (2006) Anorexia and the MacCAT-T Test for Mental Competence: Validity, Value, and Emotion. *Philosophy, Psychiatry, & Psychology,* 13, 283 - 287.

CHELSEY, E. B., ALBERTS, J. D., KLEIN, J. D., & KREIPE, R. E. (2003) Pro or Con: Anorexia Nervosa and the Internet. *Journal of Adolescent Health*, 32, 123–124.

CHERNIN, K. (1986) *The Hungry Self: Women, Eating and Identity,* New York, Perennial Library: Harper and Row Publishers

CHERNIN, K. (1981) *The Obsession: Reflections on the Tyranny of Slenderness,* New York, Harper Perennial.

CHRISMAN, N. J. (1981) Secret Societies and the Ethics of Urban Field Work. IN RYNKIEWICH, M. A. & SPRADLEY, J. P. (Eds.) *Ethics and Anthropology: Dilemmas in Fieldwork.* Malabar, Florida, Robert E. Krieger Publishing Company Inc.

CLIFFORD, J. (1997) Spatial Practices: Fieldwork, Travel, and the Disciplining of Anthropology. IN GUPTA, A. & FERGUSON, J. (Eds.) *Anthropological Locations: Boundaries and Grounds of a Field Science.* Berkeley, Los Angeles & London, University of California Press.

COCKELL, S. J., GELLER, J. & LINDEN, W. (2002) Decisional Balance in Anorexia Nervosa: Capitalizing on Ambivalence. *European Eating Disorders Review,* 11, 75 - 89.

COCKELL, S., ZAITSOFF, S. & GELLER, J. (2004) Maintaining Change following Eating Disorders Treatment. *Professional Psychology: Research and Practice, 35,* 527–534.

COFFEY, A. (1999) *The Ethnographic Self: Fieldwork and the Representation of Identity,* London, Thousand Oaks & New Delhi, SAGE.

COLLIER, D. A. & TREASURE, J. (2004) Editorial: The Aetiology of Eating Disorders. *The British Journal of Psychiatry,* 185, 363 - 365.

COLLIER, S. J. & LAKOFF, A. (2005) On Regimes of Living. IN ONG, A. & COLLIER, S. J. (Eds.) *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems.* Oxford, Blackwell Publishing.

COLLIER, S. J. & ONG, A. (2005) Global Assemblages, Anthropological Problems. IN ONG, A. & COLLIER, S. J. (Eds.) *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems.* Oxford, Blackwell Publishing.

COLLINS, R. (1994) Why the Social Sciences Won't Become High-Consensus, Rapid-Discovery Sciences. *Sociological Forum*, 9, 155-177.

COLTON, A. & PISTRANG, N. (2004) Adolescents' Experiences of Inpatient Treatment for Anorexia Nervosa. *European Eating Disorders Review,* 12.

CORIN, E. (1998) Refiguring the Person: The Dynamics of Affects and Symbols in an African Spirit Possession Cult. IN LAMBEK, M. & STRATHERN, A. (Eds.) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia.* Cambridge & New York, Cambridge University Press.

CORIN, E. (2007) The "Other" of Culture in Psychosis: The Ex-Centricity of the Subject. IN BIEHL, J. A. W. A. S., GOOD, B. & KLEINMAN, A. (Eds.) *Subjectivity: Ethnographic Investigations.* Berkeley, University of California Press.

CORIN, E. (2010) The Thickness of Being: Intentional Worlds, Strategies of Identity, and Experience among Schizophrenics. IN GOOD, B., FISCHER, M. M. J., WILLEN, S. S. & DEL VECCHIO GOOD, M.-J. (Eds.) *A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities* Malden, MA & Oxford, Wiley-Blackwell.

CRAPANZANO, V. (2004) Afterword. IN LAMBEK, M. & ANTZE, P. (Eds.) *Illness and Irony: On the Ambiguity of Suffering in Culture.* New York & Oxford, Berghahn Books.

CRISP, A. H, & BURNS, T. (1983) The Clinical Presentation of Anorexia Nervosa in Males. *International Journal of Eating Disorders,* 2**,** 5 - 10.

CRUZ, M. & PINCUS, H. A. (2002) Research on the Influence That Communication in Psychiatric Encounters Has on Treatment. *Psychiatric Services,* 53**,** 1253 - 1265.

CSIPKE, E & HORENE, O. (2007) Pro-Eating Disorder Websites: Users' Opinions. *European Eating Disorders Review,* 15, 196 – 206.

CURTIN, D. W. (1992) Food/Body/Person. IN CURTIN, D. W. & HELDKE, L. M. (Eds.) *Cooking, Eating, Thinking: Transformative Philosophies of Food.* Bloomington, Indiana University Press.

CURTIN, D. W. & HELDKE, L. M. (1992) Introduction. IN CURTIN, D. W. & HELDKE, L. M. (Eds.) *Cooking, Eating, Thinking: Transformative Philosophies of Food.* Bloomington, Indiana University Press.

CUSSINS, C. M. (1998) Ontological Choreography: Agency for Women Patients in an Infertility Clinic. IN BERG, M. & MOL, A. (Eds.) *Differences in Medicine: Unraveling Practices, Techniques, and Bodies.* Durham & London, Duke University Press.

DAILY MAIL [Uncredited] (2007, January 6th) Pro-Anorexia Websites Killing People. *The Daily Mail.*

DAVIES, P. & LIPSEY, Z. (2003) Ana's gone surfing. *The Psychologist* 16**,** 424 - 425.

DAVIS, J. L. (2000) Weight-Loss Tip: Add Extra Calcium to a Low-Fat Diet. *Web MD*. Published at: www.webmd.com.

DAY, K. & KEYS, T. (2009) Anorexia/Bulimia as Resistance and Conformity in Pro-Ana and Pro-Mia Virtual Conversations. IN MALSON, H. & BURNS, M. (Eds.) *Critical Feminist Approaches to Eating Disorders.* London & New York, Routledge.

DeANGELIS, T. (March 2002) A Genetic Link to Anorexia. *Monitor on Psychology, American Psychological Association* 33.

DE CERTEAU, M. (1984) *The Practice of Everyday Life,* Berkeley, Los Angeles & London, University of California Press.

DELEUZE, G. (1998) *Essays Critical and Clinical,* London Verso.

DELEUZE, G. (2007) *Two Regimes of Madness: Texts and Interview 1975 - 1995,* New York, Semiotext(e).

DELEUZE, G. & GUATTARI, F. (2004) *A Thousand Plateaus: Capitalism and Schizophrenia,* London & New York, Continuum.

DENZIN, N. K. & LINCOLN, Y. S. (2003) Introduction: The Discipline and Practice of Qualitative Research. IN DENZIN, N. K. & LINCOLN, Y. S. (Eds.) *The Landscape of Qualitative Research: Theories and Issues (Second Edition).* London, Thousand Oaks & New Delhi, SAGE.

DERRIDA, J. (1997) *Of Grammatology,* Baltimore, John Hopkins University Press.

DERRIDA, J. (2001) *Writing and Difference,* London, Routledge Classics.

DERRIDA, J. (2004) *Dissemination,* London & New York, Continuum.

DESJARLAIS, R. (1997) *Shelter Blues: Sanity and Selfhood among the Homeless,* Philadelphia, University of Pennsylvania Press.

DESJARLAIS, R. (2010) *Struggling Along: The Possibilities for Experience among the Homeless Mentally Ill.* IN GOOD, B. J., FISCHER, M. M. J., WILLEN, S. S. & DEL VECCHIO GOOD, M.-J. (Eds.) *A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities.* Malden, MA & Oxford, Wiley-Blackwell.

DEWALT, K. & DEWALT, B. (2002) *Participant Observation: A Guide for Fieldworkers,* Walnut Creek & Lanham, Altamira Press.

DH (2001) *The Expert Patient: A New Approach to Chronic Disease management for the 21st Century.* London, Department of Health.

DIAS, K. (2003) The Ana Sanctuary: Women's Pro-Anorexia Narratives in Cyberspace. *Journal of International Women's Studies,* 4**,** 31 - 45.

DIRKSEN, V., HUIZING, A. & SMIT, B. (2010) 'Piling on Layers of Understanding': the Use of Connective Ethnography for the Study of (Online) Work Practices. *New Media & Society,* 12**,** 1045–1063.

DOLAN, D. (2003, February 2nd) Learning to Love Anorexia? 'Pro Ana' Websites Flourish. *The New York Observer.*

DOUGLAS, M. (2002) *Purity and Danger: An Analysis of Concepts of Pollution and Taboo,* London & New York, Routledge Classics.

DOWARD, J. & REILLY, T. (2003, August 17th) How Macabre World of the Web Offers Fresh Insights on Anorexics. *The Guardian.*
Published at: http://www.guardian.co.uk/medicine/story/0,,1020508,00.html

DRAPER, H. (1998) Treating Anorexia Without Consent: Some Reservations. *Journal of Medical Ethics,* 24**,** 5 - 7.

DUMIT, J. (2006) Illnesses You Have to Fight to Get: Facts as Forces in Uncertain, Emergent Illnesses. *Social Science & Medicine,* 62, 577 – 590.

DUNBAR, M. (1986) *Catherine: The Story of a Young Girl who Died of Anorexia,* Harmondsworth, Penguin Books.

DURKHEIM, E. (2002) *Suicide: A Study in Sociology,* London & New York, Routledge Classics

ECKERMANN, L. (1997) Foucault, Embodiment and Gendered Subjectivities: The Case of Voluntary Self-Starvation. IN PETERSEN, A. & BUNTON, R. (Eds.) *Foucault, Health and Medicine.* London & New York, Routledge.

EIVORS, A., BUTTON, E., WARNER, S. & TURNER, K. (2003) Understanding the Experience of Drop-out from Treatment for Anorexia Nervosa. *European Eating Disorders Review,* 11**,** 90–107.

ELIOT, T. S. (1963) *Collected Poems 1909 - 1962,* London & Boston, Faber and Faber.

ELLIOTT, C. (2004) *Better Than Well: American Medicine Meets the American Dream,* New York & London, W. W. Norton & Co.

ELLMANN, M. (1993) *The Hunger Artists: Starving, Writing and Imprisonment,* Cambridge MA, Harvard University Press.

EPSTEIN, S. (1996) *Impure Science: AIDS, Activism, and the Politics of Knowledge,* Berkeley, Los Angeles & London University of California Press.

EPSTON, D. & MAISEL, R. (2009) Anti-Anorexia/Bulimia: A Polemics of Life and Death. IN MALSON, H. & BURNS, M. (Eds.) *Critical Feminist Approaches to Eating Dis/Orders.* London & New York, Routledge.

ESTROFF, S. E. (1993) Identity, Disability, and Schizophrenia: The Problem of Chronicity. IN LINDBAUM, S. & LOCK, M. (Eds.) *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life.* Berkeley, Los Angeles & London, University of California Press

FAIRBURN, C. G. & BOHN, K. (2004) Eating Disorder NOS (EDNOS): An Example of the Troublesome "Not Otherwise Specified" (NOS) Category in DSM-IV. *Behaviour Research and Therapy,* 43**,** 691 - 701.

FASSIN, D. (2007) Humanitarianism as a Politics of Life. *Public Culture,* 19, 3, 499 – 520.

FATHALLAH, J. (2006) *Monkey Taming,* London, Random House.

FAVRET-SAADA, J. (1980) *Deadly Words: Witchcraft in the Bocage,* Cambridge, Cambridge University Press.

FEDERICI, A. & KAPLAN, A. S. (2008) The Patient's Account of Relapse and Recovery in Anorexia Nervosa: A Qualitative Study. *European Eating Disorders Review,* 16, 1–10.

FELD, R., WOODSIDE, D. B., KAPLAN, A. S., OLMSTED, M. P. & CARTER, J. C. (2001) Pretreatment Motivational Enhancement Therapy for Eating Disorders: A Pilot Study. *International Journal of Eating Disorders,* 29**,** 393 - 400.

FERREDAY, D. (2003) Unspeakable Bodies: Erasure, Embodiment and the Pro-Ana Community. *International Journal of Cultural Studies,* 6**,** 277 - 295.

FICHTER, M. M. & DASER, C. (1987) Symptomatology, Psychosexual Development and Gender Identity in 42 Anorexic Males. *Psychological Medicine,* 17, 409-418.

FINN, J. & LAVITT, M. (1994) Computer Based Self-Help Groups for Sexual Abuse Survivors. *Social Work With Groups,* 17, 41 - 46.

FISCHER, M. J. (2007) To Live with What Would Otherwise Be Unendurable: Return(s) to Subjectivities. IN BIEHL, J. O., GOOD, B. & KLEINMAN, A. (Eds.) *Subjectivity: Ethnographic Investigations,* Berkeley & London, University of California Press.

FLAHERTY, M. G. & FINE, G. A. (2001) Present, Past, and Future: Conjugating George Herbert Mead's Perspective on Time. *Time Society,* 10**,** 147 - 161.

FLICKER, S., HAANS, D. & SKINNER, H. (2004) Ethical Dilemmas in Research on Internet Communities. *Qualitative Health Research,* 14**,** 124 - 134.

FOUCAULT, M. (1977) *Discipline and Punish: The Birth of the Prison,* London, Penguin Books.

FOUCAULT, M. (1980) *Power/Knowledge: Selected interviews and other writings 1972-1977,* New York, Pantheon Books.

FOUCAULT, M. (1986) Of Other Spaces. *Diacritics,* 16**,** 22 - 27.

FOUCAULT, M. (2001) *Madness and Civilization: A History of Insanity in the Age of Reason,* London, Routledge Classics.

FOUCAULT, M. (2003) *The Birth of the Clinic: An Archaeology of Medical Perception,* London & New York, Routledge Classics.

FOUNTAIN, J. (1993) Dealing With Data. IN HOBBS, D. & MAY, T. (Eds.) *Interpreting the Field: Accounts of Ethnography.* Oxford, Oxford University Press.

FOX, A. P. & LEUNG, N. (2008) Existential Well-Being in Younger and Older People with Anorexia Nervosa - A Preliminary Investigation. *European Eating Disorders Review,* 17**,** 24 - 30.

FOX, N., WARD, K. & O'ROURKE, A. (2005) Pro-Anorexia, Weight-Loss Drugs and The Internet: An 'Anti-Recovery' Explanatory Model of Anorexia. *Sociology of Health and Illness***,** 944 - 971.

FRANK, A. W. (1997) *The Wounded Storyteller: Body, Illness and Ethics (New Edition),* Chicago & London, University of Chicago Press.

FRIEDMAN HANSEN, J. (1981) The Anthropologist in the Field: Scientist, Friend, and Voyeur'. IN RYNKIEWICH, M. A. & SPRADLEY, J. P. (Eds.) *Ethics and Anthropology: Dilemmas in Fieldwork.* Malabar, Florida, Robert E. Krieger Publishing Company Inc.

GANS, M. & GUNN, W. B. (2003) End Stage Anorexia: Criteria for Competence to Refuse Treatment. *International Journal of Law and Psychiatry,* 26**,** 677 - 695.

GARFINKEL, P. E. (1995) Classification and Diagnosis of Eating Disorders. IN BROWNELL, K. D. & FAIRBURN, C. G. (Eds.) *Eating Disorders and Obesity: A Comprehensive Handbook.* New York & London, The Guilford Press.

GARNER, D. M. & BEMIS, K. M. (1982) A Cognitive-Behavioral Approach to Anorexia Nervosa. *Cognitive Therapy and Research,* 6**,** 123 - 150.

GARRETT, C. (1998) *Beyond Anorexia: Narrative, Spirituality and Recovery,* Cambridge, Cambridge University Press.

GAVIN, J., RODHAM, K. & POYER, H. (2008) The Presentation of 'Pro-Anorexia' in Online Group Interactions. *Qualitative Health Research,* 18**,** 325 - 333.

GELLER, J., COCKELL, S. J. & DRAB, D. L. (2001) Assessing Readiness for Change in the Eating Disorders: The Psychometric Properties of the Readiness and Motivation Interview. *Psychological Assessment,* 13, 189–198.

GIBBON, S. & NOVAS, C. (Eds.) (2008) *Biosocialities, Genetics and the Social Sciences: Making Biologies and Identities,* London and New York, Routledge.

GILBERT, K. R. (2001) Introduction. IN GILBERT, K. R. (Ed.) *The Emotional Nature of Qualitative Research.* Boca Raton, CRC Press.

GILES, D. (2006) Constructing Identities in Cyberspace: The Case of Eating Disorders. *British Journal of Social Psychology,* 45**,** 463 - 477.

GILMAN, S. (1988) *Disease and Representation: Images of Illness from Madness to AIDS,* New York, Cornell University Press.

GIORDANO, S. (2005 A) *Understanding Eating Disorders: Conceptual and Ethical Issues in the Treatment of Anorexia and Bulimia Nervosa,* Oxford, Clarendon Press.

GIORDANO, S. (2005 B) Anorexia and its Moral Foundations. *The International Journal of Children's Rights,* 13, 149 - 160.

GIORDANO, S. (2010) Anorexia and Refusal of Life-Saving Treatment: The Moral Place of Competence, Suffering, and the Family. *Philosophy, Psychiatry, & Psychology,* 17**,** 143 - 154.

GOFFMAN, E. (1959) *The Presentation of Self in Everyday Life,* London, Penguin Books.

GOFFMAN, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates,* London, Penguin Books.

GOFFMAN, E. (1963) *Stigma: Notes on the Management of Spoiled Identity,* London, Penguin Books.

GOFFMAN, E. (1981) *Forms of Talk,* Philadelphia, University of Pennsylvania Press.

GOOD, B. J. (1993) *Medicine, Rationality and Experience: An Anthropological Perspective,* Cambridge, Cambridge University Press.

GOODCHILD, S. (2006, October 30th) How Pro-Anorexic Porn's Poisonous Diet 'Thinspires' Young Women to Waste Away. *Independent.ie.*
Published at: http://independent.ie/opinion/analysis/how-proanorexic-porns-poisonous-diet-thinspires-young-women-to-waste-away-75793.html

GOOLDIN, S. (2008) Being Anorexic: Hunger, Subjectivity and Embodied Morality. *Medical Anthropology Quarterly,* 22**,** 274 - 296.

GORDON, R. A. (1990) *Anorexia and Bulimia: Anatomy of a Social Epidemic,* Oxford & Cambridge MA, Blackwell.

GOSS, K. & GILBERT, P. (2002) Eating Disorders, Shame and Pride: A Cognitive-Behavioural Functional Analysis. IN GILBERT, P. & MILES, J. (Eds.) *Body Shame: Conceptualisation, Research and Treatment.* Hove & New York, Bruner-Routledge.

GOWERS, S. G., WEETMAN, J., SHORE, A., HOSSAIN, F. & ELVINS, R. (2000) Impact of Hospitalisation on the Outcome of Adolescent Anorexia Nervosa. *British Journal of Psychiatry,* 176**,** 138 - 141.

GRAHAME, N. (2009) *Dying to be Thin: The True Story of My Lifelong Battle Against Anorexia,* London, John Blake.

GREENFIELD, L. (2004) Thin. *HBO Documentary Films.*

GREMILLION, H. (2003) *Feeding Anorexia: Gender and Power at a Treatment Center,* Durham and London, Duke University Press.

GRIFFITHS, R. & RUSSELL, J. (1998) Compulsory Treatment of Anorexia Nervosa Patients. IN VANDEREYCKEN, W. & BEUMONT, P. J. V. (Eds.) *Treating Eating Disorders: Ethical, Legal and Personal Issues.* London, The Athlone Press.

GROSSBERG, L. (2000) History, Imagination and the Politics of Belonging. IN GILROY, P., GROSSBERG, L. & McROBBIE, A. (Eds.) *Without Guarantees: In Honour of Stuart Hall,* London & New York, Verso.

GROSSBERG, L. (2010) Affect's Future: Rediscovering the Virtual in the Actual. IN GREGG, M. & SEIGWORTH, G. J. (Eds.) *The Affect Theory Reader.* Durham & London, Duke University Press.

GROSZ, E. (1994) *Volatile Bodies: Towards a Corporeal Feminism,* Bloomington & Indianapolis, Indiana University Press.

GROSZ, E. (2001) *Architecture from the Outside: Essays on Virtual and Real Space,* Cambridge MA, MIT Press.

GUDEMAN, S. & RIVERA, A. (1989) Colombian Conversations: The Strength of the Earth. *Current Anthropology,* 30**,** 267-281.

GUPTA, A. & FERGUSON, J. (1997) Discipline and Practice: "The Field" as Site, Method, and Location in Anthropology. IN GUPTA, A. & FERGUSON, J. (Eds.) *Anthropological Locations: Boundaries and Grounds of a Field Science.* Berkeley, Los Angeles & London, University of California Press.

HACKING, I. (1995) *Rewriting the Soul: Multiple Personality and the Sciences of Memory,* Cambridge MA, Harvard University Press.

HACKING, I. (1999) *The Social Construction of What?,* Cambridge MA & London, Harvard University Press.

HALSE ANDERSON, L. (2009) *Wintergirls,* New York, Speak, Penguin Books USA.

HAMMERSLEY, M. & ATKINSON, P. (1995) *Ethnography: Principles in Practice (Second Edition),* London, Routledge.

HAMMERSLEY, M. & ATKINSON, P. (2007) *Ethnography: Principles in Practice (Third Edition),* Oxford & New York, Routledge.

HANNERZ, U. (2003) Being There... and There... and There!: Reflections on Multi-Site Ethnography. *Ethnography,* 4**,** 201 - 217.

HARAWAY, D. J. (1991) *Simians, Cyborgs, and Women: The Reinvention of Nature,* London, Free Association Books.

HARAWAY, D. (1993) The Biopolitics of Postmodern Bodies: Determinations of Self in Immune System Discourse. IN LINDBAUM, S. & LOCK, M. (Eds.) *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life.* Berkeley, Los Angeles & London, University of California Press.

HARAWAY, D. (1999) A Cyborg Manifesto. IN DURING, S. (Ed.) *The Cultural Studies Reader (Second Edition).* London & New York, Routledge.

HARAWAY, D. (2008) Otherwordly Conversations, Terran Topics, Local Terms. IN ALAIMO, S. & HEKMAN, S. (Eds.) *Material Feminisms.* Bloomington, Indiana, Indiana University Press.

HARRIES, P. (1992) Facilitating Change in Anorexia Nervosa: The Role of Occupational Therapy. *The British Journal of Occupational Therapy,* 55**,** 334 - 339.

HASTRUP, K. & HERVIK, P. (1994) Introduction. IN HASTRUP, K. & HERVIK, P. (Eds.) *Social Experience and Anthropological Knowledge.* New York & London, Routledge.

HAYWOOD, L. (2007, December 17th) Anorexia Not Models' Fault. *The Sun,* 12.

HEPWORTH, J. (1999) *The Social Construction of Anorexia Nervosa,* London, SAGE.

HEYWOOD, L. (1996) *Dedication to Hunger: The Anorexic Aesthetic in Modern Culture,* Berkeley, Los Angeles & London, University of California Press.

HIGBED, L. & FOX, J. R. E. (2010) Illness Perceptions in Anorexia Nervosa: A Qualitative Investigation. *British Journal of Clinical Psychology,* 49**,** 307 – 325.

HINE, C. (2000) *Virtual Ethnography.* London, Thousand Oaks & New Delhi, SAGE.

HINE, C. (2007) Connective Ethnography for the Exploration of E-science. *Journal of Computer-mediated Communication* 12, Issue 2.
Published at: http://jcmc.indiana.edu/vol12/issue2/hine.html

HIRSCHAUER, S. (1998) Performing Sexes and Genders in Medical Practice. IN BERG, M. & MOL, A. (Eds.) *Differences in Medicine: Unravelling Practices, Techniques, and Bodies.* Durham & London, Duke University Press.

HOLLIDAY, J., WALL, E., TREASURE, J. & WEINMAN, J. (2005) Perceptions of Illness in Individuals with Anorexia Nervosa: A Comparison with Lay Men and Women. *International Journal of Eating Disorders,* 37, 50–56.

HOPE, T. (1995) Personal Identity and Psychiatric Illness. IN GRIFFITHS, A. P. (Ed.) *Philosophy, Psychology and Psychiatry.* Cambridge, Cambridge University Press.

HOPE, T. (2004) *Medical Ethics: A Very Short Introduction,* Oxford & New York, Oxford University Press.

HORNBACHER, M. (1998) *Wasted: Coming Back from an Addiction to Starvation,* London, Flamingo.

HORNBACHER, M (2000) *Piégée: Mémoires d'une Anorexique,* Paris, Poche.

HORNSBY-SMITH, M. (1993) Gaining Access. IN GILBERT, N. (Ed.) *Researching Social Life.* London, SAGE.

HOROWITZ, A. V. & SCHEID, T. L. (Eds.) (1999) *A Handbook for the Study of Mental Health: Social Contexts, Theories & Systems,* Cambridge, Cambridge University Press.

HOWARD, B. (2007, 17th - 23rd March) Louise is the New Pin-Up for Anorexics. *Reveal,* 14 – 15.

HOWLETT, M., MCCLELLAND, L. & CRISP, A. H. (1995) The Cost of the Illness that Defies. *Postgraduate Medical Journal,* 71**,** 36-39.

ILLICH, I. (2001) *Limits to Medicine: Medical Nemesis - The Expropriation of Health (New Edition),* London, Marion Boyars.

JACKSON, M. (1998) *Minima Ethnographica: Intersubjectivity and the Anthropological Project,* Chicago, University of Chicago Press.

JACKSON, M. (2002) Familiar and Foreign Bodies: A Phenomenological Exploration of the Human-Technology Interface. *Journal of the Royal Anthropological Institute (New Series),* 8**,** 333-346.

JACOBS BRUMBERG, J. (2000) *Fasting Girls: The History of Anorexia Nervosa (Revised and Updated Edition),* New York, Vintage Books.

JAMES, H. (1990) *Complete Stories 1884 – 1891,* New York, The Library of America.

KAYE, W. H., BULIK, C. M., PLOTNICOV, K., THORNTON, L., DEVLIN, B., FICHTER, M. M., TREASURE, J., KAPLAN, A., WOODSIDE, D. B., JOHNSON, C. L., HALMI, K., BRANDT, H. A., CRAWFORD, S., MITCHELL, J. E., STROBER, M., BERRETTINI, W., JONES, I. (2008) The Genetics of Anorexia Nervosa Collaborative Study: Methods and Sample Description, *International Journal of Eating Disorders,* 41, 289 – 300.

KEARNEY, M. (1995) The Local and the Global: The Anthropology of Globalization and Transnationalism. *Annual Review of Anthropology,* 24**,** 547 - 565.

KELLENER, D. (1994) Self-Help Groups and their Relationship to Medicine. IN GABE, J., KELLENER, D. & WILLIAMS, G. (Eds.) *Challenging Medicine.* London, Routledge.

KEYS, A., BROZEL, J., HENSCHEL, A., MICKELSEN, O. & TAYLOR, H. L. (1950) *The Biology of Human Starvation,* Minneapolis, University of Minnesota Press.

KING, S. A. (1996) Researching Internet Communities: Proposed Ethical Guidelines for the Reporting of Results. *Information Society,* 12, 119 - 128.

KIRSCHENBLATT-GIMBLETT, B. (1996) The Electronic Vernacular. IN MARCUS, G. (Ed.) (1996) *Connected: Engagements with Media.* Chicago and London, Late Editions: University of Chicago Press.

KLIEFIELD, E., WAGNER, S. & HALMI, K. A. (1996) Cognitive-Behavioral Treatment of Anorexia Nervosa. *The Psychiatric Clinics of North America,* 19**,** 715–737.

KLEINMAN, A. (1986) *Social Origins of Distress and Disease: Depression, Neurasthenia and Pain in Modern China,* New Haven, Yale University Press.

KLEINMAN, A. (1988) *The Illness Narratives: Suffering, Healing and the Human Condition,* New York, Basic Books.

KLEINMAN, A., DAS, V. & LOCK, M. (Eds.) (1997) *Social Suffering,* Berkeley & London, University of California Press.

KOHLER RIESSMAN, C. (1998) Woman and Medicalization: A New Perspective. IN WEITZ, R. (Ed.) *The Politics of Women's Bodies: Sexuality, Appearance and Behaviour.* New York & Oxford, Oxford University Press.

KRISTEVA, J. (1982) *Powers of Horror: An Essay on Abjection,* New York, Columbia University Press.

KUTCHINS, H. & KIRK, S. A. (1997) *Making Us Crazy: DSM - The Psychiatric Bible and the Creation of Mental Disorders* London, Constable.

KYRIACOU, O., TREASURE, J. & SCHMIDT, U. (2008) Understanding how Parents Cope with Living with Someone with Anorexia Nervosa: Modeling the Factors that are Associated with Carer Distress. *International Journal of Eating Disorders* 41**,** 233 - 242.

LA FONTAINE, J. S. (1985) Person and Individual: Some Anthropological Reflections. IN CARRITHERS, M., COLLINS, S. & LUKES, S. (Eds.) *The Category of the Person: Anthropology, Philosophy, History.* Cambridge, Cambridge University Press.

LACAN, J. (2001) *Écrits: A Selection (New Edition),* London Routledge Classics.

LAING, R. D. (1976) *The Divided Self, a Study of Sanity and Madness,* London Penguin Books.

LAMBEK, M. (1998) Body and Mind in Mind, Body and Mind in Body: Some Anthropological Interventions in a Long Conversation. IN LAMBEK, M. & STRATHERN, A. (Eds.) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia.* Cambridge & New York, Cambridge University Press.

LAMBEK, M. (2004 A) Introduction: Irony and Illness - Recognition and Refusal. IN LAMBEK, M. & ANTZE, P. (Eds.) *Illness and Irony: On the Ambiguity of Suffering in Culture* New York & Oxford Berghahn Books.

LAMBEK, M. (2004 B) Rheumatic Irony: Questions of Agency and Self-Deception as Refracted through the Art of Living with Spirits. IN LAMBEK, M. & ANTZE, P. (Eds.) *Illness and Irony: On the Ambiguity of Suffering in Culture.* New York & Oxford, Berghahn Books.

LAMBEK, M. & ANTZE, P. (1996) Introduction: Forecasting Memory. IN ANTZE, P. & LAMBEK, M. (Eds.) *Tense Past: Cultural Essays in Trauma and Memory.* New York & London, Routledge.

LAMBEK, M. & STRATHERN, A. (Eds.) (1998) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia.* Cambridge & New York, Cambridge University Press.

LATOUR, B. (1987) *Science in Action,* Cambridge MA, Harvard University Press.

LATOUR, B. (2002) Gabriel Tarde and the End of the Social. IN JOYCE, P. (Ed.) *The Social in Question: New Bearings in History and the Social Sciences.* London & New York, Routledge.

LATOUR, B. (2005) *Reassembling the Social: An Introduction to Actor-Network Theory,* Oxford Oxford University Press.

LATOUR, B. & WOOLGAR, S. (1986) *Laboratory Life: The Construction of Scientific Facts,* Princeton, Princeton University Press.

LAW, J. (2003) Notes on the Theory of the Actor Network: Ordering, Strategy and Heterogeneity. Published by the *Centre for Science Studies, Lancaster University*, at:
http://www.comp.lancs.ac.uk/sociology/papers/Law-Notes-on-ANT.pdf

LAW, J. (2007) Making a Mess with Method. IN OUTHWAITE, W. & TURNER, S. P. (Eds.) The SAGE Handbook of *Social Science Methodology.* London, Thousand Oaks & New Delhi, SAGE

LAW, J. & HETHERINGTON, K. (2003) Allegory and Interference: Representation in Sociology. Published by the *Centre for Science Studies, Lancaster University,* at:
http://www.lancs.ac.uk/fass/sociology/papers/law-hetherington-allegory-interference.pdf

LAW, J. & MOSER, I. (1999) Managing, Subjectivities and Desires. *Concepts and Transformation: International Journal of Action Research and Organizational Renewal,* **4,** 249 - 279.

LAW, J. & URRY, J. (2004) Enacting the Social. *Economy and Society,* **33,** 390 - 410.

LEANDER, K.M. & McKIM, K.K. (2003) Tracing the Everyday "Sittings" of Adolescents on the Internet: A Strategic Adaptation of Ethnography Across Online and Offline Spaces. *Education, Communication, Information,* 3, 211–40.

LEE, R. (1993) *Doing Research on Sensitive Topics,* London, Newbury Park & New Delhi, SAGE.

LEE-POTTER, C. (2006, March 26th) The Best Anorexic There Could Be. *Independent on Sunday.*

LE GRANGE, D. & GELMAN, T. (1998) Patients' Perspectives of Treatment in Eating Disorders: A Preliminary Study. *South African Journal of Psychology,* **28,** 182 - 186.

LESTER, R. J. (1995) Embodied Voices: Women's Food Ascetisism and the Negotiation of Identity. *Ethos,* **23,** 187 - 222.

LESTER, R. J. (1997) The (Dis)Embodied Self in Anorexia Nervosa. *Social Science and Medicine,* **44,** 479 - 489.

LESTER, R. J. (2007) Critical Therapeutics: Cultural Politics and Clinical Reality in Two Eating Disorder Treatment Centres. *Medical Anthropology Quarterly,* **21,** 369 - 387.

LESTER, R. J. (2009) Brokering Authenticity: Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic. *Current Anthropology,* **50,** 281 - 302.

LEVENKRON, S. (1978) *The Best Little Girl in the World,* New York & Boston, Warner Books.

LEVI, P. (2004) *If this is a Man* and *The Truce,* London, Abacus.

LIPINSKI, K. (2007, June 11th) I Was an Internet Anorexic. *Grazia,* 60 – 64.

LIU, A. (2007) *Gaining: The Truth about Life after Eating Disorders,* New York & Boston, Wellness Central, Hachette Book Group.

LOCK, M. (1993) *Encounters with Ageing: Mythologies of Menopause in Japan and North America,* Berkeley, University of California Press.

LOCK, M. & KAUFERT, P. A. (1998) Introduction. IN LOCK, M. & KAUFERT, P. A. (Eds.) *Pragmatic Women and Body Politics.* Cambridge, Cambridge University Press.

LOCK, M. (2003) Medicalization and the Naturalization of Social Control. IN EMBER, C. R. & EMBER, M (Eds.) *Encyclopedia of Medical Anthropology, Volume 1: Health and Illness in the World's Cultures*, New York, Springer.

LONG, D., HUNTER, C. L. & GEEST, S. V. D. (2008) When the Field is a Ward or a Clinic: Hospital Ethnography. *Anthropology and Medicine,* 15**,** 71 – 78.

LOW, S. M. & LAWRENCE-ZUNIGA (2003) Locating Culture. IN LOW, S. M. & LAWRENCE-ZUNIGA, D. (Eds.) *The Anthropology of Space and Place: Locating Culture,* Oxford, Blackwell.

LUHRMANN, T. M. (1989) *Persuasions of the Witch's Craft: Ritual Magic in Contemporary England,* Cambridge MA, Harvard University Press.

LUHRMANN, T. M. (2001) *Of Two Minds: An Anthropologist Looks at American Psychiatry,* New York, Vintage Books.

LUPTON, D. (1996) *Food, the Body and the Self,* London, Thousand Oaks & New Delhi, SAGE.

LUPTON, D. (1997) Foucault and the Medicalisation Critique. IN PETERSEN, A. & BUNTON, R. (Eds.) *Foucault, Health and Medicine.* London & New York, Routledge.

MACKENZIE, C. & STOLJAR, N. (Eds.) (2000) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self,* Oxford, Oxford University Press.

MACSWEEN, M. (1993) *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa,* London & New York, Routledge.

MALKKI, L. H. (1997) News and Culture: Transitory Phenomenon and the Fieldwork Tradition. IN GUPTA, A. & FERGUSON, J. (Eds.) *Anthropological Locations: Boundaries and Grounds of a Field Science.* Berkeley, Los Angeles & London, University of California Press.

MALSON, H. (1998) *The Thin Woman: Feminism, Post-Structuralism and the Social Psychology of Anorexia Nervosa*, London, Routledge.

MALSON, H. (1999) Women under Erasure: Anorexic Bodies in a Postmodern Context. *Journal of Community and Applied Social Psychology,* 9, 137–53.

MALSON, H. (2009) Appearing to Disappear: Postmodern Femininities and Self-Starved Subjectivities. IN MALSON, H. & BURNS, M. (Eds.) Critical Feminist Approaches to Eating Disorders. London & New York, Routledge.

MARCUS, G. (1995) Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography *Annual Review of Anthropology,* 24**,** 95 - 117.

MARCUS, G. (Ed.) (1996) *Connected: Engagements with Media,* Chicago and London, Late Editions: University of Chicago Press.

MARCUS, G. E. (1998) *Ethnography through Thick and Thin,* Princeton, New Jersey, Princeton University Press.

MARCUS, G. E. (2008) The End(s) of Anthropology: Social/Cultural Anthropology's Signature Form of Producing Knowledge in Transition. *Cultural Anthropology,* 23**,** 1 - 14.

MARGO, J. L. (1987) Anorexia Nervosa in Males: A Comparison with Female Patients. *British Journal of Psychiatry,* 151, 80-83.

MARINO, J. M., ERTELT, T. E., WONDERLICH, S. A., CROSBY, R. D., LANCASTER, K., MITCHELL, J. E., FISCHER, S., DOYLE, P., GRANGE, D. L., PETERSON, C. B. & CROW, S. (2009) Caffeine, Artificial Sweetener, and Fluid Intake in Anorexia Nervosa. *International Journal of Eating Disorders,* 42**,** 540 - 545.

MARKHAM, A. N. (2005) The Methods, Politics, and Ethics of Representation in Online Ethnography. IN DENZIN, N. K. & LINCOLN, Y. S. (Eds.) *The SAGE Handbook of Qualitative Research (Third Edition).* Thousand Oaks, London & New Delhi, SAGE.

MARTIN, E. (1994) *Flexible Bodies: Tracking Immunity in American Culture – from the Days of Polio to the Age of AIDS,* Boston, Beacon Press.

MARTIN, E. (2007) *Bipolar Expeditions: Mania and Depression in American Culture,* Princeton & Oxford, Princeton University Press.

MARTIJN, C., SMEETS, E., JANSEN, A., HOEYMANS, N. & SCHOEMAKER, C. (2009) Don't Get the Message: The Effect of a Warning Text Before Visiting a Proanorexia Website. *International Journal of Eating Disorders,* 42**,** 139 - 145.

MASSUMI, B. (1992) *A User's Guide to Capitalism and Schizophrenia: Deviations from Deleuze and Guattari,* Cambridge MA, MIT Press.

MASSUMI, B. (1995) The Autonomy of Affect. *Cultural Critique,* No. 31, The Politics of Systems and Environments, Part II**,** 83 -109.

MASSUMI, B (2002) *Parables for the Virtual: Movement, Affect, Sensation,* Durham & London, Duke University Press.

MASSUMI, B. (2010) The Future Birth of the Affective Fact: The Political Ontology of Threat. IN GREGG, M. & SEIGWORTH, G. J. (Eds.) *The Affect Theory Reader.* Durham & London, Duke University Press.

MATTINGLY, C. (1998) *Healing Dramas and Clinical Plots: The Narrative Structure of Experience,* Cambridge, Cambridge University Press.

MAUSS, M. (1985) A Category of the Human Mind: The Notion of Person; The Notion of Self. IN CARRITHERS, M., COLLINS, S. & LUKES, S. (Eds.) *The Category of the Person: Anthropology, Philosophy, History.* Cambridge, Cambridge University Press.

MCGRATH, R. (1984) Medical Police. *Ten-8,* 14**,** 13 - 18.

MCGRATH, R. (2002) *Seeing her Sex: Medical Archives and the Female Body,* Manchester & New York, Manchester University Press.

MCSHERRY, B. (1997) Force-Feeding and Anorexia. *Journal of Law and Medicine,* 5**,** 8 - 13.

MEAD, G. H. (1932) *The Philosophy of the Present,* Chicago, University of Chicago Press.

MEAD, G. H. (1967) *Mind, Self & Society From The Standpoint Of A Social Behaviorist,* Chicago & London, Phoenix Books, University of Chicago Press.

MCA (2005) *Mental Capacity Act*, published at: http://www.legislation.gov.uk

MELAMED, Y., MESTER, R., MARGOLIN, J. & KALIAN, M. (2003) Involuntary Treatment of Anorexia Nervosa. *International Journal of Law and Psychiatry,* 26**,** 617 - 626.

MHA (1983) *Mental Health Act 1983,* London, Department of Health.

MHA (2007) *Mental Health Act 2007,* London, Department of Health.

MIAH, A. & RICH, E. (2008) *The Medicalization of Cyberspace,* Oxford & New York, Routledge.

MILLER, D. & SLATER, D. (2000) *The Internet: An Ethnographic Approach,* Oxford & New York, Berg.

MILLER, W. R. (1998) Enhancing Motivation for Change. IN MILLER, W. R. & HEATHER, N. (Eds.) *Treating Addictive Behaviors (Second Edition).* London, Peplum.

MOL, A. (1998) Missing Links, Making Links: The Performance of Some Atheroscleroses. IN BERG, M. & MOL, A. (Eds.) *Differences in Medicine: Unraveling Practices, Techniques, and Bodies.* Durham & London, Duke University Press.

MOL, A. (2000) Pathology and the Clinic: An Ethnographic Presentation of Two Atheroscleroses. IN LOCK, M., YOUNG, A. & CAMBROSIO, A. (Eds.) *Living and Working with the New Medical Technologies: Intersections of Inquiry.* Cambridge, Cambridge University Press.

MOL, A. (2002 A) *The Body Multiple: Ontology in Medical Practice,* Durham & London, Duke University Press.

MOL, A. (2002 B) Cutting Surgeons, Walking Patients: Some Complexities Involved in Comparing. IN LAW, J. & MOL, A. (Eds.) *Complexities: Social Studies of Knowledge Practices.* Durham & London, Duke University Press.

MOL, A. (2008) I Eat an Apple: On Theorizing Subjectivities. *Subjectivity,* 22, 28 – 37.

MOL, A. & BERG, M. (1998) Differences in Medicine: An Introduction. IN BERG, M. & MOL, A. (Eds.) *Differences in Medicine: Unraveling Practices, Techniques and Bodies.* Durham & London, Duke University Press.

MOL, A. & LAW, J. (1994) Regions, Networks and Fluids: Anaemia and Social Topology. *Social Studies of Science,* 24, 641 - 671.

MOL, A. & LAW, J. (2002) Complexities: An Introduction. IN LAW, J. & MOL, A. (Eds.) *Complexities: Social Studies of Knowledge Practices.* Durham & London, Duke University Press.

MONTGOMERY HUNTER, K. (1991) *Doctors' Stories: The Narrative Structure of Medical Knowledge,* Princeton, New Jersey, Princeton University Press.

MORRIS, B. (1991) *Western Conceptions of the Individual,* Oxford, Berg.

MOSER, I. & LAW, J. (2003) 'Making Voices': New Media Technologies, Disabilities, and Articulation. Published by the *Centre for Science Studies, Lancaster University*, at: http://www.comp.lancs.ac.uk/sociology/papers/Moser-Law-Making-Voices.pdf.

MULVEEN, R. & HEPWORTH, J. (2006) An Interpretive Phenomenological Analysis of Participation in a Pro-Anorexia Internet Site and its Relationship with Disordered Eating. *Journal of Health Psychology,* 11, 283 – 296.

MUNRO, A. (1997) *Selected Stories,* London, Vintage.

MURRAY, J. W. (2001) Kenneth Burke: A Dialogue of Motives. *Philosophy and Rhetoric,* 35, 1.

NEHEMAS, A. (2000) *The Art of Living: Socratic Reflections from Plato to Foucault (New Edition),* Berkeley, Los Angeles & London, University of California Press.

NGAI, S. (2001) Jealous Schoolgirls, Single White Females, and Other Bad Examples: Rethinking Gender and Envy. *Camera Obscura,* 47, 16 (2), 177 - 229.

NICE (2004) *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*, National Collaborating Centre for Mental Health, London, The British Psychological Society and Gaskell.

NICHTER, M. (1998) The Mission within the Madness: Self-Initiated Medicalization as Expression of Agency. IN LOCK, M. & KAUFERT, P. A. (Eds.) *Pragmatic Women and Body Politics.* Cambridge, Cambridge University Press.

NORDBØ, R. H. S., ESPESET, E. M. S., GULLIKSEN, K. S., SKA°RDERUD, F. & HOLTE, A. (2006) The Meaning of Self-Starvation: Qualitative Study of Patients' Perception of Anorexia Nervosa. *International Journal of Eating Disorders,* 39, 556 - 564.

NORRIS, M. L., BOYDELL, K. M., PINHASD, L. & KATZMAN, D. K. (2006) Ana and the Internet: A Review of Pro-Anorexia Websites. *International Journal of Eating Disorders,* 39**,** 443 - 447.

OAKES-ASH, R. (2001) *Good Girls Do Swallow,* Edinburgh & London, Mainsteam Publishing.

OAKLEY, A. (1981) Interviewing Women: A Contradiction in Terms. IN Roberts, H. (Ed.) *Doing Feminist Research.* London, Routledge & Kegan Paul.

O'CONNOR, M., SIMMONS, T. & COOPER, M. (2003) Assumptions and Beliefs, Dieting, and Predictors of Eating Disorder-Related Symptoms in Young Women and Young Men. *Eating Behaviours,* 4, 1-6.

O'CONNOR, R. A. & VAN ESTERIK, P. (2008) De-Medicalizing Anorexia: A New Cultural Brokering. *Anthropology Today,* 24**,** 6 - 9.

OLWIG, K. F (1997) Cultural Sites: Sustaining a Home in a Deterritorialized World. IN OLWIG, K.F. & HASTRUP, K. (Eds.) *Siting Culture: The Shifting Anthropological Object.* London & New York, Routledge.

OLWIG, K.F. & HASTRUP, K. (1997) Introduction. IN OLWIG, K.F. & HASTRUP, K. (Eds.) *Siting Culture: The Shifting Anthropological Object.* London & New York, Routledge.

ORWELL, G. (2001) *Down and Out in Paris and London (New Edition),* London, Penguin Classics.

ORBACH, S. (1993) *Hunger Strike (New Edition),* London, Penguin Books.

ORBACH, S. (1998) *Fat is a Feminist Issue: The Anti-Diet Guide for Women and Fat is a Feminist Issue II,* London, Arrow Books.

OSBORNE, T. & ROSE, N. (1999) Do the Social Sciences Create Phenomena?: The Example of Public Opinion Research. *British Journal of Sociology,* 50**,** 367-396.

PALMER, B. (2005) Concepts of Eating Disorders. IN TREASURE, J., SCHMIDT, U. & FURTH, E. V. (Eds.) *The Essential Handbook of Eating Disorders.* Chichester, Wiley.

PASSARO, J. (1997) "You Can't Take the Subway to the Field!:" "Village" Epistemologies in the Global Field. IN GUPTA, A. & FERGUSON, J. (Eds.) *Anthropological Locations: Boundaries and Grounds of a Field Science.* Berkeley, Los Angeles & London, University of California Press.

PATEL, D. R., PRATT, H. D. & GREYDANUS, D. E. (2003) Treatment of Adolescents with Anorexia Nervosa. *Journal of Adolescent Research*, 18, 244 - 260.

PEREC, G. (1989*) L'Infra-Ordinaire,* Paris, Editions du Seuil.

PEREC, G. (2000) *Espèces d'Espaces,* Paris, Galilée.

PLATO (2005) *Phaedrus,* London, Penguin Classics.

POLLACK, D. (2003) Pro-Eating Disorder Websites: What Should Be the Feminist Response? *Feminism & Psychology,* 13, 246 – 251.

PORTER, R. (1987) *A Social History of Madness: Stories of the Insane,* London, Weidenfeld and Nicolson.

PROBYN, E. (1987) The Anorexic Body. IN KROKER, A. & KROKER, M. (Eds.) *Body Invaders.* New York, St Martin's Press.

PROBYN, E. (1996) *Outside Belongings: Disciplines, Nations and the Place of Sex,* New York & London, Routledge.

PROBYN, E. (2000) *Carnal Appetites: FoodSexIdentities,* London & New York, Routledge.

PROCHASKA, J. E. & DICLEMENTE, C. C. (1992) The Transtheoretical Approach. IN NORCROSS, J. C. & GOLDFIELD, I. L. (Eds.) *Handbook of Psychotherapy Integration.* New York, Basic.

RABINOW, P. (1999) Artificiality and Enlightenment: From Sociobiology to Biosociality. IN BIAGIOLI, M. (Ed.) *The Science Studies Reader.* New York & London, Routledge.

RAMAMURTHY, A. (1997) Constructions of Illusion: Photography and Commodity Culture. IN WELLS, L. (Ed.) *Photography: A Critical Introduction,* London, Routledge.

RANK, Otto (1971) *The Double,* Chapel Hill North Carolina, University of North Carolina Press.

RATHNER, G. (1998) A Plea Against Compulsory Treatment of Anorexia Nervosa Patients. IN VANDEREYCKEN, W. & BEAUMONT, P. (Eds.) *Treating Eating Disorders.* London, Athlone Press.

REID, M., BURR, J., WILLIAMS, S. & HAMMERSLEY, R. (2008) Eating Disorders Patients' Views on their Disorders and on an Outpatients Service: A Qualitative Study. *Journal of Health Psychology,* 13**,** 956 - 960.

REYNOLDS WHYTE, S., VAN DER GEEST, S. & HARDON, A. (2002) *Social Lives of Medicines,* Cambridge, Cambridge University Press.

RICOEUR, P. (1992) *Oneself as Other,* Chicago, University of Chicago Press.

RIES, N. (1997) *Russian Talk: Culture and Conversation during Perestroika,* Ithaca & London, Cornell University Press.

ROBINSON, P. (2009) *Severe and Enduring Eating Disorder (SEED): Management of Complex Presentations of Anorexia and Bulimia Nervosa,* Oxford, Wiley-Blackwell.

ROCKWELL, L. E. (1990) Frames of Reference and Modalities used by Occupational Therapists in the Treatment of Patients with Eating Disorders. *Occupational Therapy in Mental Health,* 10**,** 47 - 59.

ROLLNICK, S., MILLER, W. R. & BUTLER, C. C. (2008) *Motivational Interviewing in Health Care: Helping Patients Change Behavior,* New York, Guilford Press.

ROSE, N. (2007) *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century,* Princeton, Princeton University Press.

ROULEAU, C. R. & VON RANSON, K. M. (2011) Potential Risks of Pro-Eating Disorder Websites. *Clinical Psychology Review,* 31**,** 525 - 531.

SAGE, M. (2006, February 24th) "A Website Killed Our Suzy." *Closer,* 42 – 43.

SALEM, D. A., BOGAT, G. A., & REID, C. (1997) Mutual Help Goes On-Line. *Journal of Community Psychology,* 25, 189 - 207.

SANABRIA, E. (2009) Le Médicament, Un Object Evanescent: Essai sur la Fabrication et la Consommation des Substances Pharmaceutiques. *Techniques & Culture,* 52 - 53**,** 168 - 189.

SANER, E. (2010, 27th February) I Was a 'Good Anorexic.' *The Guardian.*

SASS, L. A. (1994) *Madness and Modernism, Insanity in the Light of Modern Art, Literature and Thought,* Cambridge MA, Harvard University Press.

SATO, Y. (2003) Autonomy and Anorexia Nervosa. *Lancet,* 362**,** 1937.

SAUKKO, P. (2000) Between Voice and Discourse: Quilting Interviews on Anorexia. *Qualitative Inquiry,* 6, 299-317

SCHEFF, T. J. (Ed.) (1975) *Labeling Madness,* Englewood Cliffs, N.J, Prentice-Hall, Inc.

SCHEPER-HUGHER, N. (1992) *Death Without Weeping: the Violence of Everyday Life in Brazil,* Berkeley, University of California Press.

SCHMIDT, U., BONE, G., HEMS, S., LESSEM, J. & TREASURE, J. (2002) Structured Therapeutic Writing Tasks as an Adjunct to Treatment in Eating Disorders. *European Eating Disorders Review,* 10**,** 1 - 17.

SCHMIDT, U. & TREASURE, J. (2006) Anorexia Nervosa: Valued and Visible. A Cognitive-Interpersonal Maintenance Model and its Implications for Research and Practice. *British Journal of Clinical Psychology* 45**,** 343-366.

SCHMIDT, U. (2009, February) *Royal College of Psychiatrists' Briefing on Pro Ana Websites.* London, Royal College of Psychiatrists.

SEIGWORTH, G. J. & GREGG, M. (2010) An Inventory of Shimmers. IN GREGG, M. & SEIGWORTH, G. J. (Eds.) *The Affect Theory Reader.* Durham & London, Duke University Press.

SERPELL, L., TREASURE, J., TEASDALE, J. & SULLIVAN, V. (1999) Anorexia Nervosa: Friend or Foe. *International Journal of Eating Disorders,* 25, 177 - 186.

SERRES, M. (2008) *The Five Senses: A Philosophy of Mingled Bodies (I),* London & New York, Continuum.

SESAN, R. (1994) Feminist Inpatient Treatment for Eating Disorders: An Oxymoron? IN FALLON, P. & KATZMAN, M. A. (Eds.) *Feminist Perspectives on Eating Disorders.* New York, Guildford Press.

SHARP, C. W., CLARK, S. A., DUNAN, J. R., BLACKWOOD, D. H. R. & SHAPIRO, C. M. (1994) Clinical Presentation of Anorexia Nervosa in Males: 24 New Cases. *Eating Disorders,* 15, 125 - 134.

SHEARSMITH-FARTHING, K. (2001) The Management of Altered Body Image: A Role for Occupational Therapy. *The British Journal of Occupational Therapy,* 64, 387 - 392.

SHELLEY, R. (1997) *Anorexics on Anorexia,* London, Jessica Kingsley.

SHILLING, C. (2003) *The Body and Social Theory (Second Edition),* London, Thousand Oaks & New Delhi, SAGE.

SHOWALTER, E. (1987) *The Female Malady: Women, Madness and Culture,* London, Virago.

SILVERMAN, D. (2001) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction (Second Edition),* London, Thousand Oaks & New Delhi, SAGE.

SKULTANS, V. (1998) *The Testimony of Lives: Narrative and Memory in Post-Soviet Latvia,* London, Routledge.

SLaM (2006) Guidelines for Assisted Feeding in Patients Displaying Extreme Dietary Restraint. *South London and Maudsley NHS Foundation Trust's Eating Disorders Unit, King's College London.*

SLATER, N. (2005) *The Kitchen Diaries,* London, Fourth Estate.

SMITH, D. (1990) *The Conceptual Practices of Power: A Feminist Sociology of Knowledge,* Boston, Northeastern University Press.

SOJA, E. W. (1996) *Thirdspace: Journeys to Los Angeles and other Real-and-Imagined Places,* Oxford, Blackwell Publishing.

SONTAG, S. (2002) *Illness as Metaphor* and *AIDS and Its Metaphors,* London, Penguin Classics.

SPENCER, M. (2006, August 6th) The Shape We're In: Why Women are to Blame for our Obsession with Being Thin. *The Observer.*

STEWART, K. (1996) *A Space on the Side of the Road: Cultural Poetics in an "Other" America,* Princeton, New Jersey, Princeton University Press.

STEWART, K. (2005) Cultural Poesis: The Generativity of Emergent Things. IN Denzin, N. K., & LINCOLN, Y. S. (Eds.) *The SAGE Handbook of Qualitative Research (Third Edition).* London, Thousand Oaks & New Delhi, SAGE.

STEWART, K. (2007) *Ordinary Affects,* Durham & London, Duke University Press.

STEWART, K. (2010 A) Atmospheric Attunements. *Environment and Planning D: Society and Space,* Advanced Online Publication, Published Online 30 September 2010, 1 – 10.

STEWART, K. (2010 B) Worlding Refrains. IN GREGG, M. & SEIGWORTH, G. J. (Eds.) *The Affect Theory Reader.* Durham & London, Duke University Press.

STRATHERN, A. & LAMBEK, M. (1998) Embodying Sociality: Africanist-Melanesianist Comparisons. IN LAMBEK, M. & STRATHERN, A. (Eds.) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia.* Cambridge, Cambridge University Press.

STRATHERN, M. (2004) *Partial Connections (Updated Edition),* Walnut Creek, Lanham & Oxford, Alta Mira Press, Rowman and Littlefield.

STRAUSS, A. L. (1997) *Mirrors and Masks: The Search for Identity,* New Brunswick, New Jersey, Transaction Publishers.

SZASZ, T. (2010) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (50th Anniversary Edition),* New York, Harper Collins.

TAGG, J. (1988) *The Burden of Representation: Essays on Photographies and Histories,* London, The Macmillan Press.

TAIT, C. (2006, July 8th) I Loved Feeling Hungry. *The Guardian Weekend.*

TAN, J. (2003) The Anorexia Talking? *The Lancet,* 362, (9391): 1246.

TAN, J. (2005) Bridging the Gap between Facts and Values. *World Psychiatry,* 4, **,** 92 - 93.

TAN, J., HOPE, T. & STEWART, A. (2003 A) Anorexia Nervosa and Personal Identity: The Accounts of Patients and their Parents. *International Journal of Law and Psychiatry,* 26**,** 533 - 548.

TAN, J., HOPE, T. & STEWART, A. (2003 B) Competence to Refuse Treatment in Anorexia Nervosa. *International Journal of Law and Psychiatry,* 26**,** 697–707.

TAN, J., HOPE, T., STEWART, A. & FITZPATRICK, R. (2003) Control and Compulsory Treatment in Anorexia Nervosa: The Views of Patients and Parents. *International Journal of Law and Psychiatry,* 26**,** 627 - 645.

TAN, J., STEWART, A., FITZPATRICK, R. & HOPE, R. A. (2006) Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values. *Philosophy, Psychiatry, & Psychology,* 13**,** 267 - 282.

TAN, J., STEWART, A., FITZPATRICK, R. & HOPE, T. (2010) Attitudes of Patients with Anorexia Nervosa to Compulsory Treatment and Coercion. *International Journal of Law and Psychiatry,* 33**,** 13 – 19.

TAN, J., STEWART, A. & HOPE, T. (2009) Decision-Making as a Broader Concept. *Philosophy, Psychiatry, & Psychology,* 16 345 - 349.

TANG, N. (2002) Interviewer and Interviewee Relationships between Women. *Sociology,* 36, 703-721.

TARDE, G. (1999) *Monadologie et Sociologie,* Le Plessis, Institut Synthélabo Pour le Progrès de la Connaissance.

TAUSSIG, M. (1980) Reification and the Consciousness of the Patient. *Social Science and Medicine,* 14B**,** 3 - 13.

TAUSSIG, M. (1993) *Mimesis and Alterity: A Particular History of the Senses,* New York & London, Routledge.

TAYLOR, C. (1989) *Sources of the Self: The Making of the Modern Identity,* Cambridge, Cambridge University Press.

TAYLOR, J. (1998) *Body Horror: Photojournalism, Catastrophe and War,* Manchester, Manchester University Press.

TAYLOR, J. (2007, July 12th) The Rise of DIY Plastic Surgery. *Metro.*

TIERNEY, S. (2006) The Dangers and Draw of Online Communication: Pro-Anorexia Websites and their Implication for Users, Practitioners, and Researchers. *Eating Disorders,* 14, 181 – 190.

TILLER, J., SCHMIDT, U. & TREASURE, J. (1993) Compulsory Treatment for Anorexia Nervosa: Compassion or Coercion? *The British Journal of Psychiatry,* 162**,** 679 - 680.

TREASURE, J. (1997) *Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers,* Hove, East Sussex, Psychology Press.

TREASURE, J. & SCHMIDT, U. (2005) Treatment Overview. IN TREASURE, J., SCHMIDT, U. & VAN FURTH, E. (Eds.) *The Essential Handbook of Eating Disorders.* Chichester, Wiley.

TREASURE, J. & SCHMIDT, U. (2008) Motivational Interviewing in Eating Disorders. IN ARKOWITZ, H., WESTRA, H., MILLER, W. & ROLLNICK, S. (Eds.) *Motivational Interviewing and the Promotion of Mental Health.* New York, Guilford Press.

TREASURE, J., SMITH, G. & CRANE, A. (2007) *Skills-based Learning for Caring for a Loved One with an Eating Disorder: The New Maudsley Method,* London, Routledge.

TREASURE, J. & WARD, A. (1997) A Practical Guide to the Use of Motivational Interviewing in Anorexia Nervosa. *European Eating Disorders Review,* 5, 102 - 114.

TREICHLER, P. A., CARTWRIGHT, L. & PENLEY, C. (1998) Introduction: Paradoxes of Visibility. IN TREICHLER, P. A., CARTWRIGHT, L. & PENLEY, C. (Eds.) *The Visible Woman: Imaging Technologies, Gender, and Science.* New York & London, New York University Press.

TURKLE, S. (1995) *Life on the Screen: Identity in the Age of the Internet,* London, Weidenfeld & Nicolson.

TURNER, B. S. (1992) *Regulating Bodies: Essays in Medical Sociology,* London, Routledge.

TURNER, V. (1967) *The Forest of Symbols: Aspects of Ndembu Ritual,* New York, Cornell University Press.

TUCKER, I. (2010) Everyday Spaces of Mental Distress: the Spatial Habituation of Home. *Environment and Planning D: Society and Space,* 28, 526 - 538.

UCA, E. R. (2004) *Ana's Girls: The Essential Guide to the Underground Eating Disorder Community Online,* Bloomington, Indiana, Author House.

UDOVITCH, M. (2002, September 8th) A Secret Society of the Starving. *The New York Times.*

VAN HOEKEN, D., SEIDELL, J. & HOEK, H. W. (2005) Epidemiology. IN TREASURE, J., SCHMIDT, U. & VAN FURTH, E. (Eds.) *The Essential Handbook of Eating Disorders.* Chichester, Wiley.

VAN LOON, J. (2002) A Contagious Living Fluid: Objectification and Assemblage in the History of Virology. *Theory, Culture & Society,* 19, 107 - 124.

VITOUSEK, K. B. (2005) Alienating patients from the "Anorexic Self": Externalizing and related strategies. *Seventh International Conference on Eating Disorders,* London.

VITOUSEK, K., WATSON, S. & WILSON, G. T. (1998) Enhancing Motivation for Change in Treatment-Resistant Eating Disorders. *Clinical Psychology Review,* 18, 391 - 420.

WALKER BYNUM, C. (1987) *Holy Feast and Holy Fast: The Religious Significance of Food to Medieval Women,* Berkeley & Los Angeles, University of California Press.

WARD, K. (2007) 'I love you to the Bones': Constructing the Anorexic Body in 'Pro-Ana' Message Boards. *Sociological Research Online,* 12**,**
Published at: http://www.socresonline.org.uk/12/2/ward.html.

WARIN, M. (2003) Miasmatic Calories and Saturating Fats: Fear of Contamination in Anorexia. *Culture, Medicine and Psychiatry,* 27**,** 77 - 93.

WARIN, M. (2005) Transformations of Intimacy and Sociality in Anorexia: Bedrooms in Public Institutions. *Body Society,* 11**,** 97 – 113.

WARIN, M. (2006) Reconfiguring Relatedness in Anorexia. *Anthropology and Medicine,* 13**,** 41 - 54.

WARIN, M. (2010) *Abject Relations: Everyday Worlds of Anorexia,* New Brunswick, New Jersey & London, Rutgers University Press.

WASKUL, D. & DOUGLAS, M. (1996) Considering the Electronic Participant: Some Polemical Observations on the Ethics of Online Research. *Information Society,* 12, 129 - 139.

WATSON, C. W. (Ed.) (1999) *Being There: Fieldwork in Anthropology,* London, Pluto Press.

WATTS, J. H. (2008) Emotion, Empathy and Exit: Reflections on Doing Ethnographic Qualitative Research on Sensitive Topics. *Medical Sociology Online,* 3**,** 3 - 14.

WHO (2007) *International Statistical Classification of Diseases and Related Health Problems 10th Revision,* Anorexia Nervosa & Atypical Anorexia Nervosa F50.0 – 50.1, Geneva, World Health Organization.

WILLEMS, D. (1998) Inhaling Drugs and Making Worlds: A Proliferation of Lungs and Asthmas. IN BERG, M. & MOL, A. (Eds.) *Differences in Medicine: Unraveling Practices, Techniques, and Bodies.* Durham & London, Duke University Press.

WILLIAMS, G. (1984) The Genesis of Chronic Illness: Narrative Re-Construction. *Sociology of Health and Illness,* 6**,** 175 - 200.

WILLIAMS, S. J. (2000) Chronic Illness as Biographical Disruption or Biographical Disruption as Chronic Illness? Reflections on a Core Concept. *Sociology of Health and Illness,* 22**,** 40 - 67.

WILLIAMS, M. & MAY, T. (1996) *Introduction to the Philosophy of Social Research,* Oxford & New York, Routledge.

WILLIAMS, P. M., GOODIE, J. & MOTSINGER, C. D. (2008) Treating Eating Disorders in Primary Care. *American Family Physician,* 77**,** 187 - 195.
WILLIAMS, S. & REID, M. (2007) A Grounded Theory Approach to the Phenomenon of Pro-Anorexia. *Addiction Research & Theory,* 15**,** 141 - 152.

WILLIAMS, S. & REID, M. (2009) Understanding the Experience of Ambivalence in Anorexia Nervosa: the Maintainer's Perspective. *Psychology and Health,* iFirst**,** 1 - 17.

WILLIAMS, T. (2000) The Timeless World of a Play. IN GUSSOW, M. & HOLDITCH, K. (Eds.) *Tennessee Williams: Plays 1937 - 1955.* New York, The Library of America.

WILSON, E. (2006, June 29th) The Lovely Bones. *The Guardian.*

WILSON, J. L., PEEBLES, R., HARDY, K. K. & LITT, I. F. (2006) Surfing for Thinness: A Pilot Study of Pro-Eating Disorders Web Site Usage in Adolescents with Eating Disorders. *Pediatrics,* 118, 1635 - 1643.

WILSON, P. (2001) A Policy Analysis of the Expert Patient in the United Kingdom: Self-Care as an Expression of Pastoral Power? *Health and Social Care in the Community*, 9, 134 – 142.

WILSON, S. M. & PETERSON, L. C. (2002) The Anthropology of Online Communities. *Annual Review of Anthropology,* 31**,** 449 - 467.

WOLF, N. (1990) *The Beauty Myth,* Toronto, Vintage Books.

WOODWARD, K. (2008) Hanging Out and Hanging About: Insider/Outsider Research in the Sport of Boxing. *Ethnography,* 9**,** 536 - 561.

WOSTEAR, S. (2006, January 17th) Sick Anorexia Websites. *The Sun.*

YAGER, J. (1995) The Management of Patients with Intractable Eating Disorders. IN BROWNELL, K. D. & FAIRBURN, C. G. (Eds.) *Eating Disorders and Obesity: A Comprehensive Handbook.* New York & London, The Guilford Press.

YATES, R. (2007) *Revolutionary Road,* London, Vintage Books.

YIN LIM, P. & AGNEW, P. (1994) Occupational Therapy with Eating Disorders: A Study on Treatment Approaches. *The British Journal of Occupational Therapy,* 57**,** 309 - 314.

ZOLA, I. K. (1972) Medicine as an Institution of Social Control. *Sociological Review,* 20**,** 487 - 504.